STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555161	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Napa Valley Care Center	3275 Villa Lane Napa, CA 94558

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written transfer notification to one of 30 sampled residents (Resident 6) or to his representative upon Resident 6's transfer to an acute care hospital on 4/2/2025. This failure had the potential for Resident 6 and/or his representative not to be informed of his rights to return to the facility following a hospitalization. Findings:During a review of Resident 6's admission Record, dated 7/22/2025, the admission Record indicated Resident 6 was admitted to the facility on [DATE] with a diagnosis of chronic respiratory failure (a long-term condition where the lungs cannot adequately exchange oxygen and carbon dioxide). During a review or Resident 6's Progress Notes, dated 4/2/2025, the Progress Notes indicated at 10:28 p.m., Resident 6 appeared to be jaundice (a condition characterized by the yellowing of the skin, mucous membranes, and whites of the eyes) and confused. The physician was notified of the altered mental status (a change in a person's level of consciousness, awareness, and cognitive function) and the jaundice. At 10:30 p.m., the Progress Notes indicated (name of the doctor) ordered to send Resident 6 to (name of the hospital) and if Resident 6 worsens or becomes unstable, to send him via 911. At 11:27 p.m., the Progress Notes indicated Resident 6 was picked up by two emergency medical technicians and left the facility.During a review of Resident 6's Bed Hold Policy and Notification, dated 12/31/2024, the section that indicated to be completed upon transfer was blank. This blank section identifies the name of the resident, when and where the resident was transferred to, the name, date, and time the person who was notified of the transfer, and if the person notified has been informed of their rights to hold the resident's bed. During an interview on 7/25/2025 at 9:24 a.m., with the Director of Nursing (DON), the DON confirmed that there was no documented evidence a written transfer notification was provided to Resident 6 or his representative when Resident 6 was transferred to a hospital on 4/2/2025.During a review of the facility's policy and procedure (P&P) titled, Bed-Holds and Returns, dated October 2022, the P&P indicated, 1. All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice: a. notice 1: well in advance of any transfer (e.g., in the admission packet); and b. notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours).

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to initiate and create a care plan (an individualized plan that provides direction on the type of care a patient needs) for one of 30 sampled residents (Resident 125), when Resident 125 was placed on contact precautions (infection control measures used to prevent the spread of infectious agents that can be transmitted through direct or indirect contact with a resident or their environment) on 5/12/2025. This failure had the potential to not provide the necessary care and treatment for Resident 125.Findings:During a review of Resident 125's admission Record, dated 7/22/2025, the admission Record indicated Resident 125 was admitted to the facility on [DATE] with diagnosis of facial weakness following a cerebral infarction (when blood supply to part of the brain is blocked or reduced).During an interview on 7/21/2025 at 5:14 p.m., with the Infection Preventionist (IP), IP stated Resident 125 was on contact precautions because Resident 125 had a wound on his scrotum which tested positive for MRSA (Methicillin-resistant Staphylococcus aureus, a type of bacteria that has become resistant to many of the antibiotics used to treat an ordinary staph infection).During a review of Resident 125's Progress Notes, dated 5/12/2025 at 1:25 p.m., the Progress Notes indicated a wound was noted with MRSA and contact isolation precautions were started. The Progress Notes further indicated IP was updated on the new orders and culture results.During a concurrent interview and record review on 7/23/2025 at 2:15 p.m., with MDS (Minimum Data Set) Coordinator 1 (MDS 1) , Resident 125's isolation precautions care plan was reviewed. MDS 1 stated IP created the isolation precautions care plan on 6/12/2025 (a month after Resident 125 tested positive for MRSA) and not 5/12/2025. MDS 1 further stated the initiation date of a care plan can be changed but not the creation of the care plan. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated March 2022, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation . 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the care plans: a. when there has been a significant change in the resident's condition.