

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555017	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Riverwalk Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 4000 Harrison Street Riverside, CA 92503	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to review and update its facility assessment to accurately reflect the current resident census (official count or survey of a population) and the sufficient staffing levels required to meet residents' needs. This failure resulted in an inaccurate evaluation of the staffing necessary to provide appropriate care and support for the residents. Findings: On December 11, 2025, at 3:42 p.m., a concurrent interview and record review was conducted with the Administrator (ADM). The ADM stated he was responsible for conducting the facility assessment. The ADM stated the last facility assessment was updated on November 11, 2025. During a review of the facility assessment dated [DATE], the ADM stated the facility assessment should reflect the accurate census of the facility and sufficient staffing needs. The ADM stated the general staffing plan of the facility assessment indicated the facility census was between 20-41, requiring an average of two charge nurses and six CNAs per shift. The ADM stated that section of the facility assessment was inaccurate and probably came from another sister facility's assessment. The ADM stated the facility has always had a maximum census of 146. The ADM stated the facility assessment dated [DATE], did not accurately reflect the facility census and sufficient staffing needs of the residents. A review of the facility policy and procedures titled Facility Assessment, revised October 2018, indicated .Once a year, and as needed, a designated team conducts a facility-wide assessment to ensure that the resources are available to meet the specific needs of our residents. The facility assessment also includes a detailed review of the resources available to meet the needs of the resident population. This part of the assessment includes all personnel including regular employees (full and part time). The facility assessment is intended to help our facility plan for and respond to changes in the needs of our resident population and helps to determine budget, staffing, training, equipment and supplies needed.		

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, on four of four residents reviewed for quality of care (Residents 130, 33, 78, and 178), the facility failed to ensure: 1. For Resident 130, the ophthalmologist (eye doctor) consult visits were addressed, care-planned and recorded in the resident's record. In addition, the facility did not address Resident 130's right eye cataract surgery performed on December 5, 2025. This failure had the potential for Resident 130 to experience complications and worsened vision due to a possible delay in treatment to address her vision needs; 2. For Resident 33, the physician's order to restrict 1500 milliliters (ml - unit of measurement) fluid restriction per day, was followed correctly. In addition, the fluid intake and output monitoring due to fluid restriction was not performed. This failure places Resident 33 at risk for complications related to fluid overload (fluid build up in tissues that may lead to rapid weight gain, swelling in arms, legs, and face, shortness of breath, and heart problems); 3. For Resident 78, the Cervical Thoracic Orthosis (CTO- a rigid medical device used to immobilize and support the neck and upper back) brace was applied according to the physician orders. In addition, there was no comprehensive care plan developed or initiated to address the use of CTO. This failure had the potential to prevent Resident 78 from experiencing the needed therapeutic benefits of the CTO brace to improve her condition; and 4. For Resident 178, the facility did not identify, address, and refer to the physician, multiple skin discolorations identified on December 8, 2025. This failure resulted in a delay in treatment and placed Resident 178 at risk for complication. Findings: 1a. On December 8, 2025, at 9:44 a.m., an observation with a concurrent interview was conducted with Resident 130. Resident 130 was observed in lying in bed, alert, and interviewable. Resident 130's right eye was observed with redness, swelling, and with dry, white crusted discharge on the right lower eyelid. In a concurrent interview, Resident 130 stated she had a right cataract surgery performed in December 5, 2025. On December 10, 2025, Resident 130's record was reviewed. Resident 130 was admitted to the facility on [DATE], with diagnoses including diabetes (high blood sugar). The document titled, Progress Notes, dated August 7, 2025, indicated, .Physician History and Physical. The resident has the capacity to understand and make decisions. The document did not indicate Resident 130 had history of eye problem or disease upon admission to the facility. The following ophthalmology consult notes, provided to the facility by the ophthalmology clinic on December 10, 2025, indicated: -On September 22, 2025, .+(positive) for glaucoma (eye condition that progressively damages the optic nerve, which connects eye to the brain, leading to irreversible vision loss and potential blindness) .blurry vision .unable to see far and close .progressively worse symptoms .FINDINGS .Visually significant cataract (clouding of eye's natural lens, making vision blurry, hazy, or less colorful) .OD (right eye) .glaucoma .Proceed with CE (Cataract Extraction - procedure to remove cloudy eye lens and replace it with a clear artificial one to restore clear vision .; -On November 3, 2025, .Pt (patient) is here for pre-op (Preparation before surgery) .Will proceed with surgery OD (right eye) .Pt understand CE may not improve vision . -On September 5, 2025, a report completed by (name of physician) .Operative Report .Preoperative (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Diagnosis: Visually significant cataract, right eye .Postoperative Diagnosis: Visually significant cataract, right eye .Indication for surgery: Patient complained of poor vision. Vision cannot be improved by eyeglasses .Procedure: Cataract Extraction with Phacoemulsification (technique used in cataract surgery to break up a cloudy eye lens) and Primary Intraocular Lens Implant (IOL- artificial lens placed inside the eye during cataract surgery) right eye .Patients eye was dressed with Antibiotic and ointment and eye patch and eye shield . -On September 6, 2025, .Patient is S/P (status post) CE with IOL OD, post op (after surgery) day .Patient c/o (complained of) pain OD .Impression: Pseudophakia (condition where the eye's natural lens has been replaced by an IOL).Plan .Ocuflox (eye antibiotic) and Pred Forte (eye drop medication to treat inflammatory eye condition) increased to every 1 hr (hour) OD and return in three days. There was no documented evidence Resident 130 was assessed or evaluated by the licensed nurses or primary physician prior to referral to the ophthalmologist on September 22, 2025. In addition, there was no documented evidence a care plan was developed or initiated to address Resident 130's glaucoma and right eye cataract after it was identified by the ophthalmologist on September 22, 2025. On December 10, 2025, at 12:45 p.m., an interview was conducted with Case Manager (CM). The CM stated she was responsible for arranging needed appointments for the residents such ophthalmology consults. The CM stated Resident 130 complained of her poor vision and inability to see, so she took it upon herself to arrange the appointments with the ophthalmologist. The CM stated she did not inform the licensed nurses of Resident 130's complains of poor vision prior to arranging the ophthalmology consult visits. The CM stated she guessed she had to communicate Resident 130's poor vision problem prior to arranging the ophthalmology consult visits but she did not. On December 10, 2025, at 2:20 p.m., an interview with a concurrent record review was conducted with Licensed Vocational Nurse (LVN) 3. LVN 3 stated Resident 130 had physician's orders for ophthalmology consults in September 22, November 3, and December 5, 2025. LVN 3 stated there was no documentation the licensed nurses noted in their progress notes the results of the ophthalmology visits and there was no care plan developed to indicate the reason for the ophthalmology consults on these dates. On December 11, 2025, at 9:15 a.m., an interview with a concurrent record review was conducted with the Director of Nursing. The DON stated the following: - She was not aware of any vision problem diagnosis for Resident 130 upon admission to the facility; - Resident 130 did not have a physician evaluation for poor vision complaint prior to the referral of an ophthalmology consult; - The CM should have communicated with the licensed nurses about Resident 130's concern on her vision so the licensed nurses can do the proper evaluation and assessment prior to the referral to the ophthalmologist; - A care plan was not developed to address Resident 130's glaucoma and right eye cataract diagnosis. The DON stated this should have been done in September when the ophthalmologist identified it; - There was no progress notes from the licensed nurses indicating the ophthalmology consult visits (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident 130 was monitored for side effects of the eye antibiotic (Ocuflox) since December 6, 2025. On December 11, 2025, at 9:15 a.m., an interview with a concurrent record review was conducted with the Director of Nursing. The DON stated the following: - There was no progress notes documented by the licensed nurses