STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555153	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Oaks Healthcare Center	11300 Fair Oaks Boulevard Fair Oaks, CA 95628

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to promptly act upon identified concern and request for a room change for one of 34 sampled residents (Resident 151), when the facility failed to honor and address Resident 151's power of attorney (POA, a person designated to make decisions) request to transfer Resident 151 to a different room.This failure had the potential to contribute to Resident 151's inability to rest and sleep and had the potential to affect Resident 151's emotional well-being and quality of life.A review of the admission record indicated the facility admitted Resident 151 in January of 2026 with multiple diagnoses which included Alzheimer's disease (an irreversible, progressive brain disorder that slowly destroys memory and thinking skills and the ability to carry out the simplest tasks) and traumatic brain bleed.A review of Resident 151's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 1/11/26, indicated the resident had severely impaired cognition (the ability to think and process information).A review of the care plan initiated 1/15/26 indicated that Resident 151 had a communication problem. The interventions included, Anticipate and meet needs.Monitor for physical/nonverbal indicators of discomfort or distress.Discuss with.family concerns or feelings regarding communication difficulty.A review of psychosocial care plan dated 1/15/26, the care plan indicated that Resident 151 had a psychosocial well-being problem related to facility placement. The care plan goal indicated, The resident will have no indicators of psychosocial well-being problem. One of the interventions directed facility to provide opportunities for the resident's family to participate in Resident 151's care.During an observation on 2/10/26 at 8:50 a.m., a loud yelling was coming from Resident 151's room. Several of the nursing staff ran toward the noise and identified Resident 151's roommate Resident 131 as the one who was yelling toward Resident 151, who was her roommate. After a moment, Resident 151 was observed leaving her room and walking in the hallway toward nursing station.During an interview with Resident 151's Responsible Party (RP) on 2/11/26 at 1:15 p.m., the RP stated that his wife, Resident 151 was moved to her current room less than 2 weeks ago. The RP stated that Social Services Director (SSD) called him prior the move and warned. that the roommate [Resident 131] had some issues with previous roommate, but.assured that [Resident 151's name] safety will not be affected by this move. The RP continued, Problems started immediately. As soon as [Resident 131) sees anyone entering her room, she starts screaming, as loud as she can. The RP explained that one day his wife's roommate was yelling at Resident 151 to get out of here non-stop, for over 30 minutes. The RP stated, When [Resident 131] is in room, [Resident 151's name] is afraid and when I encourage her to go to her room and lay down, she says no and starts crying. She is unable to tell me what is bothering her, but I can see that she is afraid of her roommate.During a continued interview with Resident 151's RP on 2/11/26 at 1:15 p.m., the RP stated since Resident 151 was moved to this room, she had been walking all day non-stop, unable to rest and sleep at night. The RP stated he spoke a few times with SSD and other staff about moving his wife to a different room, explained what was going on with her roommate, and all he was told there was no available room to move his wife. The RP stated the situation was very frustrating for him and his wife. The RP added, This is affecting her health - she is (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not able to rest, her ankles are swollen and huge because she's walking all the time and unable to lay down and rest.At night they put [Resident 151's name] to sleep on the couch is common room and then in the middle of the night move her to her bed when the roommate falls asleep.but as soon as [roommate's name] wakes up, she starts yelling again and my wife gets scared of her and leaves. The RP stated, I have been asking them for almost 2 weeks to move [Resident 151's name] to another room and nothing is done. Nobody cares.They do not care about patients or their rights.A review of nursing progress note (NPN) dated 2/6/26 at 11:28 p.m., indicated, Husband [Resident 151's RP name] expressed concerns about the resident current room and roommate and requested that the resident be transferred to another room.Stated.Resident [151] cannot get adequate rest. The NPN indicated that Resident 151's RP did not like the roommates telling the resident [Resident 151] to get out of the room. The NPN indicated the Director of Nursing (DON) and Social Services were notified of the issue and the RP's request.During an interview on 2/12/26 at 9:20 a.m., with DON and Regional Consultant (RC 1), the DON stated that the facility was aware of Resident 131's behaviors and added, [Resident 131's name] had always had issues with her roommates.Her previous roommate was moved out of that room due to her daughter's complaints. The DON validated that she was aware that Resident 151's roommate (Resident 131) was verbally aggressive to Resident 151, was aware that staff placed Resident 151 to sleep on couch in day room and was aware about RP's request to transfer his wife to a different room. The DON stated the facility had plans to transfer Resident 151 to a different room but have not done the transfer yet.During an interview on 2/12/2026 at 10:40 a.m., with SSD, the SSD stated she was made aware of Resident 131's yelling behavior toward Resident 151. The SSD confirmed that RP requested a room change for Resident 151 last week and the facility was still working on it. The SSD stated she informed Resident 151's RP that Resident 151 will be moved to a different room when the facility will have available bed.A review of the facility's policy and procedure (P & P) titled, Resident Rights, dated 2/2021, indicated, Federal and State laws guarantee certain basic rights to all residents of this facility. There rights include.voice grievances to the facility.have the facility respond to his or her grievances. A review of the facility's P & P titled Grievances/Complaints, Filing revised on 4/2017, indicated residents and their representatives have the right to file grievances, either orally or in writing to the facility staff. The policy indicated, The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure proper storage of medications when:Household and personal items were stored in medication carts and non-cleanable equipment used for multiple residents was kept with medications;Facility staff did not monitor refrigerator temperatures for staff vaccines twice daily; and,Medications were left in Resident 57's room.These deficient practices had potential for improperly stored and inadequately monitored medications, which could lead to unsafe and ineffective medication use for residents and staff. Thus, increasing the risk of contamination and infection for residents. 1. During a concurrent observation and interview on 2/13/26 at 9:16 a.m., with Licensed nurse 4 (LN 4) in the nursing station in [NAME] Wing (B Wing), a mouth guard used by residents was observed stored inside the medication cart 2. LN 4 stated mouth guards were always stored in the medication cart so they don't get lost. When asked if storing resident mouth guards in the medication cart could spread infection between residents, LN 4 stated she did not know. LN 4's personal purse was also observed stored inside the medication cart. During an observation and interview on 2/13/26 at 1:37 p.m., with LN 3 in A Wing, cigarettes belonging to a resident were observed stored inside the medication cart 1. LN 3 stated there was no other place to store the cigarettes and reported that cigarettes had been kept in the medication cart for as long as she had worked at the facility. A non-cleanable cloth blood pressure cuff (absorbable material) with a nurse's name on it was also stored in the medication cart 1 and used on residents. When asked how the cloth blood pressure cuff was cleaned between residents, LN 3 stated she would wipe it with sanitation wipes. When asked if wiping a cloth (absorbent) blood pressure cuff would make it cleanable, LN 3 stated she did not know. During a concurrent observation and interview on 2/13/26 at 1:57 p.m., with the Infection Preventionist (IP) in A Wing, the IP confirmed that personal blood pressure cuff and a carton of cigarettes were stored in the medication cart 1 and stated it should not be stored in the medication cart. The IP stated the cloth blood pressure cuff was not cleanable and could spread infection from one resident to another. The IP stated personal items did not belong in medication storage areas. 2. During an observation and interview on 2/13/26 at 3:39 p.m. with the Infection Preventionist (IP), the IP stated she stopped monitoring temperatures for the staff vaccine refrigerator in 11/2025. The refrigerator was located in the staff development classroom next to the Infection Preventionist's desk. The facility did not have documentation to show that refrigerator temperatures for vaccines were monitored twice daily, as required, to ensure medication safety and effectiveness. A review of the facility policy and procedure (P&P) titled Medication Labeling and Storage (dated 2001), the P&P indicated, .2.The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner . A review of the facility P&P title Vaccine Storage and Handling (dated July 2024), the P&P indicated .1. Temperatures must be checked and documented: a.Twice daily (beginning and end of clinic/business day) . 