STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555049	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lodi Nursing & Rehabilitation	1334 S. Ham Lane Lodi, CA 95242

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure safe medication storage in the medication refrigerator located at Nurse Station 1 for a census of 69 residents when:1. The medication refrigerator was observed with extensive frost buildup and temperature outside the facility's required range per policy; and,2. The facility had not implemented a log or tracking system for routine cleaning and defrosting of the medication refrigerator.These failures had the potential to contribute to unsafe medication storage and use, which could affect the health and well-being of vulnerable elderly residents.Findings: 1.During a concurrent observation and interview on 3/3/26, at 8:35 a.m., in the facility's medication room at Nurse Station 1, accompanied by Licensed Nurse (LN) 2, the medication refrigerator used to store insulins, tuberculin tests, eye drops, and the emergency kit was observed with heavy frost buildup on the top section. Further observation indicated the refrigerator temperature was 24 degrees Fahrenheit, which was outside the facility's required temperature range. During the interview, LN 2 acknowledged the findings and stated she was unsure who was responsible for defrosting the refrigerator. LN 2 further stated that the refrigerator temperature should be maintained between 36 and 46 degrees Fahrenheit. LN 2 stated that medications stored in the refrigerator must be kept within a specific temperature range, as improper temperatures could damage the medications and affect their effectiveness. During an interview on 3/4/26, at 1:08 p.m., LN 7 stated that nursing staff were required to check the medication refrigerator located in the medication rooms twice daily, during the morning shift and night shift, to ensure the temperature remains within the acceptable range and to monitor refrigerator cleanliness and the absence of frost buildup. LN 7 further stated that medications stored in the refrigerator include insulins and eye drops, which must be maintained within a specific temperature range. LN 7 stated that temperatures outside of the required range could affect the mechanism of action of the medication and their effectiveness. During a phone interview on 3/05/2026, at 11:09 a.m., the Pharmacy Consultant (PC) stated that his expectation for the facility was that nursing staff check the medication refrigerator temperatures as required by facility policy and ensure the temperature remained within the acceptable range. The PC stated that when temperature was outside of the acceptable range, staff should take corrective action and notify the responsible personnel so the issue can be addressed. The PC further stated that temperature excursions could occur; however, they should be promptly addressed. The PC also stated that nursing staff should monitor the refrigerator for excessive frost buildup and defrost the refrigerator when needed. During an interview on 3/5/26, at 3:45 p.m., the Infection Prevention (IP) Nurse stated that nursing staff were required to check the medication refrigerator temperature during the morning shift and night shift, clean the refrigerator weekly, and visually monitor the refrigerator for frost buildup that might require defrosting. The IP Nurse further stated that tuberculin tests and other medications requiring refrigeration were stored in the medication refrigerator at Nurse Station 1 and might be negatively affected if exposed to temperature below the required range. During an interview on 3/6/26, at 10:23 a.m., the Director of Nursing (DON) stated that medication refrigerator temperature should be (continued on next page)

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	maintained within the proper range, and if it was found to be outside of the required temperature range, it should be addressed immediately. The DON stated there was a risk involved when certain medications that require storage at specific temperatures were not maintained within the required range, as improper storage temperature could affect the effectiveness of the medications. The DON further stated that his expectation was that the medication refrigerator should be always maintained in a clean condition and should be routinely monitored for the frost buildup. The DON explained that excessive frost buildup could affect the internal refrigerator temperature by lowering it, which could potentially impact the medications stored in the refrigerator. 2.During a concurrent observation and interview on 3/3/26, at 8:35 a.m., LN 2 explained that when the temperature was found to be out of range, staff should notify the Director of Maintenance (DOM) immediately, remove the medications from the refrigerator, place them in another refrigerator, defrost and clean the unit, and then return the medications once the appropriate temperature was restored. During an interview on 3/4/26, at 1:08 p.m., LN 7 stated that medication refrigerator should be cleaned and defrosted as needed. LN 7 further stated that she was unaware of any cleaning log that was developed for cleaning/defrosting the medication rooms refrigerators. During an interview on 3/5/26, at 3:45 p.m., the IP Nurse stated that nursing staff were required to check the medication refrigerator temperature during the morning shift and night shift, clean the refrigerator weekly, and visually monitor the refrigerator for frost buildup that might require defrosting. The IP Nurse added that she was not aware of any scheduled log or system in place for routine cleaning or defrosting of the medication refrigerator. During an interview on 3/6/26, at 10:23 a.m., the DON stated that the medication refrigerator should be maintained clean and free of frost buildup, and any frost accumulation should be addressed promptly. The DON further stated that the medication refrigerator was expected to be defrosted on a monthly basis; however, the DON acknowledged that the facility had not implemented a log or tracking system for routine cleaning and defrosting of the medication refrigerator to ensure ongoing monitoring and prevention of frost buildup that could lead to out-of-range temperatures. Review of the facility's policy and procedure (P&P) titled MEDICATION STORAGE IN THE FACILITY, revised in January 2025, indicated, Medications and biological are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Procedures. K. Medications requiring refrigeration or temperatures between 2 C (36 F) and 8 C (46 F) are kept in the refrigerator with a thermometer to allow temperature monitoring. The P&P did not address storage of the vaccine which were sensitive to extreme temperature. The P&P did not address who in the facility was responsible for maintaining and defrosting the refrigerator.

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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, distribute, and serve food in accordance with professional standards for food service safety when:1. Two water pitchers, multiple spoons, spatulas, a blender, two metal baking sheets, and plates were stored wet, 2. A bag of uncooked pasta did not have a use by date; and, 3. A lunch cart did not have a cover, and two lunch plates in the food delivery cart were not fully covered. These failures had the potential of leading to a food-borne illness (an illness that comes from eating contaminated food) for all 69 residents receiving facility prepared meals.Findings:1a. During a concurrent observation and interview on 3/3/26, at 8:28 AM, with the Assistant Dietary Manager (DM), in the kitchen, two water pitchers were observed placed wet on the kitchen shelf next to the hot water dispenser machine. The DM confirmed the two water pitchers were stored wet. The DM stated the two water pitchers should have been dried completely before placing them on the kitchen shelf. The DM further stated bacteria could grow when water pitchers were stored wet.1b. During a concurrent observation and interview on 3/3/26, at 8:32 AM, with the DM, in the kitchen, multiple spoons and spatulas were stored wet in the dry utensil storage drawer, a blender was stored wet in the food preparation counter, two metal baking sheets were stacked wet on top of each other on the dry cooking pan storage area, and plates were stacked wet on the food preparation counter. The DM confirmed the multiple spoons, spatulas, the blender, two metal baking sheets, and plates were stored wet in the kitchen. The DM stated the utensils, blender, baking sheets and plates should have been dried completely before storing them in the food preparation area in the kitchen. The DM further stated bacteria could grow when utensils were stored wet.2.During a concurrent observation and interview on 3/3/26, at 8:49 AM, with the DM, in the kitchen dry food storage area, a bag of uncooked pasta had been removed from its original package and was stored in a clear plastic bag with no used by date. The DM confirmed the bag of uncooked pasta did not