indicating the result of ophthalmology consult visits performed on the resident in September 22, November 3, and September 5, 2025. The DON stated these should have been done. - When Resident 130 came back from her right eye cataract surgery, the licensed nurses should have conducted an assessment to the right eye and monitored the resident for complications such as redness and swelling, for 72 hours. The DON stated this was not done; - A care plan should have been developed to address Resident 130 right eye post cataract surgery needs; and - There was no documentation Resident 130 was monitored for the adverse effects of the eye antibiotic Ocuflox since started December 6, 2025. The facility's policy and procedure titled, Care Plans, Comprehensive Person Centered, dated December 2016, was reviewed. The policy indicated, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is develops and implemented for each resident .The Interdisciplinary Team, in conjunction with the resident and his/her family or legal representatives, develop and implement a comprehensive, person-centered plan for each resident . The care plan interventions are derived from thorough analysis of the information gathered .The comprehensive, person-centered care plan will .include measurable goals and objectives .Describe the services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental, and psychosocial well-being . Incorporate identified problem areas .Incorporate risk factors associated with identified problems . Reflect the treatment goals, timetables, and objectives in measurable outcomes . Areas of concern that are identified during the assessment will be evaluated before interventions are added to the care plan . Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's condition change . The facility policy and procedure titled, Referrals, Consults, dated December 2008, was reviewed. The policy indicated, .Referrals for medical services must be based on physician evaluation of resident need and related physician order .Social services or designee will collaborate with the nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician .Staff will document the referral in the resident's medical record . 2. On December 8, 2025, in interview with a concurrent record review was conducted with Resident (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Documentation .The following information should be recorded in the resident's medical record .The date and time the procedure was performed .the name and title of the individual who performed the procedure .The amount in (mLs) of fluids consumed by the resident during the shift .The type of liquid consumed (i.e. tea, milk, coffee, soup, etc .) The signature and title of the person recording the data . 3. On December 8, 2025, at 2:57 p.m., Resident 78 was observed in the dining/activity room, sitting in the wheelchair. Resident 78 was observed without the neck support brace. In a concurrent interview with Resident 78, Resident 78 was asked about the neck brace. Resident 78 stated she was uncomfortable with the neck brace on and did not want to have it on. On December 9, 2025, at 10:51 a.m., Resident 78 was observed in the hallway, sitting in the wheelchair with the neck support brace. On December 10, 2025, at 1:53 a.m., Resident 78 was observed in the dining area, sitting in the wheelchair with the neck support brace. On December 10, 2025, Resident 78's record was reviewed. Resident 78 was admitted to the facility on [DATE], with diagnoses which included compression fracture (a break and collapse) T5 to T6 (fifth and sixth thoracic [middle section of the vertebral column, located between the neck and the lower back]) vertebrae (backbone). The history and physical dated October 22, 2025, indicated Resident 78 could make her needs known but could not make medical decisions. The Minimum Date Set (an assessment tool) dated December 1, 2025, indicated a Brief Interview for Mental Status (a cognitive assessment tool) score of 7 (severely impaired). The physician order dated November 28, 2025, indicated, .Cervical Thoracic Orthosis brace (CTO brace) when out of bed. During an interview on December 10, 2025, at 11:54 a.m., with the Restorative Nursing Assistant (RNA), she stated the Physical Therapist (PT) or the RNA will apply the CTO brace on the resident. She stated a Certified Nursing Assistant (CNA) can also apply the CTO brace on a resident. She stated the PT usually demonstrates how to apply the CTO brace. During a concurrent interview and record review on December 11, 2025, with the Physical Therapy Assistant (PTA), he stated Resident 78 was alert, oriented and able to follow simple instructions. He also stated Resident 78 was calm and cooperative. He stated Resident 78 had an order to have the CTO brace on when out of bed. He stated the CTO brace was used for immobilization to prevent twisting, bending and any movement that will prevent healing of Resident 78's spine. The PTA stated the CTO brace was fitted for Resident 78 and easy to apply. He stated PT demonstrated to the CNAs how to apply the CTO brace whenever they get Resident 78 out of bed. The PTA stated he was not sure if all the CNAs were given the instructions on how to apply the CTO brace. On December 11, 2025, at 9:10 a.m., Resident 78 was observed lying in bed. CNA 3 was observed sitting in between bed A and bed B. CNA 4 was observed sitting in between bed B and bed C. In a concurrent interview with CNA 3 and CNA 4, who were assigned as sitters (a person who provides one-on-one supervision, companionship, and assistance for elderly or at-risk residents), CNA 3 stated Resident 78's CTO brace was in the closet. She stated the CNA should apply the CTO brace on (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 78 when out of bed. CNA 3 stated the CNAs received instructions on how to apply the CTO brace. CNA 4 stated there were occasions when Resident 78 refused to put on the CTO brace. CNA 4 stated on December 8, 2025, Resident 78 refused to wear the CTO brace, and she informed PT. CNA 4 stated PT told her Resident 78 should put on the CTO brace when out of bed. During a concurrent interview and record review on December 11, 2025, at 10:01 a.m., with the Director of Nursing (DON), she stated Resident 78 had an order to use CTO brace when out of bed. The DON stated the expectation was for the staff to follow the physician's order. The DON also acknowledged Resident 78 did not have a comprehensive care plan developed to address the use of the CTO brace. She stated comprehensive care plans were utilized to provide patient-centered goals and interventions. The facility policy and procedure titled Physician ORDERS, ACCEPTING TRANSCRIBING, AND IMPLEMENTING (NOTING), dated January 2017, indicated, .Licensed nursing personnel will ensure that written (noting), telephone, and verbal orders will be recorded and implemented . 4. On December 8, 2025, at 10:20 a.m., Resident 178 was observed lying in bed, alert, not able to answer questions. Resident 178 was observed with multiple discolorations (purplish to reddish), with variable sizes, in between the knuckles of the left hand. Resident 178 was not able to answer when asked what happened to his left hand. During an interview on December 12, 2025, at 2:30 p.m., with Treatment Nurse (TN) 1, she stated Resident 178 had an arterial ulcer (a non-healing sore/wound on the legs or feet caused by poor blood flow) on the left calf. She stated Resident 178's arterial ulcer had treatment orders. TN 1 assessed Resident 178 and stated Resident 178 had multiple purplish discolorations on both arms, in-between knuckles of the left hand, both shoulders and on the left calf. TN 1 stated she was not aware of Resident 178's multiple skin discolorations. During an interview on December 12, 2025, at 3:03 p.m., TN 2, she stated she just assessed Resident 178 skin condition. TN 2 confirmed Resident 178 had multiple purplish discolorations on both arms and shoulders, and a large purple discoloration on the left calf. TN 2 stated the multiple skin discolorations should have been identified during showers or during daily care. She stated there was no documentation Resident 178's multiple skin discolorations were identified, assessed, and that the physician was notified. During an interview on December 11, 2025, at 3:20 p.m., with the DON, she stated CNAs utilized a shower sheet when a skin issue was identified. She stated the CNA will give the shower sheet to the treatment nurse who will assess the resident's skin condition and will notify the physician. The DON stated there was no documented evidence that Resident 178's multiple skin discolorations were identified and assessed and reported to the physician. She also stated multiple skin discolorations were considered a change of condition and should have been reported to the physician. The facility policy and procedure titled SKIN INTEGRITY (abrasion/skin tear/surgical wound), revised September 2013, indicated, . The purpose of this procedure is to guide the prevention and treatment of abrasions, discoloration, rashes, skin tears and other skin integrity issues.Staff will inspect skin during care and notify Physician for new skin integrity issue. The facility policy and procedure titled Acute Condition Changes &ndash; Clinical Protocol, revised March 2018, indicated, .Direct care staff, including nursing assistants, will be trained in recognizing (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	subtle but significant changes in the resident (for example, a decrease in food intake, increased agitation, changes in skin color or condition) and how to communicate these changes to the Nurse.		