3. A review of the admission record indicated Resident 57 was admitted to the facility in early 2023 with diagnosis which included anxiety disorder, atherosclerosis (hardening of the arteries), and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	osteoporosis (weakened bones). During a review of Resident 57's Minimum Data Set (MDS, an assessment tool) dated 12/25, the MDS showed a Brief Interview of Mental Status (BIMS, a cognitive screening tool) score of 15/15, which indicated no cognitive impairment. During a review of Resident 57's Order Summary Report [OSR], the OSR indicated Resident 57 had medications that were given in the morning. The medications included acetaminophen (used to treat pain) 500 mg (milligrams, a unit of measurement), multivitamin with minerals, simethicone (used to relieve symptoms of excess gas in the stomach and intestines), and senna (used to treat constipation). During a concurrent observation and interview on 2/10/26 at 10:17 a.m. with Resident 57 in her bedroom, two pills were found inside a clear plastic medication cup sitting on her overbed table. Resident 57 stated the pills were her morning medications, and the nurse dropped off the cup for her and she would take them throughout the morning. During an interview on 2/10/26 at 1:50 p.m. with Licensed Nurse (LN 4), LN 4 was shown a picture of Resident 57's pills and confirmed the medications were Resident 57's morning medications and stated medications should not have been left unattended at bedside. LN 4 confirmed Resident 57 did not have any orders to self-administer her medications. During an interview on 2/13/26 at 11:04 a.m. with the Assistant Director of Nursing (ADON), the ADON stated medications should not be left at bedside, her expectation was for the nurse to stay and watch the residents take the pills. This was important to ensure the residents did not miss a dose of medication. During a review of the facility policy and procedure (P&P) titled, Administering Medications, dated 4/19, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed.Medications are administered in accordance with prescriber orders, including any required time frames.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, interview, and record review the facility failed to follow therapeutic diets (a nutritionally tailored meal plan prescribed by a physician and planned by a dietitian to treat, manage, or prevent specific medical conditions) for four of 147 sampled residents (Resident 75, Resident 166, Resident 111, & Resident 109).These failures had the potential to cause negative health outcomes for Resident 75, Resident 166, Resident 111, & Resident 109.During a review Resident 75's lunch meal ticket, (undated) ticket indicated, Diet Order: Fortified.During an observation on 2/11/26, at 11:54 a.m., [NAME] 1 did not add the fortified item (a prescribed diet, deliberately increasing the calorie and protein density of regular meals, snacks, and desserts to combat involuntary weight loss and malnutrition) to Resident 75's lunch meal tray. Kitchen staff were observed placing Resident 75's meal tray onto the tray cart.During an interview on 2/11/26, at 11:55 a.m., with Registered Dietician (RD). RD stated Resident 75 did not get the fortified item on the lunch meal tray.During a review of the facility's Fortified Lunch Menu, indicated, the fortified item for lunch on 2/11/26 was Pork: 1 oz extra BBQ Sauce, Brussels Sprouts: 1/2 oz melted margarine.During a review of Resident 109's lunch meal ticket (undated) ticket indicated, Diet Order: Easy to Chew [also known as the IDDSI (The International Dysphagia Diet Standardization Initiative) Level 7 Easy to Chew diet: which consists of soft, tender, and moist foods that require minimal chewing], Fortified.During a review of the Winter Menu Spreadsheet, dated 2/11/26, Spreadsheet indicated, IDDSI Lvl 7.Chocolate Chip Bar.Soak/Drain.During an observation on 2/11/26, at 12:07 p.m., [NAME] 1 did not add the fortified item to Resident 109's lunch meal tray. Dietary aid (DA) 1 placed the regular dessert item on Resident 109s lunch meal tray. Kitchen staff were observed placing Resident 109's lunch meal tray onto the tray cart.During an interview on 2/11/26, at 12:07 p.m., with Certified Dietary Manager (CDM), CDM stated, Resident 109 did not receive the fortified item, and they got the regular dessert (dry Chocolate chip cookie bar), and should have gotten the soaked and drained dessert.During a review of Resident 111's lunch meal ticket (undated), ticket indicated, Diet Order: Fortified.During observation on 2/11/26, at 12:25 p.m., [NAME] 1 did not add the fortified item to Resident 111's lunch meal tray. Kitchen staff placed Resident 111's meal tray onto the tray cart.During an interview on 2/11/26, at 12:25 p.m., with CDM, CDM stated, Resident 111 did not receive the fortified item.During a review of Resident 166's lunch meal ticket (undated), ticket indicated, Diet Order: Fortified.During an observation on 2/11/26, at 12:39 p.m., [NAME] 1 did not place the fortified item on Resident 166's lunch meal tray. Kitchen staff placed Resident 166's lunch meal tray onto the tray cart.During an interview on 2/11/26, at 12:39 p.m., with CDM, CDM stated, Resident 166 did not receive the fortified item.During an interview on 2/11/26, at 3:36 p.m., with Registered Dietician (RD), RD stated, it is his expectation that all kitchen staff follow therapeutic diet orders for all residents.During a review of the facility's policy and procedure (P&P) titled, Therapeutic Diets dated 2017, the P&P indicated, Therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences.

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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 safely store and distribute food according to professional practice standards for a census of 147 residents when:Sandwiches were stored in unsealed bags;Olives were stored in an unsealed container;Black and brown bananas were found in the kitchen; andTest tray vegetable holding temperature was below the acceptable range.This failure had the potential to result in food borne illness (any illness resulting from eating contaminated/spoiled/improperly stored foods) for residents who consume facility food.Findings:During a concurrent observation and interview on 2/10/26 at 8:09 a.m. in the kitchen with the Certified Dietary Manager (CDM), eight sandwiches were found in the refrigerator in unsealed plastic bags. The CDM confirmed the findings and stated the bags should be sealed.During a concurrent observation and interview on 2/10/26 at 8:20 a.m. in the kitchen with the CDM, a container of black olives was found in the refrigerator with the lid not closed. The CDM confirmed the findings and stated the container should be sealed completely.During a concurrent observation and interview on 2/10/26 at 8:23 a.m. in the kitchen with the CDM, two boxes of black and brown bananas were found in the kitchen. The CDM confirmed the findings and stated the bananas should have been thrown out.During a concurrent observation and interview on 2/11/26 at 1:12 p.m. in the kitchen with the CDM, the last tray of food was checked for temperature. Cooked Brussel sprouts were tested. The temperature of the Brussel sprouts was 125 degrees. The CDM confirmed the findings, and agreed the temperature was below the appropriate holding temperature of 140 degrees.During a review of the facility policy and procedure (P&P) titled, STORAGE OF FOOD AND SUPPLIES, undated, the P&P indicated, Food and supplies will be stored properly and in a safe manner.During a review of the facility P&P titled, PROCEDURE FOR REFRIGERATED STORAGE, undated, the P&P indicated, Food should be covered.Produce will be delivered frequently and rotated in the order it is delivered to assure that fresh product is used, free of any witling or spoilage.During a review of the facility P&P titled, FOOD PREPERATION, undated, the P&P indicated, Food shall be prepared by methods that conserve nutritive value, flavor and appearance.Hot foods should be held prior to service at 140 degrees or above.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain an effective infection control program for six of 34 sampled residents (Resident 123, Resident 172, Resident 56, Resident 181, Resident 59, and Resident 2) when:Staff did not change gloves after bowel care and staff did not perform hand hygiene in between glove use during wound care for Resident 123; Staff did not wear proper Personal Protective Equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) for Resident 172 on contact isolation (measure to prevent the spread of germs transmitted by direct or indirect contact with patient or their environment);Staff did not wear proper PPE for Residents 56 on Enhanced Barrier Precaution (EBP - an intervention designed to reduce transmission of resistant organisms);Unlabeled intravenous (IV) tubing (IV, a sterile, flexible tube used to deliver fluids, and medications directly into the bloodstream) was left hanging after use and not stored properly for Resident 181; Dirty urinal was not changed and kept for five months for Resident 59; Staff did not perform hand hygiene before and after entering Resident 2's room with EBP signage; and,Staff failed to follow proper infection control practices during medication administration increasing the risk potential to spread infections.These failures increased the potential for Resident 123 to develop wound infection and increased the risk for cross-contamination (movement or transfer of harmful bacteria from one person, object, or place to another), and potential exposure of Resident 56, Resident 59, Resident 172, Resident 181, and Resident 2 to germs.1. A review of the admission Record indicated Resident 123 was admitted August of 2024 with diagnoses including dementia (a progressive state of decline in mental abilities) and spinal stenosis in the lumbar region (commonly called pinched nerves in the back, this leads to pain, numbness or weakness in the legs). A review of Resident 123's care plan initiated 12/31/24 indicated, [Resident 123] has pressure ulcer [localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence] to coccyx r/t [related to] Immobility, refusing to reposition. The goal of care indicated, .remain free from infection . During an observation on 2/12/26 starting at 9:27 a.m. with the Treatment Nurse (TN) and Certified Nursing Assistant 2 (CNA 2) in Resident 123's room. Resident 123 was assisted to turn on her side by the TN and CNA 2. The foam dressing on Resident 123's coccyx area was partially detached, soaked and resident had a bowel movement (BM). The TN removed the old dressing, and both the TN and CNA 2 used wet wipes to clean Resident 123's BM. The TN handed CNA 2 the wipes used to clean Resident 123's BM. The TN removed her gloves and put on new gloves after cleaning Resident 123's BM then TN proceeded with the wound treatment. The TN did not perform hand hygiene in between glove use, and the CNA 2 did not change her gloves after handling the soiled wipes. During an interview on 2/12/26 at 9:49 a.m. with the TN, outside Resident 123's room. The TN stated Resident 123's foam dressing was soaked with drainage and a little bit of BM. The TN further stated before she