indicate a used by date. The DM stated the bag of uncooked pasta should have had a used by date labeled once removed from its original package. The DM further stated the uncooked pasta could have been expired and residents could have gotten sick by eating expired pasta. The DM stated food without expiration dates should not be used.3. During an observation on 3/3/26, at 12:12 PM, with Certified Nursing Assistant (CNA) 4, CNA 4 was observed taking an uncovered lunch food cart from the dining room and left it outside in the hallway outside a resident's room. Two lunch meal plates were further observed to not be fully covered with a plate cover.During a concurrent observation and interview on 3/3/26, at 12:14 PM, with CNA 4, CNA 4 was observed taking plates from the uncovered food cart and was delivering meal trays to residents' rooms. CNA 4 confirmed the food cart did not have a cover and the two lunch meal plates were not fully covered with a plate cover. CNA 4 stated the food carts and meal plates usually were covered when brought outside from the kitchen.During a concurrent observation and interview on 3/3/26, at 12:18 PM, with CNA 5, CNA 5 was observed delivering lunch meal trays from the uncovered food cart to residents' rooms. CNA 5 confirmed the food cart was not covered. CNA 5 stated the food could have cooled off faster and could cause bacteria when food was served from an uncovered food cart.During an interview on 3/3/26, at 12:21 PM, with the Registered Dietitian (RD), the RD stated the food carts and food plates should have been completely covered before they left the dining room. The RD further stated the temperature of the food could drop and go into a danger zone which could lead to bacteria buildup in the food when food was not covered completely. The RD stated bacteria from food could cause residents to get sick from a food borne illness. The RD further stated food temperatures in the danger zone could decrease the freshness of the food.During an interview on 3/3/26, at 12:25 PM, with the Director of Staff Development (DSD), the DSD the stated the food cart should have been be fully covered and insulated to maintain the required food temperature. The DSD further stated to prevent potential food contamination and the food from getting cold; the meal plates and the food cart (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should have been fully covered.During an interview on 3/6/26, at 11:17 AM, with the Administrator (ADM), the ADM stated the dishes in the kitchen should have been dried completely before being stored in the dry dish storage area. The ADM further stated storing dishes when wet could potentially cause infection. The ADM stated food that was stored without an expiration date could be potentially expired food. The ADM further stated using food that was potentially expired could cause food borne illness. The ADM stated to maintain food temperature, the food cart should be insulated and the food plates should have been fully covered before serving food to the residents. The ADM further stated to avoid potential food contamination, the food plates that were not fully covered should have been discarded and the food with fully covered plate covers should have been served to residents.During a review of the facility's (policy and procedure) P&P titled, DISHWASHING, dated 2023, the P&P indicated, .Dishes are to be racked loosely without overlapping.Dishes are to be air dried in racks before stacking and storing.During a review of the facility's P&P titled, STORAGE OF FOOD AND SUPPLIES, dated 2023, the P&P indicated, .All food will be dated-month, day, year.No food will be kept longer than the expiration date on the product. Dry food items which have been opened, such as pudding, gelatin, biscuit mix, pancake mix, dry cereal, spices, coffee, noodles , etc will be tightly closed, labeled and date.During a review of the facility's P&P titled, LABELING AND DATING OF FOODS, dated 2023, the P&P indicated, .All food items in the storeroom, refrigerator, and freezer need to be labeled and dated.Newly opened food items will need to be closed and labeled with an open date and used by the date that follows the various storage guidelines.During a review of the facility's P&P titled, COVERING FOOD DURING TRANSPORT, dated 2023, the P&P indicated, .Food will be delivered from the kitchen to residents in a safe and sanitary manner that does not cause contamination.If tray leaves the dining room and is being delivered to patient rooms, all food on the tray needs to be covered.All hot food will be covered to maintain the proper temperature.The cart should be kept closed to protect the remaining trays.

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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 practice appropriate infection prevention and control measures for a census of 69, when:Resident 86 had perishable food at the bedside that was not consumed or discarded two days after the date,An opened and half-filled single-use skin ointment packet was left on Resident 85's overbed table after being used during incontinent care,Certified Nursing Assistant (CNA) 6 did not wear personal protective equipment (PPE- equipment such as protective clothing, gloves, masks or other garments used to prevent or minimize exposure to hazards) when assisting Resident 93 who was on contact precautions (infection control steps used in a healthcare setting to prevent the spread of germs that are passed by direct contact with a patient or their environment),Resident 1's linens were not changed in a timely manner after blood was left exposed on the bed sheets and blankets,Resident 6's vital signs (measurements of the body's basic functions such as body temperature, blood pressure, hear rate and breathing rate) were obtained with ungloved hands while on enhanced barrier precautions (EBP- an infection control strategy in nursing homes requiring staff to wear gowns and gloves during high-contact resident care, such as bathing, dressing, or device care); and,Resident 76's puncture site (specific spot on the body where a needle or other sharp instrument has entered the skin for medical reasons) was cleaned using the resident's personal tissue after a blood glucose finger stick (a fast method used to check current blood sugar levels by pricking the fingertip with a tiny needle). These failures had the potential to spread infection to staff and other residents in the facility. Findings: 1. During a concurrent observation and interview on 3/3/26, at 11:24 AM, with the Director of Staff Development (DSD) in Resident 86's room, perishable food packed in a foam food container was noted on Resident 86's bedside table with the date 3/1/26 written on it. The DSD stated that per facility policy, perishable food needed to be discarded if it was not consumed by the resident within two hours after the resident received the food from an outside source. The DSD further stated the food had been in Resident 86's room since 3/1/26 for two days and if the resident ingested the food, Resident 86 was at risk for food contamination which could cause nausea, vomiting, and stomach pain. During an interview on 3/5/26, at 3:12 PM, with the Infection Prevention Nurse (IP), the IP stated residents' perishable food that was not stored in the refrigerator needed to be discarded within two hours after it was received. The IP stated food that remained at room temperature for more than two hours could allow bacterial growth that could cause foodborne illness and gastrointestinal (stomach and intestinal) upset due to food spoilage. During an interview on 3/6/26, at 9:45 AM, with the Director of Nursing (DON), the DON stated perishable foods needed be discarded within two hours after the resident received the food from an outside source. The DON further stated if perishable food remained in the room for more than two hours, any resident who could access and ingest the food was at risk for infection from bacterial overgrowth in the food. Review of the facility's policy and procedure (P&P) titled, Use and Storage of Food Brought in by Family or Visitors, revised in 10/2025, indicated, .Perishable foods left at bedside for extended periods .shall be discarded to reduce risk of spoilage. 