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being for one of 30 sampled residents (Resident 96) when there were no documented evidence Resident 96 was exhibiting wandering behavior prior to placing a wander guard bracelet (a wearable device designed to help prevent residents at risk of wandering from leaving a designated area in a care facility). This failure resulted in Resident 96's quality of life being negatively affected when Resident 96 stated he could not do the things he likes to do.Findings:During a review of Resident 96's admission Record, dated 7/22/2025, the admission Record indicated Resident 96 was admitted to the facility on [DATE] with metabolic encephalopathy (a condition where the brain's function is impaired due to an underlying condition such as electrolyte imbalances and infections) and generalized muscle weakness. During a review of Resident 96's Minimum Data Set (MDS, a health status screening and assessment tool) dated 6/3/2025, under Section C - Cognitive Patterns indicated Resident 96 was cognitively intact. During a concurrent observation and interview on 7/21/2025 at 4:42 p.m., in Resident 96's room, Resident 96 had a wander guard bracelet on his right ankle. Resident 96 stated he had the wander guard bracelet so that he would not go beyond the borders of the facility. Resident 96 stated he had asked the staff to remove it because he did not like it. Resident 96 stated he was restricted inside the facility and felt like he was in a police department. Resident 96 further stated that he likes to sit outside to get fresh air so that he can talk to people and make some friends. Resident 96 stated the wander guard prohibits him from going outside and making some friends. During a review of Resident 96's Order Summary Report, dated 7/23/2025, the Order Summary Report indicated an order on 6/4/2025 for a wander guard to the right ankle related to wandering/exit seeking behaviors and for the nurse to check its placement every shift until October 2027.During a review of Resident 96's MDS dated [DATE], under Section E - Behavior, indicated Resident 96 had not been exhibiting wandering behavior.During a concurrent interview and record review on 7/23/2025 at 2:59 p.m., with the Assistant Director of Nursing (ADON), Resident 96's medical record was reviewed. Resident 96's Elopement and Wandering Risk Observation/Assessment dated 5/27/2025 indicated Resident 96 had not expressed a desire to leave, had not attempted to leave the facility, and did not exhibit unsafe wandering or elopement attempts. The Elopement and Wandering Risk Observation/Assessment further indicated although Resident 96 exhibited agitation, Resident 96 may be redirected and did not warrant the use of wander alarms. The ADON confirmed that Resident 96 scored 4 on his Elopement and Wandering Risk Observation/Assessment which indicated that Resident 96 had a low risk of elopement and wandering. The ADON stated Resident 96 ambulated and there was an incident when Resident 96 attempted to leave the facility without informing the staff. The ADON confirmed Resident 96 was not reassessed for elopement and wandering risk after the incident. The ADON stated Resident 96 should have been reassessed for elopement and wandering risk.In addition, the ADON confirmed Resident 96's Informed Consent for Use of Wander/Elopement Alarm dated 6/4/2025 was incomplete. The ADON confirmed that the Informed Consent for Use of Wander/Elopement Alarm had no documentation of medical needs that address the use of wander/elopement alarm for Resident 96, had no documentation of the possible benefits of wander/elopement alarm use, had no documentation of possible risks of the wander/elopement alarm use and how will these risks be mitigated, and had no documentation of alternatives to wander/elopement alarms use that have been attempted but failed to meet Resident 96's needs. The ADON confirmed there was no documentation regarding the reason a wander guard bracelet was placed on Resident 96 on 6/4/2025. During a concurrent interview and record review on 7/23/2025 at 4:26 p.m., with the Director of Nursing (DON), the DON confirmed there was no documentation and no indication on why a wander guard bracelet was placed on Resident 96. The DON stated Resident 96 did not try to elope or had any episodes of elopement or wandering but rather Resident 96 was walking around the parameter of the facility just like what he used to do when he was at home. The DON stated she was being precautious and jumped the gun on putting a wander guard bracelet on Resident 96. The DON confirmed there was no documentation of alternative interventions done prior to putting a wander guard bracelet on Resident 96. The DON stated Resident 96 should have been reassessed for elopement and wandering behavior prior to putting a wander guard bracelet on him.During an interview on 7/24/2025 at 10:28 a.m. with the Receptionist, the Receptionist stated she works Monday to Friday from 8 a.m. to 4:30 p.m. The Receptionist stated Resident 96 would ask

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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. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of 30 sampled Residents (Residents 36 and 53) that:1.Resident 36's oxygen therapy was reviewed and updated to reflect her current clinical status. This failure had the potential to compromise the care provided to Resident 36.2.Residents 53's nasal cannula (a device used to deliver supplemental oxygen through the nose) was labeled and stored appropriately. This failure had the potential for residents to be exposed to infectious diseases. Findings:1. During a review of Resident 36's admission Record, dated 7/22/2025, the admission Record indicated Resident 36 was admitted to the facility on [DATE] with diagnosis of heart failure. During a review of Resident 36's Physician's order, dated 1/8/2025 and 1/17/2025, the physician's order indicated Oxygen at 2 liters/minute (unit of measurement) by nasal cannula (a device used to deliver supplemental oxygen through the nose), continuously for CHF (Congestive Heart Failure, a condition where the heart does not pump blood as well as it should), and the goal was to maintain the oxygen saturation (O2 Sat, a measurement of how much oxygen your blood is carrying), greater than 90 percent. Further review of the physician's order indicated to monitor the oxygen saturation every shift.During a review of Resident 36's Quarterly Minimum Data Set (MDS, a health status screening and assessment tool), dated 1/24/2025, under Section O - Special Treatment, Procedures, and Programs, the oxygen therapy was checked.During a review of Resident 36's Annual MDS, dated [DATE], under Section O - Special Treatment, Procedures, and Programs, the oxygen therapy was not checked.During a review of Resident 36's Oxygen Therapy Care Plan (an individualized plan that provides direction on the type of care a patient needs), revised 1/17/2025, the oxygen care plan indicated Resident 36 required the use of continuous oxygen related to CHF.During a review of Resident 36's Provider Progress Notes, dated 7/14/2025 by Nurse Practitioner (NP 1), the provider progress notes indicated Resident 36 has not been using oxygen per nasal cannula all the time and was used just as needed. During an observation on 7/23/2025 at 7:36 a.m., in Resident 36's room, Resident 36 was not on oxygen therapy. An oxygen concentration was next to Resident 36's foot of the bed and not powered on. During a concurrent observation and interview on 7/23/2025 at 11:41 a.m. with Licensed Vocational Nurse (LVN 8), outside of Resident 36's room, Resident 36 was not on oxygen therapy. LVN 8 stated Resident 36 was not on continuous oxygen therapy, but just as needed. During an interview on 7/23/2025 at 11:44 a.m., with Resident 36, Resident 36 stated she uses oxygen when she gets out of breath. Resident 36 stated she used oxygen sometimes and not continuously. Resident 36 stated the last time she used oxygen was last week.During a concurrent interview and record review on 7/23/2025 at 11:46 a.m., with the Assistant Director of Nursing (ADON), the physician's orders for oxygen therapy and the oxygen saturation documentation was reviewed. The ADON confirmed, Resident 36's current oxygen therapy dated 1/17/2025 was ordered as continuous. The ADON confirmed, Resident 36's O2 Sats Summary for the month of July 2025 indicated Resident 36 was either on room air or on nasal cannula. The ADON stated the nurses should collaborate with the interdisciplinary team to determine whether Resident 36 needed continuous or as needed oxygen therapy and then clarify the order with Resident 36's physician. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated October 2022, the P&P indicated, 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.2. During a review of Resident 53's admission Record, dated 7/22/2025, the admission Record indicated Resident 53 was admitted to the facility on [DATE] with diagnosis of Parkinson's Disease (a movement disorder that worsens over time).During a concurrent observation and interview on 7/21/2025 at 2:45 p.m., with Resident 53, in Resident 53's room, two portable oxygen tanks were observed in the room. One portable oxygen tank was next to Resident 53 and one portable oxygen tank was next to a console table near Resident 53's area in the room. Both portable oxygen tanks had unlabeled nasal cannulas wrapped on top of the tanks. Resident 53 stated she did not remember the last time she used the oxygen, but she uses the oxygen as needed. During a concurrent observation and interview on 7/21/2025 at 3:11 p.m., with Licensed Vocational Nurse (LVN 1), in Resident 53's room, LVN 1 confirmed the two portable oxygen tanks had unlabeled nasal cannulas wrapped on top of the tanks. LVN 1 stated the nasal cannulas should have been dated and placed in a bag.During a review of Resident 53's Physician's order, dated 11/29/2023, the physician's order indicated oxygen at two liters per minute by nasal cannula as needed for chest pain and shortness of breath and the goal was to maintain oxygen saturation (O2 Sat, a measurement of how much

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure sufficient nursing staff were available to respond to call lights in a timely manner for one of 30 sampled residents (Resident 113). This failure resulted in Resident 113 experiencing long wait times and feelings of neglect.Findings:During a review of Resident 113's Minimum Data Set (MDS, a health status screening and assessment tool), dated [DATE], the MDS indicated Resident 113 was admitted on [DATE] with diagnoses that included Multiple Sclerosis (disease that affects the nervous system and can lead to problems with movement and balance) and muscle weakness. During a review of Resident 113's Quarterly MDS Assessment, dated [DATE], the quarterly MDS assessment indicated in Section GG: Functional Abilities and Goals: that Resident 113 ambulated by wheelchair and required moderate assistance with the following tasks: (1) the ability to bathe and dry self, (2) the ability to dress and undress above the waist, (3) the ability to dress and undress below the waist, and (4) the