put on gloves she would perform hand hygiene. The TN added she did not perform hand hygiene when she removed her gloves and before putting on new gloves. The TN stated she did not see CNA 2 change her gloves after she wiped Resident 123's BM. The TN further stated CNA 2 should have changed her gloves after cleaning Resident 123's BM. During an interview on 2/12/26 at 10:22 a.m. with CNA 2. The CNA 2 stated the TN wiped most of Resident 123's BM prior to wound care. The CNA 2 acknowledged she took the soiled wipes from the TN. The CNA 2 said I did not when CNA 2 was asked if she changed her gloves after she took the soiled wipes from the TN. The CNA added, I should have changed my gloves, sanitized my hands and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	put on another gloves. During an interview on 2/12/26 at 4:03 p.m. with the Infection Preventionist (IP), the IP stated their policy was to perform hand hygiene before and after glove use during wound care. The IP further stated if a staff member provided bowel care, the expectation was for staff to remove gloves, perform hand hygiene then put clean gloves on. The IP added if the gloves are not soiled, staff still had to perform hand hygiene after removing gloves and before putting on clean ones. During an interview on 2/13/26 at 9:32 a.m. with the Director of Nursing (DON), the DON stated her expectation was for staff to use alcohol gel prior to glove use. The DON further stated she expected for staff to perform hand hygiene in between glove use and for staff to change gloves after providing bowel care. A review of the facility's policy and procedure revised October 2023 and titled, Handwashing/Hand Hygiene indicated, This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections .Hand hygiene is indicated .immediately before touching a resident .after contact with .body fluids, or contaminated surfaces .after touching a resident .before moving from work on a soiled body site to a clean body site on the same resident .immediately after glove removal .Use an alcohol-based hand rub containing at least 60% alcohol for most clinical situations .The use of gloves does not replace hand washing/hand hygiene .Perform hand hygiene before applying non-sterile gloves .When removing gloves, pinch the glove at the wrist and peel away from the hand .Hold the removed glove in the gloved hand .Perform hand hygiene. 2. During a review of Resident 172's admission records, the records indicated Resident 172 was admitted in January 2026 with diagnoses that included sepsis (the body's extreme response to infection) and. enterocolitis due to clostridium difficile (infection caused by a bacteria that causes inflammation of the colon). Resident 172's minimum data set (MDS, a federally mandated resident assessment tool) dated 1/29/26 indicated Resident 172 had moderate cognitive impairment. During a review of Resident 172's physician order, dated 2/11/26, the order indicated, Place resident in CONTACT Transmission-Based precautions to help prevent the spread of an active transmissible infection. C DIFF. During an observation on 2/10/26 at 12:57 p.m. in Resident 172's room, a signage was observed posted by the door of Resident172's room that indicated CONTACT PRECAUTIONS. The signage further indicated that everyone must perform hand hygiene and wear gloves and gown before room entry and before room exit. Certified Nursing Assistant 3 (CNA 3) was observed entering Resident 172's room holding a meal tray without wearing gown. During an observation on 2/11/26 at 3:40 p.m. in Resident 172's room, CNA 4 was observed inside Resident 172's room without PPE. During an interview on 2/11/26 at 4:01 p.m. with CNA 4, CNA 4 confirmed Resident 172 was on contact precaution. CNA 4 confirmed not wearing PPE while inside Resident 172's room and stated she was just updating the name on the board and not doing care. CNA 4 stated it was important to wear PPE for infection control and for staff protection. During an interview on 2/11/26 at 4:07 p.m. with Licensed Nurse 9 (LN 9), LN 9 stated staff should be wearing PPEs every time they go inside a room on contact precaution and stated, .If they are going (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inside, they need to gown up. LN 9 further stated it was important to wear PPEs to prevent transmission of diseases and stated, .the room was already compromised. During an interview on 2/11/26 at 4:41 p.m. with the Infection Preventionist (IP), the IP stated that staff know if a resident is on contact isolation and stated that the expectation was for staff to not cross the threshold unless they have PPE. The IP further stated staff are not supposed to go inside a room on contact isolation without PPE. During a concurrent observation and interview on 2/12/26 at 12:40 p.m. with Nurse Consultant 2 (NC 2) in Resident 172's room, Occupational Therapist (OT) was observed exiting the curtain inside Resident 172's room without PPE. NC 2 confirmed that OT was not wearing PPE while inside the room and stated OT might be providing care for Resident 172's roommate. Resident 172's roommate was not on contact isolation and was observed sitting on a wheelchair in the hallway outside the room. During an interview on 2/12/26 at 3:41 p.m. with the Director of Nursing (DON), the DON stated that for residents on contact isolation, staff should wear gown and gloves. The DON stated that this was important to stop the spread of infection among residents and staff. The DON further stated if staff are not in contact with the resident, staff are not required to wear PPEs even if the resident was on contact isolation. The DON stated that the contact precaution is only for the resident and not the resident's environment and stated that anyone can enter a room on contact isolation without PPE if they are only writing on the board. During a review of the facility's policy and procedure (P&P) titled Isolation – Categories of Transmission-Based Precautions, revised 10/2018, the P&P indicated, .1. Contact precautions may be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment.5. Staff and visitors will wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed. 3. During a review of Resident 56's admission records, the records indicated Resident 56 was admitted to the facility in January 2026 with diagnosis that included osteomyelitis of vertebra (infection of the spine). Resident 56's MDS indicated Resident 56 had intact cognition. During a review of Resident 56's care plan, initiated on 1/6/26, the care plan indicated, [Resident 56] requires Enhanced Barrier Precautions r/t invasive device: PICC line [Peripherally Inserted Central Catheter – a long, thin, flexible tube that delivers fluids and medications through a vein in the arm].Implement enhanced barrier precautions (gown, gloves) when providing high risk care activities. During an observation on 2/12/26 at 12:26 p.m. in Resident 56's room, two CNAs were observed entering Resident 56's room and closing the curtains to provide privacy. Signage on the door indicated enhanced barrier precaution for Resident 56's roommate but not for Resident 56. During an interview on 2/12/26 at 12:32 p.m. with CNA 3, CNA 3 stated assistance was provided by CNA 3 and another CNA for Resident 56 while turning and assisting the doctor during assessment. CNA 3 stated she was aware of the enhanced barrier precaution signage posted by the door and that the signage was not for Resident 56 but for Resident 56's roommate so there was no need for them to wear PPE when providing care. (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 concurrent interview and record review on 2/12/26 at 12:48 p.m. with LN 10, LN 10 stated that Resident 56 was not on EBP and that gown was not being worn when providing care for Resident 56. LN 10 confirmed from Resident 56's medical records that Resident 56 had a PICC line on the right upper arm which required Resident 56 to be on EBP. During an interview on 2/12/26 at 3:41 p.m. with the Director of Nursing (DON), the DON stated that for residents on EBP, staff should wear gowns and gloves if they provide care. During a review of the facility's P&P titled Enhanced Barrier Precautions, dated 6/2024, the P&P indicated, .1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply.5. EBPs are indicated.for residents with wounds and/or indwelling medical devices regardless of MDRO colonization.c. Examples of indwelling medical devices include:.intravenous lines (peripheral and central). 4. During a review of Resident 181's admission records, the records indicated Resident 181 was admitted to the facility in February 2026 with diagnosis that included urinary tract infection. Resident 181's MDS indicated Resident 181 had intact cognition. During a review of Resident 181's care plan, initiated 2/7/26, the care plan indicated, .The resident is on IV antibiotic [medication used to treat infections] therapy for UTI.Administer ANTIBIOTIC medications as ordered by physician. During an observation on 2/10/26 at 9:32 a.m. in Resident 181's room, Resident 181 was not in his room and an IV bag connected to an unlabeled tubing was observed hanging on the pole at bedside. The distal end of the tubing was observed hanging and exposed to air without cover. During a concurrent observation and interview on 2/10/26 at 12:59 p.m. in Resident 181's room, Resident 181 was observed sitting in wheelchair at bedside, alert and calm. The unlabeled IV tubing was still observed hanging on the IV pole exposed to air without cover. Resident 181 stated he received the antibiotic in the morning. During a concurrent observation and interview on 2/11/26 at 10:44 a.m. with Resident 181 in his room, Resident 1 stated he received his antibiotic about an hour ago. The used IV tubing was observed hanging on the IV pole, unlabeled, with the distal end of the tubing connected to the drip chamber. During a concurrent observation and interview on 2/11/26 at 3:45 p.m. with LN 11, LN 11 confirmed the unlabeled tubing, and the distal end of the tubing was connected to the drip chamber. LN 11 stated, .It's empty, needs to be removed. During an interview on 2/11/26 at 3:54 p.m. with LN 12, LN 12 stated the IV tubing was good for 24 hours. LN 4 stated IV lines are labeled with date and time to check if the line is still good and to know the time when the IV tubing was started. LN 12 added that the tip of the tubing should be covered with a cap for infection control. During a review of Resident 181's Medication Administration Record (MAR), the MAR indicated, TUBING CHANGE Q [every] 24 HRS [hours] one time a day NEW TUBING. The MAR further indicated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the tubing change was not signed on 2/10/26. During a concurrent interview and record review on 2/12/26 at 3:41 p.m. with the DON, the DON stated IV tubings are changed every 24 hours, and staff sign in the MAR to indicate that the tubing was changed. The DON stated staff do not need to label the actual tubing and that the MAR was the basis on when the tubing was changed. The DON confirmed that Resident 181's MAR indicated the tubing change was not signed on 2/10/26 which indicated that the tubing was not changed. The DON further stated the end of the tubing is covered with a cap and stated it was okay as long as the end of the tubing was not exposed. The DON stated the staff gave the antibiotic in the morning and should have thrown the tubing set. During a review of the facility's P&P titled Administration Set/Tubing Changes, dated 2001, the P&P indicated, .The purpose of this procedure is to provide guidelines for aseptic administration set changes in order to prevent infections associated with contaminated IV therapy equipment.6. Place a sterile covering device on a continuous or intermittent administration set when it is disconnected from the catheter.11. Label administration set and tubing with date, time and initials.12. Document procedure in resident's medical record. 