2. During a concurrent observation and interview on 3/3/25, at 10:55 AM, with Resident 85, in Resident 85's room, Resident 85 was observed lying in her bed with an open, half-filled packet of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	single-use skin guard ointment (a protective ointment used to protect skin from moisture and irritation) on Resident 85's overbed table. Resident 85 stated staff left the skin guard ointment on her overbed table after staff used it during Resident 85s incontinent care (care provided when a resident cannot control bladder or bowel movements). During a concurrent observation and interview on 3/3/25, at 11:12 AM, with Licensed Nurse (LN) 8, in Resident 85's room, Resident 85 was observed lying in her bed with an open, half-filled packet of single-use skin guard ointment on Resident 85's overbed table. LN 8 stated the open half filled skin guard ointment should have been discarded after it was used due to safety concerns. During an interview on 3/5/26, at 3:12 PM, with the IP, the IP stated the skin guard ointment packet was intended for single use and needed to be discarded immediately after use. The IP further stated if staff used the ointment during incontinent care and then placed the packet on the resident's overbed table, which the resident used for eating, it created a risk for food contamination and potential infection for the resident. During an interview on 3/6/26, at 9:45 AM, with the DON, the DON stated the skin guard ointment was used to protect the residents' skin during incontinent care. The DON further stated the ointment packet was intended for single use and staff were expected to discard it immediately after use and not to leave it on surfaces such as the overbed table. The DON stated leaving the used packet on the overbed table was an infection control concern because it could serve as a source of contamination and spread infection. Review of the facility's P&P titled, Infection Prevention & Control Program Policy, revised in 10/2025, indicated, .An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.Important facets of infection prevention include.Educating staff and ensuring that they adhere to proper techniques and procedures. 3. Review of Resident 93's admission RECORD, indicated Resident 93 was admitted to the facility on [DATE] with diagnoses including urinary tract infection, extended-spectrum beta-lactamase (ESBL) resistance (a type of bacteria resistant to many antibiotics), muscle weakness, sepsis (a serious bloodstream infection), pneumonia (lung infection), and anxiety disorder. Review of Resident 93's Order Summary, indicated the physician ordered .Contact Isolation Precautions – Single/Private room every shift for UTI [urinary tract infection] ESBL Provide in-room services until infection resolves .Perform hand hygiene and don [put on] gloves and gown upon room entry. Review of Resident 93's care plan initiated on 3/4/36, in the section titled, Focus, indicated, .[Resident 93] Require isolation precaution due to: ESBL in urine. In the section titled, Interventions, indicated, .Contact Precautions maintained every shift.Observed contact isolation precaution.Inform.staff on indication for isolation. During a concurrent observation and interview on 3/5/26, at 12:13 PM, with CNA 6, in Resident 93's room, a contact precaution sign was posted on Resident 93's room door. CNA 6 was noted inside the room preparing Resident 93 for lunch and positioned the overbed table across Resident 93 while Resident 93 was lying in bed. CNA 6 was observed not wearing the required PPE while inside Resident 93's room, which was under contact precautions. CNA 6 exited Resident 93's room and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated he did not wear PPE and should have worn it before entering the room because Resident 93 was on contact precautions. CNA 6 further stated that without wearing the required PPE in a room under contact precautions, he was at risk of acquiring the infection and transmitting it to others. During an interview on 3/5/26, at 3:12 PM, with the IP, the IP stated Resident 93 was placed on contact precautions due to an active urinary tract infection caused by ESBL producing bacteria, which was highly transmissible (easily spread) and difficult to treat. The IP further stated staff were expected to wear the required PPE every time they entered Resident 93's room to prevent the spread of infection in the facility. During an interview on 3/6/26, at 9:45 AM, with DON, the DON stated staff were expected to wear appropriate PPE when entering the rooms of residents on contact precautions because of the higher risk of transmission of infection. Review of the facility's P&P titled, Isolation – Categories of Transmission-Based Precautions [special infection control measures to prevent the spread of germs], revised in 10/2018, indicated, .Contact Precautions.for residents known or suspected to be infected with microorganisms [germs such as bacteria that can cause infection] that can be transmitted by direct contact with resident or indirect contact with environmental surfaces or resident-care items in the resident's environment.Staff and visitors will wear gloves (clean, non-sterile) when entering the room.Staff and visitors will wear a disposable gown upon entering the room and remove before leaving the room. 4. A review of Resident 1's Order Summary Report, dated 3/4/26, the Order Summary Report, indicated, .Change Foley catheter [a flexible, sterile tube inserted through the urethra into the bladder to continuously drain urine into a collection bag] 16Fr [16 French- size of catheter]/10ml [milliliter- unit of measurement] balloon for increased sedimentation [buildup of solid particles]/dislodged/pulled out/leakage as needed.Order Date 2/6/26 . During a concurrent observation and interview on 3/3/26, at 11:26 AM, with Resident 1, Resident 1's bed sheets and linens were observed. Resident 1 confirmed that there was blood on the linens and sheets. Resident 1 stated that he had blood in his foley catheter and a nurse changed his catheter earlier in the morning, but no one changed his sheets or bed linens. Resident 1 further stated that he did not want to be sitting on bloody or dirty linens in his bed. During a concurrent observation and interview on 3/3/26, at 11:30 AM, with CNA 6, CNA 6 confirmed that there was blood on the linens and sheets and that it needed to be cleaned right away. CNA 6 stated that residents should not have blood on their bed sheets and linens. During an interview on 3/3/26, at 11:35 AM, with the IP, the IP stated the bed sheets and linens for Resident 1 should not have been dirty with blood and needed to be cleaned right away. The IP further stated that this situation presented an infection control issue. During an interview on 3/4/26, at 11:31 AM, with the DON, the DON stated that his expectation was for dirty sheets and linens to be cleaned and bagged properly as soon as possible. The DON further stated that there would be a cross-contamination risk and a possible spread of infection when bloody linens were still in use. During a review of the facility's P&P titled, Catheter Care, Urinary, revised 9/14, the P&P indicated, .Place soiled linen into designated container. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Laundry and Bedding, Soiled, revised 10/18, the P&P indicated, .Soiled laundry/bedding shall be handled, transported and processed according to best practices for infection prevention and control.Laundry that is contaminated with blood or body substances is placed in leak-proof bags or containers. 5. Review of Resident 6's MEDICATION ADMINISTRATION RECORD, (MAR- where nurses document what and when administered ordered medications), indicated an active order for, .ENHANCED BARRIER PRECAUTIONS-Apply enhanced barrier to prevent the spread of infections.every shift-Start Date-11/19/2025 . During an interview on 3/3/26, at 2:51 PM, CNA 2 stated that residents placed on EBP might carry certain bacteria. CNA 2 further stated that staff should take additional precautions and follow the instructions on the EBP signage when providing direct care to those residents. CNA 2 stated PPE should be applied before entering the resident's room when performing direct care to prevent the spread of infection to other residents and protect staff members as well. During a concurrent observation and interview on 3/4/26, at 10:28 AM, with LN 5 during a med pass observation, Resident 6 was noted to be on EBP, with PPE available in the hallway next to the entrance door. LN 5 stated that Resident 6 was on EBP due to a history of methicillin-resistant staphylococcus aureus (MRSA- a type of bacteria responsible for difficult-to-treat infections due to its resistance to many common antibiotics which could spread through direct contact with contaminated surface, or skin-to-skin contact). LN 5 further stated that Resident 6 had scheduled blood pressure medications and that vital signs (VS) were required prior to medication administration. LN 5 performed hand hygiene, gathered equipment including a blood pressure cuff (used to measure blood pressure), stethoscope (used to listen to heart and lung sounds), pulse oximeter (used to measure heart rate and oxygen level), and a thermometer (used to measure body temp). LN 5 then knocked on Resident 6's door and entered the room, introduced herself, identified Resident 6 using name and date of birth and placed the equipment directly on the bed linen on the left side of Resident 6. LN 5 then placed the blood pressure cuff on Resident 6's left arm and adjusted the position of the cuff with ungloved hands. LN 5 obtained the stethoscope from the bed linen, placed it in her ears, checked the blood pressure, and then placed the stethoscope back on Resident 6's bed linen. LN 5 then picked up the pulse oximeter from the bed and placed it on Resident 6's left ring finger to check the oxygen