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a physician conducted the initial visit for four of six residents reviewed, for physician services (Residents 5, 12, 57, and 160). These failures had the potential to result in unidentified medical conditions and/or insufficient provision of medical treatment. Findings: On December 11, 2025, at 3:12 p.m. the following records were reviewed with the Medical Records director (MRD) for physician initial visits:- Resident 5 was admitted to the facility on [DATE]. The document titled, Progress Notes, dated March 12, 2025, indicated the physician history and physical assessment was signed as conducted and completed by Physician Assistant (PA) 1;- Resident 12 was admitted to the facility on [DATE]. The document titled, Progress Notes, dated May 31, 2025, indicated the physician history and physical assessment was signed as conducted and completed by Nurse Practitioner (NP) 2;- Resident 57 was admitted to the facility on [DATE]. The document titled, Progress Notes, dated November 14, 2025, indicated the physician history and physical assessment was signed as conducted and completed by Nurse Practitioner (NP) 1; and- Resident 160 was admitted to the facility on [DATE]. The document titled, Progress Notes, dated October 12, 2025, indicated the physician history and physical assessment was signed as conducted and completed by PA 1. In a concurrent interview, the MRD stated Residents 5, 12, 57, and 160's initial history and physical assessment were not done by their primary physicians. The MRD stated they encourage the primary physicians to do the initial visit (initial history and physical assessment) but she was not sure why it was not done. The MRD stated the primary physicians should conduct the residents' initial history and physical assessment. The facility's policy and procedure titled, Physician Visits, dated April 2013, was reviewed. The policy indicated, .The Attending Physician must make visits in accordance with applicable state and federal regulations. Non-physician practitioners)Physician Assistant, Nurse Practitioners) may perform required visits .as permitted by state and federal regulations .		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented for four out of five residents reviewed for infection control practices (Residents 66, 2, 94, and 57) when: 1.For Resident 66, nursing staff did not clean and disinfect a shared blood pressure (BP) machine with an attached BP Cuff, after use, in accordance with the facility's infection control policy; 2.For Resident 2, a disconnected foley catheter insertion tubing was observed at bedside on the floor readily and available to use;3.For Resident 94, the respiratory tubing was not changed in accordance with the facility's prevention of infection respiratory equipment policy; and4.For Resident 57 the facility did not implement Enhanced Barrier Precaution (EBP - an infection control guideline indicating the use of gowns, gloves, during high-contact resident care activities {e.g. bathing, hygiene care, and wound care} to prevent the spread of multi-drug resistant organisms and other infections) related to foley catheter (flexible tube inserted into the bladder to drain urine) since admitted to the facility in November 11, 2025. These failures had the potential to expose residents to infection and compromise residents' health and safety in the facility.Findings: 1.During a medication administration observation on December 9, 2025 at 8:28 a.m., Licensed Vocational Nurse (LVN) 5 was observed using a shared blood pressure machine with an attached BP Cuff to obtain Resident 66's blood pressure in the resident's room. On December 9, 2025, at 8:40 a.m., LVN 5 was observed returning the used BP machine and cuff to the medication cart drawer without cleaning or disinfecting the equipment. During an interview with LVN 5 on December 9, 2025 at 11:56 a.m., LVN 5 acknowledged the BP machine with cuff was returned to the medication cart drawer without being cleaned or disinfected after use. LVN 5 stated the BP machine is shared equipment and should have been cleaned and disinfected after use with a MicroKill bleach (Environmental Protection Agency, a government agency [EPA]-registered one-step cleaning and disinfectant wipes approved to kill germs on hard, non-porous surfaces) wipes available in the medication cart for infection control. During an interview with LVN 2 on December 11, 2025, at 10:40 a.m., LVN 2 stated BP machine and cuff are shared medical equipment and should be cleaned with disinfectant wipes before and after each use to prevent the transmission of infection. During an interview with the Director of Nursing (DON) on December 11, 3:15 p.m., the DON stated any shared medical equipment including BP machine and cuff should be cleaned with disinfecting wipes before and after use. A review of the facility's policies and procedures, titled Cleaning and Disinfecting of Resident-Care Items and Equipment, dated September 2022, indicated, .Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC (Centers for Disease Control and Prevention - a nationally recognized disease control and prevention organization) recommendations for disinfection and the OSHA (Occupational Safety and Health Administration &ndash; a government agency for workplace safety) Bloodborne Pathogens (disease-causing germs, like viruses or bacteria in human blood and other body fluids that can cause disease in people) Standard.Non-critical items are those that come in contact with intact skin.Non-critical resident-care items include.blood pressure cuffs.Non-critical items require cleaning followed by either low- or intermediate-level disinfection following manufacturers' instructions. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Disinfection is performed with an EPA-registered disinfectant labeled for use in healthcare settings. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). Durable medical equipment (DME) is cleaned and disinfected before reuse by another resident. 2. On December 8, 2025, at 11:26 a.m., Resident 2 was observed seating in his motorized wheelchair, well groomed, alert and interviewable. Resident 2's indwelling foley catheter bag insertion connection (tube inserted into the bladder to drain urine into a 1,000 milliliter bag- ml unit of measurement) was observed at bedside on the floor readily available for use by Resident 2. Resident 2 stated he disconnect himself from the foley catheter bag to the leg foley catheter bag (small wearable urine collection bag) twice daily. Resident 2 stated he only uses the foley catheter bag during the evening time and the leg bag during the day. Resident 2 further stated nursing does not disconnect him from the foley bag to the leg foley bag. On December 8, 2025, at 2:44 p.m., a concurrent observation and interview was conducted with the licensed vocational nurse (LVN 7). LVN 7 stated the foley catheter bag insertion tubing should not be on the floor. A concurrent record review was conducted with LVN 7. LVN 7 stated Resident 2 has not been cared planned for self-care of the foley catheter bag. LVN 7 stated nursing should be disconnecting Resident 2 from the foley catheter bag to the leg foley catheter bag and not Resident 2. On December 9, 2025, Resident 2's medical record was reviewed. Resident 2 was admitted to the facility on [DATE], with diagnoses which included chronic kidney disease (kidneys are damaged and can not filter waste and extra fluid from the blood), immunodeficiency (immune system can not fight infections), and benign prostatic hyperplasia (prostate gland grows larger in a non-cancerous way squeezing the urethra causing urinary problems). The history and physical completed November 13, 2025, indicated Resident 2 had the capacity to make decisions. The physician order dated November 13, 2025, indicated .indwelling urinary (foley) catheter.for obstructive uropathy (blockage in the urinary tract that slows or prevents urine flow). The care plan dated November 12, 2025, indicated .focus.the resident has immunodeficiency due to benign prostatic hyperplasia with lower urinary tract symptoms.intervention.the resident is at risk for contracting infections due to impaired immune status.keep the environment clean and people with infections away. There was no documented evidence of a care plan for Resident 2 to perform self-care for the foley catheter. On December 10, 2025, at 11:30 a.