5. During a review of Resident 59's admission records, the records indicated Resident 59 was admitted in May 2021 with diagnoses that included hemiplegia and hemiparesis (weakness and paralysis of one side of the body), contracture of right upper arm (permanent stiffening of muscles and tendons causing joint rigidity and limited range of motion), and visual loss of both eyes. Resident 59's MDS indicated Resident 59 had severe cognitive impairment. During a review of Resident 59's MDS Section H – Bladder and Bowel, dated 11/12/25, the MDS indicated Resident 59 had frequent urinary incontinence (involuntary leakage of urine due to loss of bladder control) with seven or more episodes of urinary incontinence, but at least one episode of continent voiding (able to control bladder). During an observation on 2/10/26 at 8:52 a.m. in Resident 59's room, Resident 59 was observed lying in bed, eyes closed, respirations even and unlabored. A urinal with brownish discoloration was observed hanging on the handle of the lowest drawer of the nightstand, labeled with Resident 59's name and dated 9/15/25. During an observation on 2/11/26 at 4:16 p.m. in Resident 59's room, Resident 59 was observed lying in bed, alert and calm, unable to make meaningful conversations. The urinal was observed hanging on the handle of the highest drawer of the nightstand, still labeled with Resident 59's name and dated 9/15/25. During an interview on 2/11/26 at 4:18 p.m. with LN 13, LN 13 stated urinals are changed whenever they were dirty and not more than 30 days for infection control. LN 30 stated five months was too long for the urinals to be changed because the residents using the same urinal for too long can get sepsis. During an interview on 2/11/26 at 4:41 p.m. with the IP, the IP stated changing of urinals must be shorter than 30 days. The IP added urinals should be changed if they look dirty because it could cause infection. The IP further stated the date on the urinals indicated when the staff started using the urinals. (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 concurrent observation and interview on 2/11/26 at 5:01 p.m. with the IP, the IP confirmed Resident 59's urinal was dated 9/15/25. The IP stated the urinal looked dirty and disgusting. During an interview on 2/12/26 at 3:41 p.m. with the DON, the DON stated urinals are changed monthly or if visibly soiled. The DON stated she was aware of Resident 59's urinal dated 9/15/25 and stated she did not know how the urinal ended up with Resident 56 for too long and the urinal should have been thrown away. During a review of the facility's P&P titled Infection Prevention and Control Program, revised 10/2018, the P&P 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. 6. During an observation on 2/10/26, at 10:08 a.m., outside Resident 2's room, Enhanced Barrier Precaution Sign (EBP: an infection control strategy for long-term care facilities to reduce multidrug-resistant organism (MDRO) transmission) was noted to instruct everyone to use hand sanitizer when entering and exiting the room. CNA 1 walked into Resident 2's room without using hand sanitizer. CNA 1 exited Resident 2's room and did not use hand sanitizer, then entered another Residents room. During an interview on 2/10/26, at 10:09 a.m., with CNA 1, CNA 1 stated she did not use hand sanitizer before or after entering Resident 2's room. During a review of Resident 2's Physician Orders dated 11/13/25, order indicated, Enhanced Barrier Precautions r/t [related to] G tube [tube surgically connected to stomach from outside the abdomen allowing artificial nutrition and medications to be administered]. During an interview on 2/13/26, at 2 p.m., with IP, IP stated it is her expectation that all staff use hand sanitizer when entering and exiting all rooms, especially rooms with enhanced barrier precautions. 7. During an observation on 2/4/26 at 12:02 p.m., LN 1 checked Resident 185's blood glucose, which was 116. LN 1 prepared Novolog insulin 20 units subcutaneously before breakfast and lunch (insulin is a medication used to lower blood sugar levels). The nurse placed the drawn-up insulin syringe back into the syringe wrapper with the needle exposed and did not administer the medication immediately while waiting for the meal tray to arrive. The syringe remained in the wrapper for approximately ten minutes and was not administered to the resident then discarded into the medication disposal container. During an observation on 2/4/26 at 12:02 p.m. LN 1 did not disinfect the glucometer with a manufacturer-approved disinfectant wipe after use. During an interview on 2/4/26 at 2:33 p.m., LN 1 stated she drew up Novolog 20 units but did not administer it immediately because the meal trays were late and felt that the dose was large and should be administered immediately before eating a meal. She stated she placed the syringe in the wrapper while waiting and reported this was not her usual practice. During an interview on 2/4/26 at 1:27 p.m., the Infection Preventionist (IP) reviewed the disinfectant product label and confirmed staff were trained to use bleach sanitation wipes for glucometers and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cavi sanitation wipes for blood pressure cuffs. The IP stated the nurse should have discarded the pre-drawn insulin syringe rather than placing it back in the wrapper because leaving the needle exposed increased the risk of infection transmission and needle stick injury. During an interview on 2/4/26 at 4:02 p.m., the Assistant Director of Nursing (ADON) stated glucometers were cleaned between each use with manufacturer-approved disinfectant wipes. The ADON stated using the incorrect disinfectant could damage the glucometer and failure to disinfect between residents increased the risk of spreading infection. A review of the facility policy titled Administering Medications, revised 4/19, indicated, Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. EvenCare G3 Blood glucometer manufacturer recommendation on page 9. Identifies bleach sanitizing wipes to be used to sanitize the glucometer in between residents.

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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 provide a safe and secure environment to ensure that one of 34 sampled residents (Resident 125) received her mail, when two packages addressed to Resident 125 and delivered to facility were not safeguarded.This failure resulted in violation of Resident 125 rights to protection of personal property and caused Resident 125 to experience emotional distress.A review of the admission record indicated the facility admitted Resident 125 in 2017 with multiple diagnoses which included multiple sclerosis (MS, a chronic progressive disease involving damage to the nerve cells in the brain and spinal cord) and heart disease.A review of a Minimum Data Set (MDS- a comprehensive assessment and screening tool), dated 12/18/2025, indicated that Resident 125 was cognitively intact (had sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment).During an interview on 2/10/26 at 12:09 p.m., Resident 125 stated that her sister who lived out of state sent her two (2) packages about 1.5-2 months ago. Resident 125 explained that one package was sent by United States Postal Service (USPS) and the other by FedEx and the packages were not delivered to her. Resident 125 stated that activity staff told her that there were 2 packages addressed to her name, but when he went to retrieve the packages, they were gone, stolen. Resident 125 stated she talked to Social Services Assistant (SSA) about missing packages and was told the facility will look for them. Resident 125 continued, Nobody knows what happened with them.I have not heard back. Resident 125 stated she and her sister were upset that both packages disappeared, or someone had stolen them.During an interview on 2/12/26, at 9:04 a.m., with Activity Director (AD), the AD explained that all mail, including packages were delivered to the main desk and then the activity staff delivered it to residents. The AD stated that if resident reported missed mail or package, the facility would look for it and if not found, will refer to social services for reimbursement. The AD added, I hear that mail was lost from time to time, and I look around and if I find it, deliver to residents.During an interview with AD in Resident 125's room on 2/12/26 at 9:45 a.m., Resident 125 stated, I informed [AD] that I did not receive packages that my sister had sent to me.