level. Lastly, LN 5 obtained the thermometer from the bed linen and checked Resident 6's temperature. After completing the vital signs, LN 5 reported the results to Resident 6, thanked the resident, gathered the equipment from the bed, and exited the room. Outside the room, after cleaning and sanitizing the equipment LN 5 stated that she should have worn PPE before entering the room and confirmed that she had direct contact with Resident 6's skin with ungloved hands while obtaining vital signs. LN 5 confirmed that she placed all equipment on Resident 6's bed linen without any barrier before using the equipment. LN 5 stated that there was a risk for cross-contamination because PPE was not used and Resident 6's skin was touched with ungloved hands while obtaining vital signs. LN 5 acknowledged that the stethoscope had been placed on Resident 6's bed prior obtaining vital signs. LN 5 stated that this practice could lead to cross-contamination and could potentially affect other residents under her care. Review of Resident 6's care plan for history of infection, MRSA, dated 12/4/24, indicated, .Interventions. Implement ENHANCE BARRIER PRECAUTION. During an interview on 3/5/26, at 3:45 PM, with the IP, the IP stated that staff were expected to follow the instructions posted on the signage for residents on EBP and to wear appropriate PPE prior (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to entering the room when performing direct contact or providing care to residents. The IP further stated that proper use of PPE was required to minimize the risk and prevent the spread of infection, and that without proper PPE there was a high risk for transmission of infection to other residents. The IP explained that staff should follow the instructions on the signage posted outside the room for residents on EBP. During an interview on 3/6/26, at 10:23 AM, with the DON, the DON stated that the expectation for nursing staff was to know the type of isolation required for each resident's infection and to adhere to the proper precaution instructions. The DON further stated that when staff did not wear appropriate PPE, there was a possibility of spreading infection. 6. Review of Resident 76's admission RECORD, indicated Resident 76 was admitted to the facility with diagnoses including type 2 diabetes mellitus (a chronic condition where the body cannot effectively use insulin or produce enough of it, leading to high blood sugar levels), and long-term use of insulin (medicine used to control blood sugar levels). During a concurrent observation and interview on 3/3/26, at 11:36 AM, LN 6 stated that Resident 76 was on blood glucose monitoring due to receiving insulin injections. LN 6 further stated that Resident 76's blood glucose levels needed to be checked prior to mealtime in order to administer insulin as ordered by physician. LN 6 reviewed the MAR, performed hand hygiene, and identified Resident 76 using the resident's name and date of birth . LN 6 explained the procedure to Resident 76, gathered the supplies including a glucometer (device used blood sugar levels), 2 alcohol prep pads, a lancet (small needle), and gloves. After putting on gloves, LN 6 inserted the test strip (a small, disposable plastic strip used with a glucometer to measure blood sugar levels) into the glucometer and entered Resident 76's room. LN 6 cleansed Resident 76's left pointer finger, as preferred by the resident, with an alcohol prep pad and performed the fingerstick using the lancet. LN 6 wiped the initial blood with an alcohol prep pad, obtained a blood drop, placed it on the test strip, and read the blood glucose level. After obtaining the reading, LN 6 grabbed a tissue from Resident 76's bedside tissue box and used it to wipe the blood from the puncture site. LN 6 then wrapped the same tissue around Resident 76's finger and applied pressure for approximately five seconds before removing the tissue. After exiting the room, LN 6 confirmed the observation and stated that wiping and holding pressure on the puncture site with the resident's tissue was not the correct way of performing the procedure. LN 6 stated that alcohol prep pads should be used to cleanse the puncture site and sterile gauze should be used to apply pressure to stop the bleeding. LN 6 further stated that using the resident's tissue on an open puncture site could allow bacteria to enter Resident 76's body through the broken skin. During an interview on 3/5/26, at 3:45 PM, the IP stated that nurses were expected to clean and sanitize the resident's bedside table prior to taking supplies to the resident's room and to use a tray or barrier to place the supplies on. The IP further stated that nurses should perform hand hygiene and put on gloves before performing the procedure. The IP stated the puncture site should be cleansed with an alcohol prep pad prior to using the lancet to perform the fingerstick and the remaining blood at the puncture site should be wiped with another alcohol prep pad or sterile gauze after completing the procedure. The IP further stated that the open puncture site could serve as a point of entry for bacteria. During an interview on 3/6/26, at 10:23 AM, the DON stated that the expectation for nurses was to follow infection control and prevention measures, including cleaning and sanitizing equipment before and after procedure, using barriers to prevent the spread of infection, and using sterile gauze or alcohol prep pads to remove blood from the puncture site during performing blood glucose monitoring. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON further stated that there was a risk for infection when remaining blood on Resident 76's skin puncture site was removed using a tissue taken from the tissue box located at Resident 76's bedside. Review of the facility's P&P titled, Infection Prevention & Control Program Policy, revised on October 2025, indicated, .An infection prevention and control program.is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure one of 23 sampled residents (Resident 19) was treated with dignity and respect when a clothing protector (adult bib) was applied during mealtime against the resident's wishes. This failure violated Resident 19's right to dignity with the potential to negatively impact Resident 19's psychosocial well-being. Findings:During a review of Resident 19's admission record, the record indicated Resident 19's diagnosis included major depressive disorder (a common, serious mental health condition characterized by persistent, intense feelings of sadness, and a loss of interest in activities that severely impacts daily functioning and social isolation) and anxiety disorder (a group of mental health conditions characterized by persistence, excessive, or dread that interferes with daily life).During a concurrent observation and interview on 3/4/26 at 8:15 a.m. with Resident 19 in Resident 19's room, Resident 19 was observed in bed in a sitting position with the meal tray placed on the overbed table. During the interview, Resident 19 stated that she did not want to wear a clothing protector.During a concurrent observation and interview on 3/4/26 at 8:19 a.m. with the Certified Nursing Assistant (CNA) 1, CNA 1 confirmed Resident 19 was wearing a clothing protector during each mealtime to prevent her clothing from getting dirty. CNA 1 stated that if a clothing protector was not available; she would obtain a towel or a cloth napkin from the dining room to place on Resident 19 to protect her clothing from getting dirty. CNA 1 further acknowledged that there was a potential risk that Resident 19 could feel left out or singled out when she was the only resident wearing a clothing protector during meals in the room. During an interview on 3/4/26 at 1:13 p.m. with the Direct of Staff Development (DSD), the DSD stated that residents had the right to make their own decisions. The DSD stated that staff should have provided Resident 19 with the opportunity to maintain dignity and independence. The DSD further stated that staff should not have applied a clothing protector without the resident being asked first, or without the family being consulted first, if appropriate. The DSD stated that applying a clothing protector without the resident's consent does not maintain the resident's dignity.During an interview on 3/4/26 at 2:47 p.m. with the Director of Nursing (DON), the DON stated that residents should have been asked for their preference regarding wearing a clothing protector prior to mealtime. The DON stated that if a resident does not wish to wear a clothing protector, staff should honor the resident's choice. The DON further stated that it should not be standard practice for staff to automatically apply a clothing protector to residents during mealtimes.Review of the facility provided policy and procedure (P&P) titled, Assistance with Meals, revised in 7/17, indicated, . Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. 3. Residents. comfort and dignity, for example. d. Avoiding the use of bibs or clothing protectors instead of napkins, unless requested by the resident.