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated the facility process is to care plan for independent resident for their foley catheter care. The DON stated Resident 2 had not been care planned on how to self-detach from the foley bag to the foley leg bag. The DON further stated Resident 2 should not have been disconnecting himself from the foley bag to the leg foley bag nursing should have been disconnecting Resident 2 from the foley catheter bag to the leg foley catheter bag. A review of the facility policy and procedure titled Indwelling Catheter Care, Urinary, revised (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	September 2014, indicated .use standard precautions when handling or manipulating the drainage system.maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag.be sure the catheter tubing and drainage bag are kept off the floor. 3.On December 8, 2025, at 11:11 a.m., Resident 94 was observed upright in bed, well groomed, alert and interviewable with nasal cannula tubing (lightweight flexible plastic tube with two prongs that fit into each nostril to deliver oxygen) connected to an oxygen concentrator (medical device that pulls in air and purifies the air to oxygen). Resident 94 stated she had been using the oxygen concentrator since admission for shortness of breath. The nasal cannula tubing was observed dated November 30, 2025. On December 8, 2025, at 11:17 a.m., a concurrent observation and interview was conducted with LVN 7. LVN 7 stated the facility process is to change respiratory tubing every seven days. LVN 7 further stated Resident 94's nasal cannula tubing should have been changed Sunday, December 7, 2025. Resident 94's medical record was reviewed. Resident 94 was admitted to the facility on [DATE], with diagnoses which included asthma (chronic lung disease), orthopnea (shortness of breath when lying flat), and immunodeficiency (immune system can not fight infections). The history and physical dated November 3, 2025, indicated Resident 94 had decision making capacity. The physician order summary dated December 5, 2025, indicated .oxygen therapy via nasal cannula @ 2-5 liter per minute as necessary for changes in episodes of respiratory distress (difficulty breathing) . The care plan dated November 4, 2025, indicated .focus.the resident has immunodeficiency.intervention.the resident is at risk for contracting infections due to impaired immune status.keep the environment clean and people with infections away. On December 10, 2025, a concurrent interview and record review was conducted with the DON. The DON stated the facility process is to change the respiratory tubing (nasal cannula tubing) weekly every Sunday. The DON further stated Resident 94's respiratory tubing should have been changed Sunday, December 7, 2025. A review of the facility policy and procedures titled Prevention of Infection Respiratory Equipment (equipment used for breathing), revised November 2011, indicated .change pre-filled humidifier when the water level becomes low.change the oxygen cannula and tubing every (7) days, or as needed.keep the oxygen cannula and tubing used prn (as necessary) in a plastic bag when not in use. 4. On December 8, 2025, an observation with a concurrent interview was conducted with Resident 57. Resident 57 was in bed, alert and interviewable. Resident 57 was observed to have a foley catheter with a covered urine drainage bag hanging by the bed and off the floor. In a concurrent interview, Resident 57 stated she had been using the foley catheter since she was admitted to the facility in November 2025. On December 8, 2025, at 9:46 a.m., an observation was conducted outside Resident 57's room. There (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was no EBP set up (gowns, gloves, mask available for staff to use upon entering the resident's room) and EBP sign in place outside Resident 57's room. On December 8, 2025, at 10:38 a.m., a second observation was conducted outside of Resident 57's room. An EBP set up was placed outside of Resident 57's room with a sign posted by the door indicating the instructions, use and purpose of EBP for Resident 57. On December 8, 2025, at 10:38 a.m., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated she was the CNA assigned to Resident 57. CNA 1 stated Resident 57 used a foley catheter and she was not on EBP before. CNA 1 stated they observe EBP on residents with foley catheter to help protect themselves and the residents from the spread on infection. CNA 1 stated the EBP equipment was just recently set up this morning by the Infection Preventionist Nurse (IPN). On December 10, 2025, Resident 57's record was reviewed. Resident 57 was admitted to the facility on [DATE], with diagnoses including obstructive reflux uropathy (condition blocked urine flow, causing backup and potential kidney damage). The physician order dated November 11, 2025, indicated, .Foley catheter 16# 10 cc bulb (foley catheter size) attached to gravity drainage bag.DX (diagnosis) of urinary retention. There is no documented evidence of an EBP physician order and/or care plan related to Resident 57's foley catheter use since her admission on [DATE]. On December 10, 2025, at 9:03 a.m., an interview with a concurrent record review was conducted with the IPN. The IPN stated Resident 57 had a physician's order for foley catheter use and she did not have an EBP order in place since admitted to the facility on [DATE]. The IPN stated residents who were admitted with foley catheters were placed on EBP to protect residents and staff from infection. The IP stated an EBP order related to foley catheter use should have been in place since Resident 57's admission On December 10, 2025, at 11:45 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 57 was admitted with a foley catheter since November 11, 2025. The DON stated Resident 57 should have been placed on EBP then. The DON stated this was missed and the EBP was not implemented until December 8, 2025. The DON stated it was important to put residents with foley catheters on EBP to help protect residents and staff from cross contamination of infection. The facility's policy and procedure titled, Enhanced Barrier Precaution, dated March 2024, was reviewed. The policy indicated, .Enhanced barrier Precautions (EBPs) are utilized to reduce the transmission of multi-drug resistant organisms (MDROs) to residents.Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the transmission of multi-drug resistant organisms (MDROs) to the residents. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities.Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include.dressing.bathing.transferring.providing hygiene.changing linens.changing briefs or assisting with toileting.device care or use.urinary catheter.wound care. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	EBPs are indicated.for residents with wounds and/or indwelling medial devices.indwelling medical devices include.urinary catheters. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at risk.Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE (Personal Protective Equipment such as gowns gloves and mask) required.