[AD] had brought mail to me and I told him. He said he will look for it.During a follow up interview on 2/12/26 at 10:30 a.m., AD stated, I remember [Resident 125's name] talked about packages that she did not receive during holidays. I went look for them but could not find them. When the AD was asked if facility offered to reimburse Resident 125 for missing packages, the AD replied, I can't remember if I discussed with social services about reimbursement.During an interview on 2/12/26 at 1:10 p.m., with front desk staff (FDS), the FDS explained that when packages were delivered to front desk, the staff would sign for those deliveries that required signatures, acknowledging that the facility have received package (s). The FDS stated the facility did not have a log of tracking the mail/package deliveries.During an interview on 2/12/26 at 3:30 p.m., the SSA stated, I heard Activities Director.looking for missing packages for [Resident 125]. I don't recall him reporting to me though. If it was reported, I'd interview the resident and treat it as missing belonging, request a receipt and reimburse the value of missed packages. The SSA stated the facility did not conduct an investigation to find the missing packages.During a review of social services (SS) note dated 2/12/26 at 4:59 pm., indicated, SS met with [Resident125] re [regarding] missing mail.and FedEx package early Jan [January] 2026-completed report of lost resident property; [Resident 125] will provide receipt/estimate value for resolution.During an interview on 2/12/26 10:40 a.m., with Social Services Director (SSD) explained that if resident reported missed packages, the facility would ask for confirmation receipt. The SSD continued, The same process as reimbursing personal items. If family send the package and was not received, we ask them for confirmation receipt and reimburse the value. A review of the policy and procedure (P&P) titled Resident's Rights reviewed 7/14/2023 indicated, Employees shall treat all residents with kindness, respect, and dignity. Federal and state (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to.access to mail.communicate in person and by mail.retain and use personal possessions.The facility was asked to provide a policy regarding missing mail and/or packages, and it was not provided.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a comfortable home-like environment for one of 34 sampled residents (Resident 70) when low sound levels were not maintained during the hours of sleep. This failure resulted in Resident 70 not being able to rest and sleep undisturbed through the night and had the potential to affect Resident 70's overall health. A review of the admission record indicated the facility admitted Resident 70 in 2022 with multiple diagnoses which included kidney disease and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), anxiety and depression.A review of Resident 70's Minimum Data Set (MDS, an assessment tool), dated 11/25/25, indicated the resident was cognitively intact and independent in decision making.A review of the care plan dated 5/10/24 indicated Resident 70 was using antidepressant medication due to inability to sleep. The care plan goal indicated that Resident 70 will not have lack of sleep. The care plan interventions indicated to monitor Resident 70 for behaviors of depression, verbalized sadness, withdrawal from activities, inability to sleep and to notify Resident 70's physician if these signs and symptoms were observed.A review of Resident 70's care plan dated 5/22/24 indicated Resident 70 was at risk for psychosocial wellbeing related to diagnoses of depression and anxiety. The interventions indicated, Observe for tearfulness, increased agitation and decreased participation in care.Allow to voice feelings and frustrations.Listen attentively.During an observation and interview in Resident 70's room on 2/10/26 at 10:02 a.m., Resident 70 was observed in her bed. Resident 70 was pleasant and answered appropriately to all questions. Resident 70 stated the facility was too noisy at night. Resident 70 stated that next door neighbor, identified as Resident 131 was yelling at her roommate days and nights. Resident 70 added, She [Resident 131] doesn't like her new roommate, who is completely non-threatening, and she [Resident 131] constantly screams to take her [roommate] away. Resident 70 explained that she used to have panic attacks and they stopped a while ago but with Resident 131's screaming, the panic attacks came back. Resident 70 stated, I can't sleep at night and unable to rest during daytime.During a continued interview on 2/10/26 at 10:02 a.m., Resident 70 stated she missed her therapy because she was too tired from inability to sleep. Resident 70 stated, Last night I woke up in the middle of night to [Resident 131's name] screaming and was not able to go back to sleep. My head hurts still. I take medications to help me with sleeping, but I have hard time to go back to sleep once I wake up at night. Resident 70 stated she frequently had complained to the staff about the screaming noise during daytime and inability to sleep at night. Resident 70 stated that 2 days ago she filed a grievance regarding noise and inability to sleep.Loud yelling noise coming from room next to Resident 70's room was observed by the Department on 2/10/26 at 12:15 p.m., on 2/10/26 at 4:50 p.m., on 2/11/26 at 8:46 a.m., and on 2/11/26 at 3:20 p.m.During an interview on 1/12/26 at 8:51 a.m., with Certified Nursing Assistant (CNA 5) stated that Resident 131 did not like her roommate and constantly yelled to get her out. CNA 5 stated that Resident 131 had verbalized that all she wanted was peace and quiet and her roommate's constant walking was upsetting to her.During an interview on 2/13/26 at 10:35 a.m., Licensed Nurse (LN 14) stated she was aware of Resident 70's complaints regarding Resident 131's loud yelling during daytime and evening. LN 14 stated the staff were trying to talk and redirect Resident 131, but it had not been always effective.During an interview on 2/12/26 at 9:20 a.m., with Director of Nursing (DON) and Nurse Consultant (NC 1), the DON stated that the facility was aware that Resident 131 had periods of yelling and noisy behaviors. The DON stated that yelling and screaming could cause frustration for residents and disrupt their sleep at night. The DON stated the facility was not aware about any resident's complaints about noisy environment.During an interview on 2/12/26 at 10:40 a.m., the Social Services Director (SSD) stated they received the grievance from Resident 70 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding noise issue but was not aware of other residents' complaints. The SSD stated the facility had to be vigilant and find solutions to ensure residents were free from unwanted noises while in the facility.A review of the facility's policy and procedure (P & P) titled, Accommodation of Needs, dated 2/2021, indicated, Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe.functioning .and well-being.The resident's individual needs and preferences are accommodated to the extent possible.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure one of 34 sampled residents (Resident 103) was free from chemical restraints and unnecessary psychotropic medications (drugs that affect brain activities associated with mental processes and behaviors) when Resident 103's Lorazepam (medication used to treat anxiety) was given without appropriate target behavior and side effects monitoring, and no care plan was developed for Resident 103's use of antianxiety medication.These failures decreased the facility's potential to provide appropriate care and monitoring of Resident 103's target behaviors and increased Resident 103's risk and exposure to side effects associated with psychotropic medications.Findings:During a review of Resident 103's admission records, the records indicated Resident 103 was admitted to the facility in January 2026 with diagnoses that included anxiety disorder (excessive, persistent fear or worry that interferes with daily life). Resident 103's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 2/3/26, indicated Resident 103 had intact cognition and did not exhibit behaviors directed toward self or others.During a review of Resident 103's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for February 2026, the MAR indicated an order for Lorazepam 0.5 mg (milligrams, a unit of measurement) 1/2 tablet by mouth every 12 hours as needed for anxiety manifested by inability to relax for 14 days. The MAR further indicated Resident 103's Lorazepam dose increased from 0.25 mg to 1mg on 2/9/26. The MAR indicated Resident 103 received Lorazepam on 2/7/26, and 2/9/26 to 2/12/26.During a review of Resident 103's electronic clinical records, there were no physician orders or MARs associated with monitoring for target behavior and side effects for Resident 103's use of Lorazepam.During a review of Resident 103's care plans, there were no care plans developed for Resident 103's use of antianxiety medication.During a concurrent interview and record review on 2/12/26 at 3:41 p.m. with the Director of Nursing (DON), the DON stated residents on psychotropic medication are monitored for target behaviors and side effects and the monitoring are documented on the MAR and on the weekly charting summary. The DON stated if antianxiety medication was given as needed, there should be behaviors present to justify giving the dose. The DON added that there should be a care plan for the use of antianxiety medication. The DON confirmed Resident 103's physician order for Lorazepam for anxiety and verified the doses were given on 2/7/26, and 2/9/26 to 2/12/26. The DON acknowledged that there were no orders and no MARs for target behavior and side effects monitoring for Resident 103's use of antianxiety medication, and there were no behavior monitoring on the weekly charting. The DON stated the expectation was to monitor target behaviors and side effects if a resident was taking psychotropic medication including antianxiety medication to monitor if the resident was having negative side effects from the medication. The DON also confirmed Resident 103 did not have a care plan for the antianxiety medication use and stated it was important because care plans are used as guides on what to do.During a review of the facility's policy and procedure (P&P) titled Psychotropic Medication Use, revised 2/2026, the P&P indicated, .2. Medications in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications:.c. Anti-anxiety medications.3. Psychotropic medication management is an interdisciplinary process that involves the resident, family, and or/ the representative and includes:.c. Adequate monitoring for efficacy and adverse consequences.e. preventing, identifying, and responding to adverse consequences.Monitoring and Adverse Consequences.2. Residents receiving psychotropic medication are monitored and the response to treatment is documented.3. Monitoring may include.behavior flowsheets, medication administration records.4. In addition, residents are monitored for adverse consequences associated with psychotropic medications.