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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. Based on observation, interview, and record review, the facility failed to accommodate the needs of two of 23 sampled residents (Resident 10 and Resident 83) when,1. Resident 10'a call lights (devices used to contact staff for assistance) was not within their reach. 2. Resident 83's call light was not within reach.This failure placed Resident 10 and Resident 83 at increased risk for unmet care needs, delayed staff response, falls, and potential for accidents or injury.Findings:1.A review of Resident 10's admission RECORD, indicated Resident 10's diagnoses included malignant neoplasm of unspecified site of left female breast (breast cancer), palliative care (care focused on comfort and quality of life), secondary malignant neoplasm of unspecified lung (cancer that spread to the lung, dementia (a condition that affects memory and thinking), metabolic encephalopathy (a condition causing confusion due to a body imbalance or illness), anxiety disorder, and pain.During a concurrent observation and interview on 3/3/26 at 11:41 AM with Resident 10 in Resident 10's room, Resident 10 was sitting in her wheelchair next to her bed and stated she did not know where the call light was and could not use it if she needed to call for help.During a concurrent observation and interview on 3/3/26 at 11:45 AM with the Activity Director (AD) in Resident 10's room, Resident 10 was seated in her wheelchair on the left side of Resident 10's bed while the call light cord was wrapped around the right bed rail. The AD stated Resident 10's call light was not within Resident 10's reach because it was placed on the opposite side of the bed, placing Resident 10 at risk of falls and accidents.A review of Resident 10's fall care plan, initiated on 12/8/25, in the section titled, Focus, indicated, [Resident 10] High risk for falls and injury., in the section titled, Interventions, indicated, .Have things needed by the resident within reach including call light.2.A review of Resident 83's admission RECORD, indicated Resident 83's diagnoses included difficulty in walking, muscle weakness, pain, and other malignant neoplasm of kidney (kidney cancer).During a concurrent observation and interview on 3/4/26 at 8:14 AM with Resident 83 in Resident 83's room, Resident 83 was sitting upright in her bed and attempted to pull out the call light from being stuck between the left bed rail and the bed frame but was unable to remove it. Resident 83 stated the call light had also been stuck during the previous shift and staff had to pull the call light out to free it. Resident 83 further stated she would ask her roommate to press the roommate's call light so she could receive assistance from staff, which could delay staff response.During a concurrent observation and interview on 3/4/26 at 8:28 AM with Certified Nursing Assistant (CNA) 3 in Resident 83's room, Resident 83 was in bed with the call light stuck to the left bedrail. CNA 3 stated that Resident 83's call light was not within Resident 83's reach and this was a safety concern. CNA 3 further stated that if Resident 83 had an emergency, she would not be able to access her call light.A review of Resident 10's fall care plan, in the section titled, Focus, initiated on 1/20/26, indicated, [Resident 83] High risk for falls and injury., in the section titled, Interventions, indicated, .Have things needed by the resident within reach including call light.During an interview on 3/6/26 at 9:45 AM with the Director of Nursing (DON), the DON stated call lights must be within residents' reach and answered promptly by staff. The DON further stated if a resident does not have access to a call light, the resident was at risk for falls and care needs could be delayed. Review of facility's policy and procedure (P&P), titled Call Lights: Accessibility and Timely Response, revised on 10/25, the P&P indicated, .Staff should facilitate call light placement within reach of resident and secure it as needed.Call system should be accessible to Residents while in bed or other sleeping accommodations in room .

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the right to be fully informed of the Bed-Hold (holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization) process for 1of 23 sampled residents (Residents 10) when the facility failed to provide a written Bed-Hold Notice to Resident 10 and her RP when transferred to the hospital on [DATE].This failure placed Residents 10 and her RP at risk for emotional distress (mental or emotional harm) and deprived Resident 10 and her RP of the option and information to keep the resident's bed during hospitalization (bed-hold).Findings:A review of Resident 10's admission RECORD, indicated Resident 10 was admitted to the facility with diagnoses which included breast cancer, lung cancer, and palliative care (care focused on comfort and quality of life), and had a resident representative (RP) listed in the admission record. A review of Resident 10's progress notes, dated 12/1/25, the progress notes indicated .Resident [Resident 10] transferred to [hospital] from PCP [Primary Care Provider] appointment.A review of Resident 10's progress notes, dated 12/8/25, the progress notes indicated, .Resident [Resident 10] arrived to facility via gurney [a wheeled stretcher used to transport patients] .During a concurrent interview and record review on 3/5/26 at 9:40 AM with Licensed Nurse (LN) 8, Resident 10's admission record was reviewed for admission, transfer, and discharge date s; and Resident 10's EHR was reviewed for a written Bed-Hold Notice. LN 8 stated Resident 10's RP had not receive a written Bed-Hold Notice when transferred to the hospital on [DATE].During an interview on 3/6/26 at 9:22 AM with LN 9, LN 9 stated a bed hold must be offered to the resident or RP when a resident was transferred to the hospital and a return to the facility was anticipated. LN 9 further stated failure to explain the bed hold process to the RP could have caused emotional distress if the resident returned to the facility and the expected return bed was not available.During an interview on 3/6/26 at 9:45 AM with the DON, the DON stated when a resident was transferred to the hospital, a written Bed-Hold Notice must be offered to the resident or RP to allow the option to hold the bed for up to seven days during hospitalization and to prevent emotional distress if the resident's bed was no longer available and a different bed was offered upon return to the facility.A review of facility's policy and procedure (P&P) titled, Bed-Holds and Returns revised in 03/17, the P&P indicated .Prior to transfers.residents or resident representative will be informed in writing of the bed-hold and return policy.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on interview, and record review, the facility failed to ensure one of the nursing interventions to prevent the development or worsening of pressure injuries (pressure ulcers) for one of 23 residents (Resident 48) was care planned and communicated to staff when a physician ordered repositioning every two hours for Resident 48 for pressure injury prevention on 2/12/26, and the intervention was not included in the care plan or the Kardex (a quick reference care sheet used by Certified Nursing Assistants [CNAs] to guide daily care).This failure created the potential for unmet pressure injury prevention needs for Resident 48. Findings:Review of Resident 48's admission RECORD indicated Resident 48 was admitted to the facility with diagnoses including primary osteoarthritis of the left shoulder (joint damage that causes pain and stiffness), difficulty walking, muscle weakness generalized, primary osteoarthritis of the right shoulder, contracture of the right ankle (stiffness that limits movement of the joint), pressure ulcer of the left buttock stage II (a skin sore with partial skin loss), major depressive disorder, dizziness and giddiness (feeling lightheaded or unsteady). Review of Resident 48's Weekly Pressure Ulcer Observation Tool dated 2/11/26, indicated that Resident 48 had left buttock pressure injury stage II present on admission.During a concurrent interview and record review on 3/6/26 at 8:40 AM, with Licensed Nurse (LN) 9, Resident 48's physician order was reviewed. Physician order for Resident 48 dated 2/12/26 indicated .Turn and reposition every 2 hours. Utilize wedges and pillows every day shift. LN 9 stated to ensure staff implemented the order for Resident 48 repositioning every 2 hours, it had to be in the care plan. LN 9 stated that nursing utilized the care plan as a reference to provide consistent care and once it was care planned, it would trigger the Kardex for CNAs quick reference guide on what care to provide residents. Resident 48's care plan was reviewed with LN 9, LN 9 stated that repositioning every 2 hours was not in the care plan. LN 9 further stated that if a pressure injury prevention intervention was not in the care plan, the resident was at risk of not receiving repositioning every two hours and the resident's pressure injury had the potential to worsen, or the resident had the potential to develop a new pressure injury.During a concurrent interview and record review on 3/6/26 at 10:32 AM with Certified Nursing Assistant (CNA) 8, CNA 8 stated that if Resident 48 required repositioning every two hours, it was expected for the nurse assigned to Resident 48 to share the information with the CNA providing care to Resident 48. CNA 8 stated that a CNA used the Kardex as a quick reference for resident care. Resident 48's Kardex was reviewed with CNA 8. CNA 8 stated that repositioning every two hours was not in the Kardex, so it was possible Resident 48 was not repositioned every two hours if it was not included in the Kardex.During an interview on 3/6/26 at 10:35 AM with LN 10, LN 10 stated that Resident 48 was bed bound, confused and was at high risk for pressure injury. Review of Resident 48's Documentation Survey Report v2 dated 2/2026 in the section titled MOBILITY: Chair/Bed-to-Chair Transfer indicated that Resident 48 was transferred from bed to chair two times in morning shift and three times in evening shift from 2/11/26 through 2/28/26, which required maximal assistance to dependent assistance. In the section titled MOBILITY: Roll Left and Right indicated Resident 48 required dependent to moderate assistance to perform bed mobility from 2/11/26 through 2/28/26.Review of Resident 48's Minimum Data Set Assessment (MDS - a standardized assessment used to evaluate a resident's health, function, and care needs) dated 2/17/26 in the section titled Section C-Cognitive Patterns indicated Resident 48's BIMS Summary Score (a score used to measure memory and thinking ability) was 7 (indicates severely impaired cognition).Review of Resident 48's N Adv - Braden Scale - for Predicting Pressure Ulcer Risk Evaluation [a tool used to predict a resident's risk of developing pressure injuries] dated 3/5/26 indicated a Braden Score of 16 (indicates Resident 48 was at risk to develop pressure injuries).Review of Resident 48's Weekly Pressure Ulcer Observation Tool dated 2/21/26, indicated that Resident 48 developed a facility acquired pressure injury on 2/21/26 while in the facility on right heel as a suspected deep tissue injury (damage to skin and tissue under the skin caused by pressure).Review of Resident 48's wound provider notes dated 3/2/26, indicated Resident (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	48 had a right heel deep tissue pressure injury.During an interview on 3/6/26 at 10:40 AM with the Director of Nursing (DON), the DON stated if an ordered intervention to reposition a resident every two hours was not provided then the resident was at risk for further skin breakdown. Review of facility's policy and procedure (P&P) titled Pressure Ulcer/Injury Risk Assessment revised in 7/2017, the P&P indicated .Risk factors that increase a resident's susceptibility to develop or not heal PU/PI [pressure ulcer/pressure injury] include.Impaired/decreased mobility and decreased functional ability.Cognitive impairment.Develop the resident-centered care plan and interventions based on the risk factors identified.The interventions must be based on current, recognized standards of care.The effects of the interventions must be evaluated.The care plan must be modified as the resident's condition changes, or if current interventions are deemed inadequate .