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light button was functioning properly for one of eight residents reviewed for resident's rights (Resident 188). This failure had the potential for delayed assistance to meet resident needs. Findings: On December 8, 2025, at 11:57 a.m., an observation with a concurrent interview was conducted with Resident 188. Resident 188 was in bed, alert, and interviewable. Resident 188 stated that her call light button hasn't worked since she was admitted last week. She demonstrated by pressing the call light button on to activate the call light, however, the call light signal bulb located outside of Resident 57's door did not turn on. Resident 188 further stated the nurses were aware of her non-functioning call light button and they had to plug and unplug the call light from the wall in order for it to work. Resident 188 stated she had to wait for someone to pass by her door to ask for help, as it was not working. Resident 188 stated she had turned on the call light at one time, but she was unsure if it worked because no one responded. She eventually transferred herself from the bed to the commode unassisted. On December 9, 2025, Resident 188's record was reviewed. Resident 188 was admitted to the facility on [DATE], with diagnoses including absence of right leg below the knee and abnormalities of gait and mobility. The Physician History and Physical, dated December 5, 2025, indicated Resident 1288 had the capacity to understand and make decisions. The Care Plan Report, dated December 3, 2025, indicated, .ADL (Activities of Daily Living - basic self-care tasks like eating, dressing, bathing, using the toilet, and moving around)/Mobility. Resident is at risk for mobility decline and requires assistance related to fluctuating ADLs, pain, recent hospitalization, recent surgery, weakness. Goal. Will have needs anticipated and met by staff. Interventions. Encourage the use of call light for assistance. On December 9, 2025, at 5:40 a.m., Certified Nursing Assistant (CNA) 1 was interviewed. CNA 1 stated Resident 188 was moved to another room. CNA 1 stated that Resident 188's call light often gets unplugged when they move the bed. CNA 1 stated the call light button stops working when unplugged, and CNAs need to plug it back in. On December 9, 2025, at 6:35 a.m., an interview with a concurrent record review, was conducted with the Maintenance Staff (MS). The MS stated a nurse from the morning shift asked him to fix the call light by Resident 188's previous bed because it was not working so he replaced it this morning. In a concurrent record review, the MS stated the staff should report and document in the Maintenance Logbook located at the nurse station if a call light button needed repair. The MS reviewed the maintenance log by the nurse station, and it did not indicate a report on Resident 188's non-functioning call light button from December 3, 2025 to December 9, 2025. The facility's policy and procedure titled, Maintenance Service, dated December 2009, was reviewed. The policy indicated, .Maintenance Service shall be provided to all areas of the building. functions or maintenance personnel include. assuring that call lights. are in good working order.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a written copy of the baseline care plan (documented information indicating the resident's initial goals for stay, summary of current medication, dietary instructions and the services and treatments to be provided or arranged by the facility) was provided to one of eight residents reviewed for Care Planning (Resident 188). This failure resulted in Resident 188 to not fully understand, due to the lack of information, the treatments and services being provided by the facility to meet her needs during her stay. Findings: On December 8, 2025, at 11:57 a.m., an observation with a concurrent interview was conducted with Resident 188. Resident 188 was in bed, alert, and conversant. Resident 188 stated she was admitted to the facility last week after a right below the knee amputation surgery. Resident 188 stated she had no idea about her discharge plan or the plan of care during her stay and she did not even know who to ask about it. Resident 188 further stated she did not receive a written copy of her baseline care plan and did not recall discussing it with facility staff. On December 9, 2025, Resident 188's record was reviewed. Resident 188 was admitted to the facility on [DATE], with diagnoses including absence of right leg below the knee and abnormalities of gait and mobility. The Physician History and Physical, dated December 5, 2025, indicated Resident 188 had the capacity to understand and make decisions. The document titled, Baseline Care Plan Person-Centered Care Planning, completed by a licensed nurse, dated December 3, 2025, indicated, .NURSING SERVICES. Cognition. Alert/cognitively intact. Reason(s) for Nursing Services. ADLS (Activities of Daily Living - basic self-care tasks like eating, dressing, bathing, using the toilet, and moving around). PT (Physical Therapy)/OT (Occupational Therapy) Management. The Section E. Baseline Care Plan Summary, Section did not indicate if the Resident or Resident Representative participated in the Baseline Care plan review with a printed /written summary provided. On December 10, 2025, at 9:23 a.m., an interview with a concurrent record review was conducted with Director of Social Services (DSS). The DSS stated they conducted a baseline care plan discussion with Resident 188 on December 3, 2025, and they did not provide a written copy of the baseline care plan. The DSS stated the facility usually did not give a copy of the baseline care plan to the residents. The facility's policy and procedure titled, .Care Plans-Baseline, dated December 2016, was reviewed. The policy indicated, .A baseline plan of care to meet the resident immediate needs shall be developed for each resident within forty eight (48) hours of admission .The resident and their representative will be provided a summary of the baseline care plan that includes but it not limited to .The initial goals of the resident .A summary of the resident's medications , and dietary instructions .Any services and treatments to be administered by the facility and personnel .acting on behalf of the facility .		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a care plan was initiated and/or developed to address the need and use of indwelling foley catheter ((flexible tube inserted into the bladder to drain urine) for one of two residents reviewed for foley catheter use (Resident 57).This failure has the potential to place Resident 57 at high risk for infection and complications related to foley catheter use. Findings:On December 8, 2025, an observation with a concurrent interview was conducted with Resident 57. Resident 57 was in bed, alert and interviewable. Resident 57 was observed to have a foley catheter with a covered urine drainage bag hanging by the bed and off the floor. In a concurrent interview, Resident 57 stated she had been using the foley catheter since she was admitted to the facility in November 2025.On December 10, 2025, Resident 57's record was reviewed. Resident 57 was admitted to the facility on [DATE], with diagnoses including obstructive reflux uropathy (condition blocked urine flow, causing backup and potential kidney damage).The physician order dated November 11, 2025, indicated, .Foley catheter 16# 10 cc bulb (foley catheter size) attached to gravity drainage bag.DX (diagnosis) of urinary retention.There was no documented evidence a care plan was developed or initiated to address the need and use of a foley catheter for Resident 57 since her admission in November 11, 2025. On December 10, 2025, at 11:45 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 57 did not have a care plan developed to address the use of a foley catheter. The DON stated that the care plan ensures staff and residents were informed about care procedures and interventions to prevent complications from foley catheter use. The DON stated that without a care plan, the staff won't be able to identify potential issues or properly care for the resident. The facility's policy and procedure titled, Care Plans, Comprehensive Person Centered, dated December 2016, was reviewed. The policy indicated, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is develops and implemented for each resident .The Interdisciplinary Team, in conjunction with the resident and his/her family or legal representatives, develop and implement a comprehensive, person-centered plan for each resident .The care plan interventions are derived from thorough analysis of the information gathered .The comprehensive, person-centered care plan will .include measurable goals and objectives .Describe the services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental, and psychosocial well-being .Incorporate identified problem areas .Incorporate risk factors associated with identified problems .Reflect the treatment goals, timetables, and objectives in measurable outcomes .The facility's policy and procedure titled, Indwelling catheter Care, Urinary, dated September 2014, was reviewed. The policy in indicated,.The purpose of this procedure is to prevent catheter- associated urinary tract infections.Review the resident's care plan to assess for any special needs of the resident.		