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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 and interview, the facility failed to ensure nursing services were provided in accordance with professional standards of practice for two of two, sampled residents (Residents 185 and 172), when:1. Nursing staff did not follow safe handling standards for hazardous medications.2. A Nurse did not obtain or verify required vital signs prior to administering medications with physician hold parameters.These failures placed residents at risk for medication-related adverse effects and placed staff at risk for exposure to hazardous medications.During an observation and review of hazardous medication administration for Resident 185, on 2/4/26 at 8:38 a.m., LN 1 prepared and administered the following hazardous medications without wearing gloves:Mycophenolate Sodium 180 mg, and Tacrolimus 1 mg medications to treat a previous kidney transplant. LN 1 handled the medications with bare hands during preparation and administration.During an observation of medication administration for Resident 172 on 2/4/26 at 9:05 a.m., LN 2 administered Metoprolol 100 mg by mouth without obtaining resident 172's blood pressure at the time of administration.A review of the medication order indicated: Give 1 tablet by mouth two times a day for high blood pressure (hypertension - high blood pressure). Hold for systolic blood pressure less than 110 or heart rate less than 55.A review of vital signs revealed resident 172's blood pressure was 107/63 at 7 a.m., as obtained by a Certified Nursing Assistant (CNA).During an interview on 2/4/26 at 9:05 a.m., LN 2 stated she accepted blood pressure results obtained by CNAs and would only recheck blood pressure herself if the reading was really high or really low.During an interview with the Assistant Director of Nursing (ADON) on 2/4/26 at 4:02 p.m., the ADON stated: The expectation is for nurses to wear PPE, including gloves, when handling hazardous medications to protect staff from harmful chemicals. The expectation is for the medication nurse to obtain the resident's current blood pressure prior to administering medications with physician hold parameters, to determine whether the medication should be given or held.Record review of policy titled Medication Administration revision date April 2019. Indicated Only licensed personnel are to administer medications and prior to administering medication vital signs will be check if applicable.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to provide Activities of Daily Living (ADLs: fundamental self-care tasks that individuals perform daily to maintain independence and hygiene) to residents dependent with ADL care for one of 34 sampled residents (Resident 30), when the facility failed to trim Resident 30's toenails after multiple requests from nursing staff.This failure had the potential for Resident 30 to experience dignity concerns related to not being groomed properly, and with the potential for fungal infection due to long toenail length. During an observation on 2/10/25, at 10:02 a.,m., in Resident 30's room. Resident 30 was observed to have long, thickened, discolored toe nails.During an interview on 2/10/26, at 10:45 a.m., with Licensed Nurse (LN) 6, LN 6 stated, Resident 30 does have long nails. During a review of Reisdent 30's Shower Sheet dated 1/15/26, sheet indicated, Toe Nails Need Clipping was checked as Yes. During a review of Reisdent 30's Shower Sheet dated 2/1/26, sheet indicated Toe Nails Need Clipping was checked as Yes. During a review of Reisdent 30's Shower Sheet dated 2/5/26, sheet indicated Toe Nails Need Clipping was checked as Yes. During an interview on 2/13/26, at 10:04 a.m., with Licensed Nurse (LN) 3, LN 3 stated, when Certified Nurse Assistants (CNAs) assist bathing residents, they will fill out the shower sheet and indicate if they need nails trimmed. If the resident is diabetic, the nurse will refer to Social services to coordinate with the podiatrist. During a concurrent interview and record review on 2/13/26, at 10:56 a.m., with Director of Nursing (DON), Resident 30's Physician Orders were reviewed. DON stated, if a Resident was referred to have their nails clipped they would have an order for the Podiatrist to come, because that is how they are reimbursed. DON stated, Resident 30 does not have an order to see the Podiatrist. DON stated, the protocol is the CNAs check the resident during showers or bathing and will select if they need the nails trimmed. DON stated, Resident 30 is diabetic he needs to see the podiatrist to cut his toenails. [NAME] stated, Resident 30 is not currently on the list to see the podiatrist. DON stated, the last time Resident 30 had a podiatry order was Decemeber of 2025.During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADLs), Supporting, dated 2001, the P&P indicated, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Resident who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure necessary treatment and services were implemented to promote healing and prevent worsening of the pressure injury (PI, area of damaged skin caused by prolonged pressure on a specific area of the body or friction) for one of 34 sampled residents (Resident 26), by failing to utilize a low air loss mattress (LAL, a special mattress designed to circulate a constant airflow used for residents who have pressure injuries) as indicated in the policy and recommended by wound care physician.This failure had the potential to impede and delay the healing for Resident 26's pressure injury and placed Resident 26 at risk for worsening of PI.A review of the admission record indicated the facility admitted Resident 26 in October of 2024 with multiple diagnoses, which included heart and kidney disease, chronic pain syndrome, and widespread edema (swelling).A review of Resident 26's admission nursing assessment dated [DATE] indicated the resident had coccyx (tailbone, lower back area) redness with intact skin.A review of Resident 26's physician history and physical note dated 10/24/24 indicated that the resident was admitted to facility for acute rehabilitation (therapy) and medical management. The physician documented that Resident 26 had right knee pain and was able to ambulate (walk) using a walker.A review of Resident 26's Minimum Data Set (MDS - a resident assessment tool) dated 10/27/24, indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was moderately impaired. The MDS indicated Resident 26 was assessed to be dependent (staff does all the effort to complete the activity) on personal hygiene, toileting, mobility, including turning and repositioning, and transferring. The MDS indicated Resident 26 was assessed to be at risk of developing pressure injuries. The MDS further indicated that Resident 26 had intact skin (no wounds) and had a non-blanchable redness (a red patch of skin that did not fade when pressed) categorized as Stage 1 PI (location not specified).During a review of Resident 26's care plan initiated on 10/21/24, the care plan indicated Resident 26 was at risk for further skin breakdown related to impaired mobility, bowel and bladder incontinence, advanced age, and presence of PI on coccyx. The care plan interventions directed nursing to keep Resident 26 clean and dry as possible. Minimize skin exposure to moisture.Provide incontinence care.Monitor for any signs of skin breakdown (sore, tender, red, or broken areas) .Weekly skin checks.A review of Interdisciplinary Team Note (IDT, a meeting where different disciplines meet and discuss resident's care issues) dated 12/23/24 indicated that on 12/20/24 Resident 26 experienced a change in condition related to alteration in skin. The IDT note indicated, Resident noted with new pressure injury to coccyx measuring 1.6 x 1.0 x 0.1 cm [centimeter, unit of measurement] partial thickness skin loss [a wound that has damage to top layer and part of the second layer of skin], shallow red smooth non-granular tissue [abnormal] noted, scant [small] sanguineous exudate [bright red, watery, bloody fluid]. The wound was classified as Stage 2 (a shallow wound with the top and part of the second layers of the skin were damaged). The IDT note indicated that Resident 26 also developed a right buttock pressure injury, measuring 0.6 x 0.4 x 0.1 cm, with damage to top and second layer of skin with abnormal tissue, and scant amount of bright red, watery, bloody fluid. A review of the care plan initiated on 12/20/24 addressed Resident 26's pressure injuries to the coccyx and right buttock. The care plan interventions directed staff to Continue to encourage resident to turn and reposition frequently.encourage resident to get out of bed periodically.Administer treatments.Assess/record/monitor wound healing weekly.Follow facility policies/protocols for the prevention and treatment of skin breakdown. The care plan did not contain utilizing LAL mattress designed to reduce pressure by allowing the resident to ?float,' which would help with PI healing.A review of Resident 26's order summary report contained a physician's order dated 1/3/25 referring Resident 26 to a contracted wound care physician group (physicians specializing in wound management and treatments) for wound evaluation.A review of Resident 26's clinical records (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contained wound evaluation and treatment note (WETN) dated 1/6/25 from the wound care physician. The wound care physician documented that Resident 26's wound increased in size and was classified as Pressure Injury Stage 3 (a deeper wound extended into the fat layer). WETN indicated that Resident 26 underwent excisional debridement (ED, a surgical procedure that involved cutting away or removing damaged tissues from the skin or subcutaneous tissue under the skin) of coccyx PI on 1/6/25 to promote healing. The WETN contained the following recommendations, Aggressive offloading [a strict approach designed to completely remove pressure, weight, and friction from a wounded area to allow it heal], Every 2 hours turning; Low air loss mattress.A review of Resident 26's clinical records had no documented evidence that the facility followed up on the recommendations of the wound care physician and utilized the low air loss mattress. A review of Resident 26's clinical records indicated that resident's physician was contacted on 3/21/25, more than two months later and an order for low air loss mattress was obtained.A review of IDT note dated 4/1/25 indicated that on 3/31/25 Resident 26 underwent another excisional debridement of her coccyx PI and the wound was classified as PI Stage 4 (injury is very deep, reaching into muscle and bone and causing extensive damage).During an interview with Certified Nursing Assistant 6 (CNA 6) on 2/13/26 at 10:25 a.m., CNA 6 stated she was familiar with Resident 26's care. CNA 6 stated Resident 26 was on LAL mattress and needed to be repositioned every two hours while in bed. CNA 6 stated that Resident 26 used to get out of bed and go to therapy and activities in the past but no longer. CNA 6 stated, We get her to wheelchair occasionally, but she won't sit for too long due to her wound on the coccyx.She complains of pain while sitting in wheelchair.During an interview with Licensed Nurse 14 (LN 14) on 2/13/26 at 10:35 a.m., LN 14 stated Resident 26 would get out of bed for up to wheelchair here and there but started refusing lately. LN 14 added, Then she developed these wounds on her bottom, and now [Resident 26] not getting out of bed.During an interview on 2/13/26 at 2 p.m., with Treatment Nurse (TN), the TN stated that facility usually