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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 interview and record review, the facility failed to ensure safe pharmaceutical services were provided with the accountability of delivered medications based on standards of practice for a resident census of 69 when medication delivery slips and manifests from the pharmacy provider were not consistently signed and dated by licensed staff upon receipt from delivery courier for accuracy and accountability of prescription medication received. This failure had the potential to result in drug diversion (illegal use of drugs), medication error, misuse, unaccounted-for and missing resident medications. Findings: Review of the facility documents titled CONSOLIDATED DELIVERY SHEETS, located in the pharmacy delivery receipt binder at Nurse Station 1, for the period of 2/3/26 to 3/3/26, indicated, . AUTHORIZED SIGNATURES ONLY (stamped signatures & dates are not acceptable). The review further revealed that the documents were incomplete, as they were not consistently signed and dated by licensed nursing staff as required. During a concurrent interview and record review on 3/3/26, at 8:15 a.m., the facility's pharmacy delivery receipt binder located at Nurse Station 1 was reviewed with Licensed Nurse (LN) 3. LN 3 confirmed that pharmacy delivery manifests were not consistently signed and dated as required, and multiple pharmacy delivery manifests dated 2/24/26, multiple manifests dated 2/25/26, and one manifest dated 3/1/26 were found missing the required signatures and dates. LN 3 stated pharmacy deliveries occurred at various times and may be delivered during any shift. LN 3 confirmed that the deliveries included medications such as psychotropic medications (prescription drugs that manage mental health conditions by altering brain chemicals to affect mood, thoughts, and behavior) and antibiotics (medications used to treat infection). LN 3 explained that the pharmacy delivers medications to Nurse Station 1, and upon delivery, the receiving nurse was responsible for verifying that the residents listed on the delivery manifest currently reside in the facility. LN 3 added the nurse who received the medications was required to sign and date each delivery manifest, and a copy of the signed manifest should be maintained in the pharmacy delivery receipt binder located at Nurse Station 1. Nurse 3 stated that the nurse who received and signed for the medications was responsible for distributing the medications to the nurses assigned to the other medication carts. LN 3 further stated that signing and dating the pharmacy delivery manifests served as proof that medications were received. LN 3 stated when the delivery manifests were not signed and dated as required, and the blank copies were placed in the pharmacy delivery receipt binder, the facility could not verify whether the medications were received, misplaced, or not delivered. During an interview on 3/4/26, at 1:08 a.m., LN 7 stated that the pharmacy was delivering medications to the facility during all shifts. LN 7 explained the process for receiving medications upon delivery. LN 7 stated that the nurse stationed at Nurse Station 1 typically received medications. LN 7 added that receiving nurse was responsible for signing and dating the delivery manifest and printing their name on the manifest to acknowledge receipt of the medications. LN 7 further stated that a copy of the signed delivery manifest should be placed in the pharmacy delivery receipt binder located at Nurse Station 1 prior to distributing the medications to other nurses. LN 7 stated when delivery manifests were not signed and dated consistently, there was a possibility that medication could be diverted or lost. During a phone interview on 3/5/26, at 11:09 a.m., the Pharmacy Consultant (PC) stated that upon medication delivery, the receiving nurse should verify the medications listed on the delivery manifest. The PC added that the nurse should also verify whether the residents listed on the manifest were currently residing in the facility, and if a resident was no longer in the facility, the medications should be returned to the delivery driver at the time of delivery. The PC stated that the nurse receiving the medication was responsible for verifying the delivery and signing the delivery manifest to acknowledge receipt. The PC stated that when pharmacy delivery manifests were not consistently signed and dated, there was a potential that medications could be missed. During an interview on 3/6/25, at 10:23 a.m., the Director of Nursing (DON) stated that (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications from the pharmacy provider were primarily received by the night shift nurses. The DON explained that licensed nursing staff were expected to reconcile medications with the medication delivery manifests and sign and date the receipts at the time of delivery. The DON further stated that when pharmacy delivery manifests were not consistently signed and dated, there was a risk that the medications received might not be appropriately reviewed. The DON further added that bubble-packed medications could potentially be broken upon delivery and the damage might not be identified if the delivery manifests were not properly reviewed, signed, and dated at the time of receipt. Review of the facility provided policy and procedure (P&P) titled Pharmacy Services Overview, revised in April 2007 indicated, . The facility shall accurately and safely provide or obtain pharmacy services .Policy Interpretation and Implementation. 3. The facility shall contract with a licensed Pharmacist to help it obtain and maintain . appropriate pharmacy services that support residents' needs, are consistent with current standards of practice, and meet state and federal requirements. This includes, but is not limited to. a. Develop, implement, evaluate, and revise (as necessary) the procedures for the provision of all aspects of pharmacy services (including ordering, delivery and acceptance, storage, distribution. documentation, and reconciliation of all medications. Review of the facility provided P&P titled MEDICATION ORDERING AND RECEIVING FROM PHARMACY, dated April 2008 indicated, . The dispensing pharmacy will transport medication to the facility in a manner that prevents contamination, degradation, and diversion of medications. Procedures. D. Upon arrival at the facility, the courier delivers the medication directly to a licensed nurse. E. The pharmacy provides a method for both parties to confirm delivery.