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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. Based on observation, interview, and record review, the facility failed to ensure medications were administered in accordance with professional standards of practice for one out of five residents (Resident 159) observed during medication administration. The failure to clarify incomplete physician orders, including a Vitamin D3 (supplement) order without a specified dose and a Toprol XL (metoprolol succinate extended release - medication for high blood pressure) order with an inappropriate holding parameter of hold if HR (heart rate) <110, resulted in unsafe medication orders for Resident 159. Findings: During a medication administration observation on December 8, 2025 at 9:21 a.m., Licensed Vocational Nurse (LVN) 2 was observed preparing and administering medications to Resident 159. 1. During a review of Resident 159's clinical record on December 8, 2025, the record indicated a physician order of Vitamin D3 (Cholecalciferol - supplement), give 1 (one) capsule by mouth one time a day every Thu (Thursday) for supplement, dated November 25, 2025. The order did not specify the medication strength. During a review of Resident 159's medical record titled Medication Administration Record (MAR), for the month of November and December 2025, the MAR indicated vitamin D3 was administered to Resident 159 on November 27, 2025 and December 4, 2025, at 9 a.m. During a concurrent interview and record review with LVN 1 on December 8, 2025 at 12:55 p.m., LVN 1 reviewed Resident 159's vitamin D3 order and confirmed the strength was missing. LVN 1 showed a medication bubble card for Resident 159 labeled vitamin D2 (supplement) 1.25 mg (milligram - unit of measurement) (50,000 units - unit of measurement) filled by the pharmacy on November 25, 2025, with directions to take one capsule by mouth one time a day every Monday for supplement and stated this was the only vitamin D medication available in her medication cart. LVN 1 stated the dose for vitamin D3 should have been clarified to determine which strength to administer to the resident every Thursday. During a concurrent interview and record review with the Director of Nursing (DON) on December 11, 2025, at 3:15 p.m., the DON reviewed Resident 159's vitamin D3 order and stated the expectation for nursing staff is to clarify unclear physician orders, including missing medication strength, upon receipt of the order or prior to medication administration. A review of the facility's policy and procedure (P&P) titled, Medication Administrations, dated April 2019, indicated, .The individual administering medication checks the label THREE (3) times to verify right dosage before giving the medication. 2. During a review of Resident 159's clinical record on December 8, 2025, the record indicated a physician order of Toprol XL Oral Tablet Extended Release 24 Hour 100 MG, give 1 (one) tablet by mouth one time a day for HTN (hypertension, high blood pressure), hold if SBP (systolic blood pressure - top number in a blood pressure reading) <110 HR <110, dated November 26, 2025. During a review of Resident 159's medical record titled MAR for December 2025, the MAR indicated the resident's HR was less than 110, and the SBP was greater than 110, and Toprol XL was administered daily to the resident. During a concurrent interview and record review with LVN 1 on December 8, 2025 at 2:42 p.m., LVN 1 reviewed Resident 159's Toprol XL order, acknowledged the resident's heart rate had been less than 110, and confirmed the medication had been administered daily. LVN 1 stated the holding parameter related to heart rate was inappropriate and should have been clarified. During a concurrent interview and record review with the Director of Nursing (DON) on December 10, 2025, at 9:24 a.m., the DON reviewed Resident 159's Toprol XL order and stated the holding parameter of HR <110 was incorrect. The DON stated the expectation for nursing staff is to clarify unclear physician orders, including inappropriate holding parameters, upon receipt of the order or prior to medication administration. During a concurrent interview and record review with LVN 2 on December 11, 2025, at 10:40 a.m., LVN 2 stated physician's medication order is electronically transmitted to the pharmacy, and nursing staff additionally fax the physician's orders to the pharmacy for pharmacy verification. LVN 2 stated if there is a concern with a physician's order, the pharmacy contacts the facility to clarify the order. LVN 2 stated the expectation for nursing staff is to clarify unclear physician's orders. A review of the facility's P&P titled, Medication Administrations, dated (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	April 2019, indicated, .If.a medication has been identified as having potential adverse consequences for the resident.the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns. A review of the facility's P&P titled, Medication Orders, Prescriber Medication Orders, dated August 10, 2023, indicated, .Medications are administered only upon clear, complete, and signed order. Medication orders specify the following.Strength of medication.Dosage.Any dose of order that appears inappropriate considering the resident's age, condition, or diagnosis is verified with the attending physician before processing.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a safe environment and provide adequate supervision to prevent accidents for one resident reviewed (Resident 2) when smoking materials were observed at Resident 2's bedside. This failure had the potential for environmental risk, hazards and accidents including fire and/or burn injuries. Findings: On December 9, 2025, at 5:53 a.m., Resident 2 was observed sitting in his motorized wheelchair, well groomed, alert and interviewable with a red carton of cigarettes between his legs. Resident 2 stated he kept his cigarettes with him at bedside. On December 9, 2025, at 7:50 a.m., Resident 2 was observed in his room and a clear yellow lighter was observed on Resident 2's bedside table. Resident 2 stated he kept his cigarettes and lighter with him at bedside. On December 9, 2025, at 7:55 a.m., a concurrent interview and record review was conducted with the Activity Director (AD). The AD stated the facility process is for the activity department to keep the residents' cigarettes and lighters and distribute the residents' cigarettes and lighter during smoke breaks. The AD stated residents were not allowed to keep smoking materials at bedside. On December 10, 2025, at 11:22 a.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated the facility process was for all smoking material to be kept with the activity department. The DON further stated residents were not to have smoking materials at bedside and Resident 2 should not have had smoking materials at his bedside. Resident 2's medical record was reviewed. Resident 2 was admitted to the facility on [DATE], with diagnoses which included hypertension (high blood pressure), and congestive heart failure (heart can not pump enough oxygen rich blood to meet the body's needs). The history and physical completed November 13, 2025, indicated Resident 2 had the capacity to make decisions. The smoking assessment dated [DATE], indicated Resident 2 denied smoking or use of tobacco products. A review of the facility policy and procedures titled Smoking Policy, revised September 2014, indicated .no lighting materials (e.g., matches, lighters), tobacco products, or smoking devices will be allowed to be kept in the possession of the resident, either on their person or in their room. All smoking materials will be retained by staff.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident received appropriate care to prevent complications of enteral feeding (feeding received directly through a tube in the stomach) when one of five residents (Resident 7) reviewed for tube feeding (TF - nutrition provided through a tube inserted into the stomach) was positioned with the head of the bed (HOB) not elevated 30-45 degrees while receiving tube feeding. This failure had the potential for Resident 7 to experience complications from tube feeding, such as aspiration (food or liquid accidentally enter the lungs), nausea, vomiting, or abdominal pain. Findings: On December 8, 2025, at 12:35 p.m., Resident 7 was observed lying in bed, receiving tube feeding nutrition. Resident 7 was observed awake, and unable to communicate. The tube feeding was infusing, and the HOB was observed flat (not elevated between 30 to 45 degrees). On December 8, 2025, at 12:44 p.m., a concurrent observation and interview was conducted with Certified Nursing Assistant (CNA) 5. CNA 5 was observed entering the room of Resident 7 and elevating the HOB position of Resident 7's bed from flat to approximately 30 degrees. CNA 5 stated the HOB of Resident 7 should have been elevated while he was receiving TF. On December 8, 2025, at 2:32 p.m., a concurrent observation and interview was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated she started the TF