utilized LAL mattresses to help with management of pressure injuries after residents were identified to have skin issue (s). The TN stated that utilizing LAL mattress helped with preventing and healing of existing PI by redistributing body weights and reducing prolonged pressure over area where the PI was located. The TN stated she was familiar with Resident 26's care and performed treatment to her Stage 4 pressure injury. TN reviewed Resident 26's physician orders and validated that the facility started utilizing LAL mattress on 3/22/25 after Resident 26's PI was already in an advanced stage. The TN stated that Resident 26's pressure injury to her coccyx was not healed and was still classified as Stage 4 at present.An interview and review of Resident 26's admission assessment was conducted with Director of Nursing (DON) and Nurse Consultant (NC 1) on 2/13/26 at 10:55 a.m. The DON validated that Resident 26 was admitted with intact skin and redness to her coccyx, identified as Stage 1 PI. The DON stated Resident 26 had treatment with [NAME] ointment, barrier cream to prevent skin breakdown and was turned and repositioned every 2 hours. The DON stated that Resident 26 initially was on pressure reducing mattress (PRM) and explained that PRM does not circulate air as LAL mattress, but it was soft. The DON stated, We implement LAL when resident develops skin injury. The DON reviewed IDT note dated 12/23/24 and stated that Resident 26 developed Stage 2 to her coccyx and right buttock. The DON stated that the facility should have utilized LAL mattress for Resident 26 at that time in addition to turning/repositioning and nutritional supplements. The DON reviewed treatment administration records for October, November, December of 2024 and January and February of 2025 and was unable to find documented evidence that the LAL mattress was ordered and utilized for Resident 26's wound management. The DON acknowledged that the order for LAL was placed on 3/21/25, three months after Resident 26 was identified to have alteration to her skin and Stage 2 PI.During a continued interview on 2/13/26 at 10:55 a.m., the DON stated that Resident 26's medical conditions and fragile skin had placed the resident at increased risk for skin breakdown. The DON added that Resident 26 was also non-compliant with turning, repositioning, and getting out of bed. The DON stated that Resident 26 should have a care plan for her non-compliance but was unable (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to find non-compliance care plan. The DON stated that Resident 26's pressure injury got worse and on 3/31/25 it was identified as Stage 4. The DON agreed that LAL mattress might have promoted the healing process of Resident 26's pressure injury.During a review of the facility's policy and procedure (P&P) titled Prevention of Pressure Injuries, dated 4/2020, indicated that the purpose of the policy was to provide information regarding identification of pressure injury risk factors and developing interventions for specific risk factors. The policy directed nursing to review the resident's care plan and identify the risk factors and develop the interventions designed to reduce or eliminate those risk factors. The policy indicated further, Select appropriate support surfaces [mattress] based on resident's risk factors, in accordance with current clinical practice.Review and select medical devices.to minimize tissue damage. The policy directed nursing to Review the interventions and strategies for effectiveness on an ongoing basis.A review of National Library of Medicine (NLM) article titled, Support Surfaces for Treating Pressure Ulcers, accessed online on 2/18/26 at www.pmc.ncbi.nih.gov indicated that low air loss mattresses helped with prevention of pressure injuries, provided substantial improvement in healing of pressure injuries when compared with soft foam mattresses, and improved patients' quality of life.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interview and record review, the facility failed to ensure a resident with bowel incontinence received appropriate treatment to restore normal bowel function for one of 34 sampled residents (Resident 66) when Resident 66 received a laxative [substance that relieve constipation by softening stool or stimulating bowel movements] while having diarrhea (loose, watery stools occurring three or more times daily) and loose stools caused by C. Difficile (C. diff- a highly contagious bacteria that causes severe diarrhea) infection.This failure had the potential to result in prolonged fecal incontinence, decreased skin integrity, dehydration, and frustration for Resident 66.Findings:During a review of Resident 66's admission records, the records indicated Resident 66 was admitted in January 2026 with diagnoses that included cellulitis of right lower limb (bacterial infection of the skin and underlying tissues in the right lower leg), severe sepsis with septic shock (a life-threatening infection that causes widespread inflammation leading to organ failure), and depression (persistent sadness, loss of interest, and functional impairment in daily life). Resident 66's Minimum Data Set (MDS, a federally mandated resident assessment tool) indicated Resident 66 had intact cognition.During a review of Resident 66's care plan, initiated 1/27/26, the care plan indicated, [Resident 66] has C. Difficile Infection.Give all meds and IV [intravenous, thru the vein] therapy as ordered.During an interview on 2/10/26 at 10:33 a.m. with Resident 66, Resident 66 stated she was diagnosed with C. Difficile and had diarrhea for three weeks. Resident 66 further stated staff were giving laxative while Resident 66 was having C. Difficile infection and diarrhea.During a review of Resident 66's physician order, dated 1/21/26, the order indicated, Senna Oral [by mouth] Tablet 8.6 MG [milligrams, a unit of measurement].Give 1 tablet by mouth two times a day for BOWEL MANAGEMENT HOLD FOR LOOSE STOOLS.During a review of Resident 66's Bowel and Bladder Task, the task indicated Resident 66 had loose stools and diarrhea from 1/22/26 to 2/12/26.During a review of Resident 66's Medication Administration Record (MAR) for February 2026, the MAR indicated Senna was administered to Resident 66 on 2/1/26, 2/3/26, 2/4/26, and 2/6/26 to 2/9/26.During a concurrent interview and record review on 2/12/26 at 3:41 p.m. with the Director of Nursing (DON) and Nurse Consultant 2 (NC 2), The DON confirmed Resident 66 had C. Difficile infection. The DON further stated laxatives were held for residents having diarrhea because laxatives can trigger more diarrhea. The NC 2 confirmed Resident 66 received Senna while having loose stools and diarrhea and stated staff should have held Senna when Resident 66 started having loose stools.During a review of the facility's policy and procedure (P&P) titled Administering Medications, revised 4/2019, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed.4. Medications are administered in accordance with prescriber orders.8. If a dosage is believed to be inappropriate or excessive for a 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.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure respiratory care was provided according to professional standards for three of 34 sampled residents (Resident 124, Resident 144, and Resident 188) when: Resident 124's nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) was on the floor;Resident 144's continuous positive airway pressure (CPAP, a medical device that is used to deliver pressurized air directly into the airways) was not placed in an infection control bag after use;Resident 188's nebulizer (machine that turns liquid medicine into a mist that can be easily inhaled) mouthpiece and tubing was left on top of the nightstand and was not placed in an infection control bag after use.These failures had the potential to result in unsafe and unsanitary delivery of respiratory care to Resident 124, Resident 144 and Resident 188. 1. A review of the admission Record indicated Resident 124 was admitted [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (one-sided weakness) following cerebrovascular disease (condition affecting blood flow to the brain such as stroke) affecting left non-dominant side and polyneuropathy (disease or dysfunction of many nerves, causing numbness or weakness in the hands and feet). Resident 124's Brief Interview for Mental Status (BIMS- an assessment tool to screen and identify memory, orientation, and judgement status of the resident) indicated moderate cognitive impairment (noticeable gaps in memory or orientation requiring assistance with daily activities) with a score of 12. A review of Resident 124's physician order dated 9/13/25 indicated an order for oxygen at 2 liters per minute (2L/min, unit of measurement) via nasal cannula (NC) for shortness of breath [SOB]/chest pain [discomfort, tightness, burning]/oxygen saturation less than 90% (considered low, blood is not carrying enough oxygen to tissues, normal levels between 95% to 100%). During a concurrent observation and interview on 2/10/26 at 3:38 p.m. with Resident 124, in Resident 124's room. Resident 124 was lying in bed, the oxygen concentrator was on at 2L/min, and the NC was on the floor. Resident 124 stated she was using oxygen and she did not know what time her [NC] fell off. During a concurrent observation and interview on 2/10/26 starting at 3:42 p.m. with Licensed Nurse 7 (LN 7), in Resident 124's room, LN 7 stated Resident 124's NC was on the floor. The LN 7 further stated Resident 124 probably removed her NC. Resident 124 stated it just came off. During a concurrent observation and interview on 2/12/26 at 10:11 a.m. with Resident 124, in Resident 124's room. Resident 124 opened her eyes when her name was called. Resident 124's oxygen concentrator was on at 2L/min, the NC was on the floor. Resident 124 stated after she ate, somebody put the oxygen on her and she did not realize her oxygen [NC] came off. During a concurrent observation and interview on 2/12/26 at 10:16 a.m. with LN 8, in Resident 124's room. The LN 8 stated around 10 a.m., Resident 124 had the NC on and now the NC was on the floor. The LN 8 took an alcohol prep pad (contains 70% isopropyl alcohol), wiped the NC using the alcohol pad and reapplied NC to Resident 124. During an interview on 2/12/26 at 3:49 p.m. with the Infection Preventionist (IP), the IP stated when a nasal cannula was on the floor, the best practice was to replace the NC. The IP further stated the NC cannot be sanitized with an alcohol prep pad. The IP added the alcohol prep pad was not sufficient (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and there was potential for contamination and infection because the population was older, immune compromised and more susceptible to infections. During an interview on 2/13/26 at 9:32 a.m. with the Director of Nursing (DON), the DON stated her expectation when a nasal cannula was on the floor was to replace the NC with a new one. A review of the facility's policy & procedure revised November 2011 and titled, Departmental (Respiratory Therapy) - Prevention of Infection indicated, The purpose of this procedure is to guide prevention of infection associated with respiratory tasks and equipment .Change the oxygen cannula and tubing every seven (7) days, or as needed .Keep the oxygen cannula and tubing used PRN [as needed] in a plastic bag when not in use 2. A review of Resident 144's clinical record indicated Resident 144 was admitted January of 2026 and had diagnoses that included pneumonia (an infection in the lungs caused by bacteria, viruses or