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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 failed to ensure safe medication administration practices were followed when medication error rate was more than 5% (% or percentage- number or ratio that expressed as a fraction of 100) with the census of 69 residents. Medication administration observations were conducted over multiple days, at varied times, in random locations throughout the facility. The facility had a total of 6 errors out of 26 opportunities which resulted in a facility wide medication error rate of 23.08 % in 1 out of 9 residents (Resident 6) during medication administration observation. These failures had the potential to result in unsafe medication use, medication errors, and noncompliance with the physician's orders.Findings: Review of Resident 6's electronic medical record, titled admission RECORD, dated 3/2026, indicated Resident 6 was admitted to the facility with diagnoses including hypertension (high blood pressure), convulsions or seizure disorder (refers to a temporary, sudden, involuntary muscle contractions), schizophrenia (mental disorder), anxiety disorder, and depression among others.During a concurrent medication administration observation and interview, with Licensed Nurse (LN) 5, at station 2 hallway, on 3/4/26, at 11:09 a.m., LN 5 prepared 12 medications to administer to Resident 6. LN 5 stated she was administering the morning medications as she was running late. The medications included pain medication, seizure medication, mental health drugs in addition to blood pressure and heart medications among others with administration time of 8 AM was being administered at 11AM. Review of Resident 6's electronic medical record, titled MEDICATION ADMINISTRATION RECORD (or MAR, where nurses document what and when administered ordered medications), dated 3/2026, the MAR record indicated six of the 12 medications were time sensitive for administration (medications to be used in a timely manner for safety and effectiveness) as follows: Furosemide Tablet 40 MG; (water pill for heart failure; MG is milligram, a unit of measure); Give 1 tablet by mouth one time a day at 8:00 a.m., order date 2/20/26. Gabapentin Oral Capsule 100 MG (pain medication for nerve pain) . Give1 capsule by mouth three times a day. at 8:00 a.m., 1200, and 4:00 p.m., order date 3/1/25. AmLODIPine Besylate (blood pressure medication) Tablet 5 MG Give 1 tablet by mouth one time a day. at 8:00 a.m., order date 3/2/25. ZyPREXA Oral Tablet 10 MG (or olanzapine, mood and mental health drug) Give 1 tablet by mouth every 12 hours. at 8:00 a.m., and 8:00 p.m., order date12/31/25. Keppra Solution . (or Levetiracetam, drug used to prevent seizure) Give 5 ml (?ml is milliliter, a measure of volume) by mouth two times a day. at 8:00 a.m., and 4:00 p.m., order date 3/1/25; and, QUEtiapine Fumarate Oral Tablet 50 MG (Quetiapine; mental health and mood control drug) Give 2 tablet by mouth every morning and at bedtime. at 8:00 a.m., and 8:00 p.m., order date 12/28/25.These ordered medications were not administered to Resident 6 at the prescribed time of 8 AM. The morning medications were due at 8 AM but were administered more than three hours past the scheduled time after 11 AM. During an interview on 3/4/26, at 1:00 p.m., Licensed Nurse (LN) 5 confirmed that medications for Resident 6 were prescribed to be given at 8:00 a.m. LN 5 further confirmed that Resident 6's medications were administered more than three hours after the scheduled time. LN 5 stated an acceptable administration window for medications was one hour before and up to one hour after the scheduled time. LN 5 stated medications scheduled for 8:00 am should have been administered between 7:00 a.m. and 9:00 a.m. LN 5 further stated that failure to administer medications within the designated time window could negatively affect Resident 6's health condition such as Resident 6's blood pressure could spike if the medication was not given within the appropriate timeframe. During an interview on 3/4/26, at 1:08 p.m., LN 7 stated medications should be administered at the prescribed time to prevent adverse reactions and maintain the residents' health condition. LN 7 further stated that when a resident was prescribed blood pressure medication and it was administered later than the acceptable timeframe, the resident might experience elevated blood pressure. LN 7 stated if anti-seizure medications were administered late, it might lead to seizure activity that could negatively affect the residents' health condition. During a phone interview on 3/5/26, at 11:09 a.m., the (continued on next page)

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	555049	A. Building B. Wing	03/06/2026

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pharmacy Consultant (PC) stated that his expectation for nurses was to administer medications within the established time window, which was 30 minutes before up to 30 minutes after the scheduled administration time as directed and documented in the electronic health record system. During an interview on 3/6/26, at 10:23 a.m., the Director of Nursing (DON) stated that his expectation for nurses during medication administration was to follow the five rights, which include the right patient, right medication, right dose, right route, and right time. The DON stated that if a medication administration delayed or administered outside the acceptable timeframe, he expected the nurse to notify the physician. The DON further explained that the physician was responsible for adjusting or changing the medication administration time if necessary. The DON further stated that there was a potential risk for adverse effects when medications were not administered as scheduled. Review of the facility's policy, titled PREPARATION AND GENERAL GUIDELINES. MEDICATION ADMINISTRATION-GENERALGUIDELINES, dated October 2017, indicated, . B. Administration. 2) Medications are administered in accordance with written orders of the attending physician. 10) Medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after) .

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure interventions were implemented to maintain and prevent decline in functional ability (the resident's ability to move and perform daily activities) for one of 23 sampled residents (Resident 31) when Resident 31's physical therapy (PT: a healthcare specialty service focused on improving movement, reducing pain, and restoring physical function through tailored exercises, manual techniques, and education) was discontinued despite a physician's order to extend physical therapy and without a plan to maintain or prevent decline in functional abilities through restorative nursing assistant (RNA - a program where trained staff help residents practice exercises and daily activities to maintain strength and mobility) services.This failure placed Resident 31 at risk for functional decline and complications related to decreased mobility such as muscle atrophy (muscle becomes smaller and weaker from lack of use), pressure injuries, contractures (permanent tightening of muscles or joints), and range of motion (ROM) limitations.Findings:Review of Resident 31's admission RECORD indicated Resident 31 was admitted to the facility in 12/2025 with diagnoses including fracture of lower end of left femur (broken lower part of the left thigh bone), periprosthetic fracture around internal prosthetic left hip joint (break in the bone around an artificial hip joint), difficulty in walking, muscle weakness, acute kidney failure, major depressive disorder, disorders of bone density and structure, neuralgia and neuritis (nerve pain and nerve inflammation), pain, personal history of transient ischemic attack and cerebral infarction without residual deficits (previous mini-stroke and stroke without lasting effects), history of falling.Review of Resident 31's Physical Therapy PT Evaluation & Plan of Treatment dated 12/4/25, in the section titled Assessment Summary indicated, .Patient [Resident 31] present to P.T.[Physical Therapy] during evaluation with decline in overall mobility requiring assistance due to recent acute hospitalization with deconditioning, pain, gen [generalized] weakness and decreased activity tolerance.Patient requires skilled PT services to minimize falls, increase LE ROM [lower extremities range of motion] and strength.increase functional activity tolerance.Patient goals .[Resident 31] I want to get better, stronger and return home safely.Potential for Achieving Goals .Patient demonstrates good rehab potential as evidenced by recent onset, good cognition.active participation.Review of Resident 31's Physical Therapy Discharge Summary dated 2/19/26, in the section titled, STG [Short-Term Goals] #5.0 - Discontinue on 2/19/26 indicated, .[Resident 31] Not medically safe, will need significant help at home.In the section titled Discharge Status and Recommendations indicated, .Patient [Resident 31] discharged to live with family/friends .Discharge Recommendation: HHPT [Home Health Physical Therapist], w/c [wheelchair] . During a concurrent observation and interview on 3/3/25 at 3:43 PM, with Resident 31 in Resident 31's room, Resident 31 was sitting in her wheelchair next to her bed. Resident 31 stated she had a fracture of her left leg, was unable to walk, and was admitted to the facility for physical therapy. Resident 31 stated physical therapy services were discontinued a couple of weeks ago and she was not doing any exercises because no one was assisting her and she was just sitting in her wheelchair and hoping to walk again.During a concurrent interview and record review on 3/4/26 at 4:54 PM, with the Director of Rehabilitation (DOR), review of Resident 31's physician order dated 1/30/26, indicated, Skilled PT services to be extended qd [every day] 5x/wk [five times per week] for 8 wks [eight weeks] for difficulty in walking, tx [treatment] may include therapeutic exercise, therapeutic activity, neuro re-education [training to improve movement and balance], gait training , w/c mgt [wheelchair management], group therapy, patient education, and caregiver training. The DOR stated the physician's order to extend the PT services for 8 weeks for Resident 31 was not followed. The DOR verified Resident 31 did not receive PT services for 8 weeks as physician ordered to extend on 1/30/26. The DOR stated the Discharge summary dated [DATE], indicated Resident 31 was discharged home, which was incorrect because Resident 31 remained in the facility and could have (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been transitioned to the RNA program. The DOR stated Resident 31 was at risk for functional decline and complications related to decreased mobility such as muscle atrophy, pressure injuries, contractures, and ROM limitations when did not receive PT services as ordered or was not enrolled in RNA program.During an interview on 3/5/26 at 10:57 AM, with the Restorative Nursing Assistant (RNA) 1, RNA 1 stated Resident 31 was not enrolled in the RNA program and was not receiving restorative nursing services.