on Resident 7 at noon on December 8, 2025. LVN 1 stated the HOB should be elevated 30 degrees when the resident receives TF, per facility practice and nursing practice, to prevent aspiration. LVN 1 stated she did not remember if she elevated the HOB of Resident 7 at 30 degrees when she started him on TF. On December 9, 2025, at 6:57 a.m., in an interview with the Director of Nursing (DON), the DON stated the HOB of Resident 7 should have been elevated 30 to 45 degrees while he was receiving TF. On December 11, 2025, at 9:10 a.m., an interview and concurrent record review was conducted with the DON. The DON stated the policies for tube feeding and administering medications through enteral tube were combined under the name Administering Medications through an Enteral Tube, and there was no specific policy only for tube feeding. On December 11, 2025, at 9:32 a.m., a concurrent observation and interview was conducted with Certified Nursing Assistant (CNA) 6. CNA 6 stated Resident 7 was total care, unable to use the bed controls by himself. CNA 6 stated Resident 7's HOB should be elevated between 30-45 degrees while receiving TF. Resident 7's record was reviewed. Resident 7 was admitted to the facility on [DATE], with diagnoses which included muscle wasting and atrophy (degeneration), dysphagia (difficulty swallowing), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach), pulmonary fibrosis (a lung disease where lung tissue becomes scarred and thickened, resulting in difficulty breathing and shortness of breath), and dementia (a progressive state of decline in mental abilities). Resident 7's physician orders, dated June 20, 2025, indicated, .Keep HOB elevated due to SOB (shortness of breath) when lying flat . Resident 7's physician orders, dated June 20, 2025, indicated, .Enteral feed (TF) order every shift .via GT (gastrostomy tubing)/Enteral Feeding Pump Start Infusion at noon . Resident 7's care plan was reviewed. The care plan, dated December 3, 2025, indicated, .Enteral Medications: Resident requires enteral medications related to swallowing problems .Will minimize risk of complications related to receipt of enteral nutrition such as aspiration, gastric (stomach) distress, nausea/vomiting .HOB elevated to at least 30 degrees . The facility policy titled, Administering Medications through an Enteral Tube,, revised November 2018, indicated .Review the resident's care plan to assess for any special needs of the resident .Assist the resident to semi-Fowler's position (when patient lies on their back with the head of the bed elevated between 30 to 45 degrees) .		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure safe and effective pharmaceutical services were provided to meet the needs of the residents when: 1. For Resident 66, medications were left unattended during medication administration. This failure had the potential for medication misuse, contamination, or access by unauthorized individuals, including residents, staff, or visitors. 2. For Resident 142, as-needed controlled substance (CS - medication with high potential for abuse and addiction) pain medication was not administered according to the physician's order. This failure had the potential to result in inadequate pain management, prolonged pain, and unnecessary discomfort for the residents. 3. For two out of nine randomly selected residents (Resident 4 and 142), documentation on Controlled Drug Record (CDR - medication count sheet, an inventory record used to document the receipt, use, and count of CS) did not reconcile with Medication Administration Record (MAR). These failures resulted in inaccurate accountability of controlled substances, which had the potential for misuse or diversion (medication taken by someone other than for whom it is prescribed) of controlled substances. Findings: 1. During a medication pass observation on December 9, 2025 at 8:28 a.m., Licensed Vocational Nurse (LVN) 5 was observed preparing two medications for Resident 66, including folic acid (supplement) and gabapentin (medication for nerve pain). LVN 5 entered the resident's room with the prepared medications on a medication tray and a blood pressure machine with an attached cuff and placed the medication tray on a bedside table away from the resident's bed. LVN 5 drew the privacy curtain and measured the resident's blood pressure, during which time the medication tray remained outside the curtain and out of the nurse's direct observation. After completing the blood pressure measurement, LVN 5 retrieved the medication tray and administered the medications to the resident. During an interview with LVN 5 on December 9, 2025 at 11:56 a.m., LVN 5 confirmed the prepared medications were left unattended and out of his direct observation while he was checking Resident 66's blood pressure. LVN 5 acknowledged the unattended medications could have been accessed by other residents, visitors, or staff. During an interview with Licensed Vocational Nurse (LVN) 2 on December 11, 2025, at 10:40 a.m., LVN 2 stated the medication tray containing medications should always remain under the nurse's control during medication administration. During an interview with the Director of Nursing (DON) on December 11, 2025 at 3:15 p.m., the DON stated medications should not be left unattended during medication administration. A review of the facility's policy and procedures (P&P) titled, Administering Medications, dated April 2019, indicated, .During administration of medications.no medications are kept on top of the cart.must be clearly visible to the personnel administering medications, and.must be inaccessible to residents or others passing by. 2. During a review of Resident 142's medical record on December 8, 2025, the record indicated a physician order for Oxycodone (controlled substance for pain) 5 mg (milligram - unit of measurement) IR (immediate release) with directions to give 1 tablet by mouth every 4 hours as needed for moderate pain (4-6) and 2 tablets by mouth every 4 hours as needed for severe pain (7-10) for 2 weeks, dated November 21, 2025. During a review of Resident 142's medical record titled, Medication Administration Record (MAR), dated November and December 2025, the MAR indicated on November 22, 2025, the resident's pain level was documented as 8, with an entry time of 3:27 a.m. In addition, the resident's pain level was documented as 7 on December 6, 2025, with an entry time of 1:29 p.m., and on December 8, 2025, with an entry time of 1:20 a.m. For all three dates, nursing staff administered oxycodone 5 mg, one tablet, despite the physician's order indicating two tablets for pain levels 7-10. During a review of Resident 142's medical record titled, Medication Count Sheet (controlled drug record, CDR), for oxycodone 5mg tablet, the documentation on the CDR indicated one tablet was removed on November 22, 2025, at 3:27a.m., and December 6, 2025, at 1:29 p.m., consistent with the documentation on the MAR. However, for the administration on December 8, 2025, at 1:20 a.m., the CDR lacked documentation indicating removal of one tablet, despite the medication being (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented as administered on the MAR. During a concurrent interview and record review with DON on December 10, 2025, at 9:24 a.m., DON reviewed Resident 142's oxycodone order and confirmed the medication was not administered in accordance with physician's order on dates when the resident's pain level was documented as severe. A review of the facility's P&P titled, Administering Medications, dated April 2019, indicated, .Medications are administered in accordance with prescriber orders.The individual administering the medication checks the label THREE (3) times to verify.the right dosage.before giving the medication. 3a. During a review of Resident 142's MAR and the CDR, dated December 2025, the MAR indicated one tablet of oxycodone 5 mg was administered on December 8, 2025, at 1:20 a.m. However, for this administration, the CDR lacked documentation indicating removal of one tablet, despite the medication being documented as administered on the MAR. During a concurrent interview and record review with the DON on December 10, 2025, at 9:24 a.m., the DON confirmed discrepancies between the CDR and the MAR, including missing CDR documentation for administration documented on December 8, 2025 at 1:20 a.m. 3b. During an inspection of Medication Cart 1A with LVN 6 on December 10, 2025 at 2:27 p.m., blister cards containing controlled substance were randomly selected from the medication cart and reviewed to verify accurate documentation of administration and accountability. Resident 4's record was concurrently reviewed with LVN 6. Resident 4 had a physician's order, dated July 15, 2025, for oxycodone-acetaminophen (a controlled substance for pain) 5-325 mg, one tablet by mouth every four hours as needed for severe pain 7-10. Resident 4's oxycodone-acetaminophen 5-325 mg CDR and December 2025 MAR were reviewed. LVN 6 confirmed the Resident 4's CDR the nursing staff removed and signed out one tablet of oxycodone-acetaminophen 5-325 mg on December 3, 2025 at 11:30 pm., but it was not documented as administered on the MAR. During a concurrent interview and record review with LVN 2 on December 11, 2025, at 10:40 a.m., LVN 2 stated the controlled substance administration process requires nursing staff to remove the controlled substance from the medication cart, document the removal on the CDR, and document the administration in the MAR after administration. During a concurrent interview and record review with the DON on December 11, 2025, at 3:15 p.m., the DON confirmed discrepancies between the CDR and the MAR, including missing MAR documentation for oxycodone-acetaminophen 5-325 mg, despite the CDR indicating one tablet was removed on December 3, 2025 at 11:30 pm. A review of the facility's P&P titled, Administering Medications, dated April 2019, indicated, .The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. As required or indicated for a medication, the individual administering medication records in the resident's medical record: the date and time the medication was administered.the signature and title of the person administering the drug.