fungi) and muscle weakness. A review of Resident 144's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 2/1/26, indicated Resident 144 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 9 out of 15 which indicated Resident 144 had impaired cognition. A review of Resident 144's active physicians' order, dated 2/12/26, indicated, . CPAP settings: Mask type:(nasal). Pressure 10-12. At bedtime for Sleep Apnea (a disorder causing breathing to start and stop several times during sleep) . During a concurrent observation and interview on 2/10/26 at 4:40 p.m., with Resident 144 in Resident 144's room, Resident 144's CPAP mask and tubing were observed lying on the nightstand and not placed into an infection control bag. Resident 144 also did not have an infection control bag in his room for CPAP storage. Resident 144 confirmed the observation. During a concurrent observation and interview on 2/10/26 at 4:50 p.m., with Certified Nurse Assistant 1 (CNA 1) in Resident 144's room, CNA 1 confirmed that Resident 144's CPAP mask and tubing were lying on the nightstand and not in an infection control bag. CNA 1 was unable to locate an infection control bag in Resident 144's room. CNA 1 stated the CPAP equipment should be stored in a bag. During a concurrent observation and interview on 2/12/26 at 3:10 p.m., with the Assistant Director of Nursing (ADON), the ADON reviewed a photograph of Resident 144's CPAP mask not in an infection control bag and left lying on the nightstand after use. The ADON stated she expects CPAP masks and nebulizer mouthpieces to be stored in a bag after use for infection control purposes. The ADON further stated the nurses are responsible for placing the respiratory equipment in the bag after use. 3. A review of Resident 188's clinical record indicated Resident 188 was admitted February of 2026 and had diagnoses that included chronic obstructive pulmonary disease (COPD, a group of diseases that causes airflow blockage and breathing-related problems) and muscle weakness. A review of Resident 188's active physicians' order, dated 2/4/26, indicated, . Levalbuterol HCl [medication used to improve breathing] Inhalation Nebulization Solution 0.63 MG/3ML [milligrams/milliliters, a unit of measure] . 3 ml inhale orally via nebulizer two times a day for COPD . During a concurrent observation and interview on 2/11/26 at 9:00 a.m., with Resident 188 in Resident 188's room, Resident 188's nebulizer mouthpiece and tubing were observed left on top of the nebulizer (continued on next page)

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	555153	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Oaks Healthcare Center	11300 Fair Oaks Boulevard Fair Oaks, CA 95628

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	machine, which was placed on top of Resident 188's nightstand. Resident 188 confirmed the observation. During a concurrent observation and interview on 2/11/26 at 9:52 a.m., with Licensed Nurse 1 (LN 1) in Resident 188's room, LN 1 confirmed that Resident 188's nebulizer mouthpiece and tubing were left on top of the nebulizer machine and not in an infection control bag after use. LN 1 stated the nebulizer mouthpiece, and tubing should be placed in a bag. During an interview on 2/13/26 at 10:29 a.m., with the Infection Preventionist (IP), the IP stated, all respiratory masks, nebulizer mouthpieces and tubing should be placed in a bag. The IP further stated the bag is antimicrobial/antibacterial and is used to keep the respiratory equipment clean and is utilized to decrease the risk of infection. The IP stated her expectation is that nurses place the respiratory equipment in the bag after use. During a review of the facility's policy and procedure (P&P) titled, Departmental (Respiratory Therapy) – Prevention of Infection, revised 2011, the P&P indicated, . The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks . store . in plastic bag, marked with residents name, between uses .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure residents are free of significant medication errors for one of 34 sampled residents (Resident 56) when Resident 56's antibiotic (medication used to treat infections) doses were not administered as ordered by the physician.This failure had the potential to result in Resident 56's prolonged use of antibiotics and not having the desired effects of the medication.Findings:During a review of Resident 56's admission records, the records indicated Resident 56 was admitted to the facility in January 2026 with diagnosis that included osteomyelitis of vertebra (infection of the spine). Resident 56's MDS indicated Resident 56 had intact cognition.During a review of Resident 56's care plan, initiated 1/6/26, the care plan indicated, .[Resident 56] is on antibiotic therapy Cefazolin [an antibiotic] 2 grams (g, a unit of measurement) every 8 hours until 2/27/26.Administer ANTIBIOTIC medications as ordered by physician.During a review of Resident 56's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for January 2026, the MAR indicated an order for Cefazolin 2 grams to be given intravenously [IV - thru the vein] every eight hours for fusion lumbar spine (a surgical procedure that connects two or more bone in the spine). The MAR further indicated Resident 56's Cefazolin doses were not signed as given on 1/8/26 and on 1/29/26.During a review of Resident 56's MAR for February 2026, the MAR indicated an order for Cefazolin 2 grams to be given intravenously three times a day for spinal infection. The MAR further indicated Resident 56's Cefazolin dose was not signed as given on 2/11/26.During a review of Resident 56's nurse progress note, dated 2/12/26 at 1:52 a.m., the note indicated, .[Resident 56] is on ceFAZolin 2 gram intravenously three times a day for SPINAL INFECTION until 2/27/26, [Resident 56] missed one dose of IV ATB [antibiotic] at 2000 [8 p.m.] on 02/11/26, called pharmacy for advice.During a review of Resident 56's nurse progress note, dated 2/12/26 at 2 a.m., the note indicated, .Received Fax orders from [physician] regarding the missed IV dose notified earlier, Orders received from [physician] as follows - 1. Please advise to ask pharmacy to expedite delivery of iv Cefazolin and give when available.During an interview on 2/12/26 at 12:04 p.m. with Resident 56, Resident 56 stated staff forgot to give her antibiotic on the night of 2/11/26 and staff had to change the timing of the antibiotic. Resident 56 further stated, .I didn't get the one last 8 p.m., that's what I missed.During a joint interview on 2/12/26 at 1:20 p.m. with Licensed Nurse 15 (LN 15) and the Assistant Director of Nursing (ADON), LN 15 stated Resident 56 was supposed to receive the Cefazolin in the evening of 2/11/26 but did not receive the antibiotic, and the physician had to change the time of the dose. The ADON stated there was no information on why the Cefazolin was not given an hour before or one hour after the scheduled time of 8 p.m. on 2/11/26. The ADON stated that it was not a missed dose because the physician was notified and the dose was given on 2/12/26 at 2 a.m., six hours after the original scheduled time.During a concurrent interview on 2/12/26 at 3:41 p.m. with the Director of Nursing (DON), the DON confirmed Resident 56 had an order for Cefazolin for spinal infection. The DON confirmed that the Cefazolin dose was not signed on the MAR for the dose on 2/11/26 at 8 p.m. and stated the reason for missing the dose was not indicated in the progress notes but the notes indicated staff had requested the pharmacy for expedited delivery. The DON stated that it looked like the medication was not delivered on time and the pharmacy miscalculated the delivery.During a concurrent interview and record review on 2/13/26 at 1:23 p.m. with the Nurse Consultant 1 (NC 1), Resident 56's MAR for January 2026 was reviewed and the NC 1 confirmed The MAR indicated Resident 56's Cefazolin doses were not signed as administered on 1/8/26 and 1/29/26. The NC 1 stated if the doses were not signed on the MAR, it meant that the doses were not given. The NC 1 stated there was no documentation on why the doses were not signed on the MAR. The NC 1 stated staff should have called the physician for the missing doses because it could delay the treatment process with infection for Resident 56.During a review of the facility's policy and procedure (P&P) titled Administering Medication, revised 4/2019, the P&P (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated, .Medications are administered in a safe and timely manner, and as prescribed.4. Medications are administered in accordance with prescriber orders, including any required time frame.7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified.20. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document on the MAR that the dose was withheld or refused.22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to maintain a safe and sanitary environment when:The glass windows were cracked and shattered in the laundry room; and,The clean linen cart cover had a rip/tear.These failures had the potential for moisture build up leading to growth of molds in the laundry area and clean linens to be exposed to contaminants such as dust. During a concurrent observation and interview with the Laundry Staff 1 (LS 1) in the clean side of the laundry area on 2/11/26 at 10:07 a.m., a cardboard was taped over a broken glass window, another window was cracked with blue tape on the cracks, and the clean linen cover had a rip (linear tear) on the top portion. The LS 1 stated she placed the cardboard to prevent cold air from coming in the room and the windows had been like this for 2-3 months. The LS 1 further stated [name of Environmental Director] knew about the rip on the clean linen cover. During an interview with the LS 2 on 2/11/26 at 10:14 a.m. in the laundry room, the LS 2 stated if the cover of the clean linen cart had a rip, there was a potential for dust to go in the clean linen. The LS 2 further stated this clean linen cart goes to the nursing station. During an interview with the Environmental Director (ED) on 2/11/26 starting at 10:18 a.m. in the laundry room, the ED stated the cracked windows had been like this for the whole year and there was no replacement ordered. The ED further stated he did not notice the rip on the clean linen cover because it was folded open every time he sees it. During an interview with the Infection Preventionist (IP) on 2/12/26 starting at 3:49 p.m., the pictures taken in the laundry room was shared with the IP. The IP stated the ripped linen cover should be replaced. The IP further stated the cardboard that was taped cannot be cleaned properly and the crack in the window was a safety hazard. During a follow up interview with the ED on 2/13/26 at 8:19 a.m. in the conference room, the ED stated the cardboard used to cover the shattered glass window was a kind of board that can be cleaned. The ED further stated the shattered glass window was not a safety issue. A review of the facility's policy & procedure (P & P) revised December 2009 and titled, Maintenance Service indicated, Maintenance service shall be provided to all areas of the building .Functions of maintenance personnel include, but are not limited to .maintaining the building in good repair and free from hazards. A review of the facility's P & P revised January 2014 and titled, Departmental (Environmental Services) - Laundry and Linen indicated, The purpose of this procedure is to provide a process for the safe .handling .and storage of linen .Clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination, such as covering clean linen carts.