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview, and record review, the facility's Quality Assurance Committee (a mandatory, internal group within a nursing home or skilled nursing facility. Its purpose is to identify, monitor, and improve the quality of care and life for residents, as required by federal law for facilities receiving Medicare or Medicaid funding) failed to meet quarterly with all required members, when the Administrator (ADM) and the Medical Director (MD) did not attend the scheduled quarterly meetings as required.This failure decreased the facility's potential to identify, monitor, implement and enhance the quality of care for residents for a census of 69.Findings:During a concurrent interview and record review on 3/6/26, at 11:17 AM, with the Director of Nursing (DON) and the ADM, the Quality Assurance and Performance Improvement (QAPI- a data-driven, proactive approach mandated by the Centers for Medicare & Medicaid Services [CMS] for healthcare facilities to continuously monitor, analyze, and improve the quality of care and services) binder was reviewed. The ADM confirmed that the previous ADM did not attend the quarter 3 meeting on 11/7/25. The ADM further confirmed that the MD did not attend any of the scheduled quarterly meetings conducted on 4/10/25 (Quarter 1), 7/28/25 (Quarter 2), or 11/7/25 (Quarter 3).During an interview on 3/6/26, at 11:52 AM, with the DON, the DON stated that it was important for the MD to attend the quarterly QAPI meetings so that the MD would be able to give his medical input for the safety and quality of care for the residents residing in the facility. The DON further stated that the MD would be able to discuss the trends that were occurring in the facility to improve resident outcomes. The DON stated the QAPI committee would not be able to work collaboratively and develop plans for improvement if the MD did not attend. The DON explained that the ADM played a vital role in conducting the quarterly QAPI meetings and following through to make sure the meetings occurred. The DON stated the ADM and the MD should have attended all the regularly scheduled QAPI meetings.During an interview on 3/6/26, at 11:58 AM, with the ADM, the ADM stated that it was important for the MD to attend the scheduled QAPI meetings so he could share his perspective on potential issues that may be occurring so the staff would be able to improve and correct themselves. The ADM further stated that the MD needed to be aware of and understand the current quality of care that was being provided at the facility. The ADM explained that the ADM needed to attend the QAPI meetings to ensure team collaboration was occurring and to discuss resident outcomes. The ADM stated that it was his expectation for all required committee members including the MD and the ADM to attend the QAPI meetings.During a review of the facility's policy and procedure (P&P) titled, Quality Assurance and Performance Improvement (QAPI) Committee, dated 7/16, the P&P indicated, .This facility shall establish and maintain a Quality Assurance and Performance Improvement (QAPI) Committee that oversees the implementation of the QAPI Program.The following individuals will serve on the committee.Administrator.Medical Director.The committee will meet at Minimum Quarterly at an appointed time.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a functioning call light system (system/device used by residents to call staff for assistance) was in place for 2 of 23 sampled residents (Resident 61 and Resident 62) when Resident 61 and Resident 62's call light was not working.This failure had the potential to result in Resident 61 and Resident 62 being unable to call staff for help when needed and their needs not being met.Findings:1a. A review of Resident 61's admission RECORD, indicated Resident 61 was admitted to the facility in the spring of 2025 with diagnoses including difficulty in walking, muscle weakness, and acute respiratory failure with hypoxia (a condition where there is not enough oxygen or too much carbon dioxide in the body).A review of Resident 61's clinical record titled, Care Plan Report, dated [DATE], indicated .Focus: Altered bladder elimination due to incontinence related to: Mobility deficit .The interventions include: Answer light promptly.Focus: High risk for falls and injury related to Attempting to get out of bed unassisted, Bladder Incontinence, Limitation of mobility.The interventions include: Have things needed by the resident within reach including call light and other common personal items.During a concurrent observation and interview on [DATE], at 2:18 PM, with Resident 61, Resident 61 pressed his call light and the light turned on for approximately two seconds before turning off automatically. Resident 61 stated the call light system had been functioning this way for a long time and that it was annoying having to use the call bell that was provided as the Certified Nursing Assistants (CNA) could not hear it or would state they were helping someone else. Resident 61 further stated that he wanted a proper call light system to use as opposed to a call bell. Resident 61 stated he used the call bell, and it was heard faintly in the next room. Resident 61's room was located at the very end of the hall away from the nurse's station.During an interview on [DATE], at 2:28 PM, with CNA 7, CNA 7 stated the call light system for Resident 61's room had not been functioning properly for quite a while.During an interview on [DATE], at 2:37 PM, with the Director of Staff Development (DSD), the DSD stated the call light system should function properly so that staff could notice if a resident needed assistance. The DSD further stated his expectation was for the call light system to function as normally as possible. The DSD stated that alternative methods like the call bell should work properly and not be faint in sound. The DSD explained that alternative methods offered to residents should be effective as well.During an interview on [DATE], at 2:47 PM, with the Director of Nursing (DON), the DON stated the call light system should be audible to raise the awareness of the staff to assist the residents in need. The DON further stated that if the call light system was down, an alternative means provided to residents should have been effective and working properly.1b. A review of Resident 62's admission RECORD, indicated Resident 62 was admitted to the facility in the summer of 2025 with diagnoses including difficulty in walking, muscle weakness, chronic pulmonary embolism (occurs when blood clots in the lungs do not dissolve, causing persistent blockage, and scarring), and thrombosis of unspecified deep veins of the right lower extremity (a serious medical condition involving a blood clot in the deep veins of the right leg, excluding specific named veins like the femoral or popliteal. It often presents with pain, swelling, redness, or warmth in the calf or thigh).A review of Resident 62's clinical record titled, Care Plan Report, dated [DATE], indicated .Focus: Mobility deficit.The interventions include: Keep call light within reach.Answer light promptly.Focus: Altered bladder elimination due to incontinence related to: Mobility deficit.The interventions include: Keep call light within reach.Answer light promptly.During a concurrent observation and interview on [DATE], at 3:03 PM, with Resident 62, Resident 62 pressed the call light and it did not turn on. No call bell or whistle was noted to be in the room as an alternative method of staff notification. Resident 62 stated she had to yell out and scream for staff to come and assist her.During an interview on [DATE], at 4:02 PM, with CNA 2, CNA 2 stated Resident 62 would get mad if the call light was not answered in a timely manner, especially when she needed to go to the restroom. CNA 2 further stated that if the call light system was not working, the (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents' mood would be affected as their needs were not met on time.During an interview on [DATE], at 8:51, with the Director of Maintenance (DOM), the DOM stated that there was a visual screening system, but not an auditory alert system at each nurses' station. The DOM further stated that if the call light system was not operating as intended, there could be a delay in the care for the residents.During a review of the facility's policy and procedure (P&P) titled, Call Lights: Accessibility and Timely Response, revised 10/25, the P&P indicated, .Call lights will directly relay to a staff member or centralized location to facilitate appropriate response.Call system should be accessible to Residents while in bed or other sleeping accommodations in room.Staff should report problems with a call light or call system immediately to their supervisor and/or maintenance director and provide alternative solutions until problem can be remedied.