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility had a medication error rate of 11.11% when three medication errors occurred out of 27 opportunities during the medication administration, for two out of five residents observed (Resident 142 and 159). These failures included administration of an incorrect dosage form (aspirin chewable tablet administered for a delayed-release order) and administration of as-needed pain medication without required pain assessment prior to administering medication, resulting in medications not being administered in accordance with physician orders and the facility's policies and procedures, which had the potential to compromise residents' medication therapy and safety. Findings: 1. During a medication administration observation on December 8, 2025 at 8:38 a.m., Licensed Vocational Nurse (LVN) 1 was observed preparing and administering seven medications to Resident 142, including aspirin (used to prevent blood clots) 81 mg (milligram - unit of measurement) chewable tablet. During a review of Resident 142's medical record on December 8, 2025, the record indicated a physician order for Aspirin Low Dose Oral Tablet Delayed Release (designed to release the drug later after ingestion rather than immediately) 81 mg with directions to give 1 tablet by mouth two times a day for CVA (cardiovascular accident - stroke) PPX (prophylaxis - preventive medication given to prevent a disease) for 35 days, dated November 5, 2025. During a concurrent interview and record review with LVN 1 on December 8, 2025 at 12:37 p.m., LVN 1 reviewed Resident 142's aspirin order, and acknowledged aspirin 81 mg, chewable tablet was administered instead of the ordered delayed-release aspirin. LVN 1 stated the delayed-release tablet is released later in the intestine and the delayed-release tablet of aspirin should have been administered to the resident. During a concurrent interview and record review with the Director of Nursing (DON) on December 10, 2025 at 9:24 a.m., the DON reviewed Resident 142's aspirin order and stated the correct dosage form of medication should be administered as ordered by the physician. A review of the facility's policy and procedures (P&P) titled, Administering Medications, dated April 2019, indicated, .Medications are administered in accordance with prescriber orders. The individual administering the medication checks the label THREE (3) times to verify. right dosage. before giving medication. 2. During a medication administration observation on December 8, 2025 at 8:38 a.m., LVN 1 was observed preparing and administering seven medications to Resident 142, including a tablet of oxycodone (narcotic medication to relieve pain) 5 mg, without assessing or asking the resident's pain level prior to administration. A review of Resident 142's medical record indicated a physician order for Oxycodone 5 mg IR (immediate release) with directions to give 1 tablet by mouth every 4 hours as needed for moderate pain (4-6) and 2 tablets by mouth every 4 hours as needed for severe pain (7-10) for 2 weeks, dated November 21, 2025. A review of Resident 142's medical record titled Medication Administration Record (MAR), dated December 2025, indicated the resident's pain level was documented as 6 with an entry time of 9:14 a.m. for the dose administered on December 8, 2025. A review of Resident 142's medical record titled Care Plan Report, dated November 5, 2025, indicated, .assess pain every shift and as indicated. During a concurrent interview and record review with LVN 1 on December 8, 2025 at 12:37 p.m., LVN 1 confirmed she did not ask or assess Resident 142's pain level prior to administering oxycodone. LVN 1 confirmed she documented the resident's pain level as 6 in the MAR and stated the documented pain level was not based on the resident's verbal report. LVN 1 stated the correct pain management process is to assess the resident's pain level and location prior to medication, administer the medication as ordered, and reassess and document the resident's pain level after medication administration. During a concurrent interview and record review with the Director of Nursing (DON) on December 10, 2025 at 9:24 a.m., the DON reviewed Resident 142's oxycodone order and stated the physician order requires nursing staff to assess the resident's pain level to determine the correct dose. The DON acknowledged that without a pain assessment, nursing staff cannot determine whether one or two tablets should be administered, and the medication would not be administered in accordance with the physician's order. 3. During a medication administration (continued on next page)		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observation on December 8, 2025 at 9:21 a.m., LVN 1 was observed preparing and administering eight medications to Resident 159, including a tablet of oxycodone 5 mg, without assessing or asking the resident's pain level prior to administration. A review of Resident 159's medical record indicated a physician order for Oxycodone 5 mg with directions to give 1 tablet by mouth every 6 hours as needed for severe pain (7-10), dated November 25, 2025. A review of Resident 159's Medication Administration Record (MAR), dated December 2025, indicated the pain level was documented as 7 with an entry time of 9:50 a.m. for the dose administered on December 8, 2025. A review of Resident 159's medical record titled Care Plan Report, dated November 12, 2025, indicated, .assess pain every shift and as indicated. During a concurrent interview and record review with LVN 1 on December 8, 2025 at 12:37 p.m., LVN 1 confirmed she did not ask or assess Resident 159's pain level prior to administering oxycodone. LVN 1 confirmed she documented the resident's pain level as 7 in the MAR and stated the documented pain level was not based on the resident's verbal report. LVN 1 stated the correct pain management process is to assess the resident's pain level and location prior to medication, administer the medication as ordered, and reassess and document the resident's pain level after medication administration. During a concurrent interview and record review with LVN 2 on December 11, 2025 at 10:40 a.m., LVN 2 reviewed Resident 142's oxycodone order and Resident 159's oxycodone order and stated the medications should be administered according to the physician's order, and assessing the resident's pain level is required as part of as-needed pain medication order to administer the appropriate pain medication and dose, as ordered by the physician. A review of the facility's P&P titled, Administering Pain Medications, dated April 2025, indicated, .procedure is to provide guidelines for assessing the resident's level of pain prior to administering analgesic pain medication.Pain management is a multidisciplinary process that include the following: identifying signs and symptoms of and assessing existing pain; recognizing situations and conditions with the potential for pain; identifying the underlying causes, intensity, duration, type, and characteristics of pain.implementing approaches to pain management based on accepted standards of practice.Conduct a pain assessment as indicated.Administer pain medications as ordered. A review of the facility's P&P titled, Pain Assessment and Management, dated April 2025, indicated, .procedure to help the staff identify pain in the resident.Ask the resident if he/she is experiencing pain.During the pain assessment, gather the following information, as indicated, from the resident.characteristics of pain, including: location; intensity (as measured on a standardized pain scale); description (e.g., aching, burning, rushing, numbness, etc.); pattern (e.g., constant or intermittent); and frequency, timing, and duration.Monitor the resident by performing a basic assessment with enough detail and as needed, with standardized assessment tools (e.g., approved pain scales, etc.) and relevant criteria for measuring pain management (e.g., target signs and symptoms).		