ability to put on and take off footwear.During an interview on [DATE] at 2:57 p.m. with Resident 113, Resident 113 stated that he had a concern regarding staff response times. Resident 113 stated that he has sat on the toilet and waited for assistance from staff for 20 to 30 minutes multiple times before a staff member was available to assist him.During a concurrent observation and interview on [DATE] at 10:20 a.m., with Resident 113, in the hallway outside his room, his right hand and arm were observed with moderate tremor-like shaking movement. Resident 113 stated that he waited 45 minutes today after pressing his call light around 8:45 a.m., because his assigned Certified Nursing Assistant (CNA 1) was pulled for shower duty and arrived around 9:30 a.m. Resident 113 stated he had physical therapy scheduled at 10:00 a.m. and needed help from staff with getting up, using the bathroom, and getting dressed for his scheduled therapy. Resident 113 stated because he was upset he was unable to get assistance from staff to get ready, he decided to cancel his therapy. Resident 113 stated, when he gets worked up he can get a little shaky. Resident 113 stated, I feel neglected. Resident 113 stated he doesn't understand why his assigned CNA 1 is often pulled to shower duty when he requires assistance with his activities of daily living (ADLs), such as toileting and hygiene care in the morning.During an interview with Licensed Vocational Nurse (LVN 3) on [DATE] at 10:34 a.m., LVN 3 confirmed, Resident 113 approached him on multiple occasions with concerns about staff response times.During an interview with CNA 2 on [DATE] at 9:22 a.m., CNA 2 confirmed, Resident 113 voiced concerns about call light response times maybe a few times a week. CNA 2 stated, there were signs posted throughout the facility that stated, Call lights are for everyone. CNA 2 stated everyone is supposed to answer call lights but really it seems like it's only the CNAs who do. CNA 2 confirmed, staffing has been an issue and the difference between having five CNAs on the floor as opposed to four CNAs, is that each CNA has less showers to do and will have more time to assist residents and answer call lights.During an interview with the Director of Nursing (DON) on [DATE] at 3:16 p.m., the DON stated her expectation on response time for call lights was The fastest.the better. DON stated that when someone must wait after pressing their call light, that 45 minutes would be a long time to wait.During an interview on [DATE] at 8:30 a.m. with the Administrator (Admin), Admin stated the facility had experienced a shortage of CNAs. Admin confirmed that the facility's program flex called, Workforce Shortage Waiver, expired on [DATE]. Admin stated the licensed nurses should be used to replace CNAs and be responsible for specific residents, carrying a full CNA assignment and completing CNA duties.During a record review of the facility's CNA Direct Care Service Hours Per Patient Per Day (CNA DHPPD, a way to measure staffing levels by how much hands-on care time each resident gets from a CNA in a nursing home each day), [DATE] to [DATE], the CNA direct care service hours indicated, for the last 3 months, the facility did not meet the minimum staffing requirement of 2.4 CNA DHPPD hours on multiple days that included:(1) [DATE] actual CNA DHPPD: 1.95 (requirement of 2.4 not met)(2) [DATE] actual CNA DHPPD: 1.96 (requirement of 2.4 not met)(3) [DATE] actual CNA DHPPD: 2.30 (requirement of 2.4 not met)(4) [DATE] actual CNA DHPPD: 2.14 (requirement of 2.4 not met)(5) [DATE] actual CNA DHPPD: 2.02 (requirement of 2.4 not met)(6) [DATE] actual CNA DHPPD: 2.14 (requirement of 2.4 not met)(7) [DATE] actual CNA DHPPD: 2.12 (requirement of 2.4 not met)(8) [DATE] actual CNA DHPPD: 2.13 (requirement of 2.4 not met)(9) [DATE] actual CNA DHPPD: 2.12 (requirement of 2.4 not met)(10) [DATE] actual CNA DHPPD: 1.98 (requirement of 2.4 not met)During a review of the California Health and Safety Code (HSC), section 1276.65, [undated], the HSC section 1276.65, indicated facilities are required to provide prompt response by facility staff to patient calls

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the medication error rate was not greater than five percent when four identified medication errors out of 27 opportunities were observed:1. Vancomycin (antibiotic used to treat serious bacterial infections) solution was not administered per medication label instructions for one of 30 sampled residents (Resident 50).2. Insulin Aspart (rapid acting medication used to decrease blood sugar) was administered at the wrong time for one of 30 sampled residents (Resident 39).3. Albuterol (medication used to prevent and treat breathing difficulties) was not administered per physician instructions for one of 30 sampled residents (Resident 16).4. Eliquis (medication to prevent and treat blood clots) was not administered per physician instructions for one of 30 sampled residents (Resident 16).These failures resulted in an overall facility medication error rate of 14.81% and had the potential to result in negative health outcomes for Resident 16, Resident 39, and Resident 50.Findings:1. During a review of Resident 50's Face Sheet (Resident Demographics), the Face Sheet indicated, Resident 50 was admitted to the facility on [DATE] with diagnoses which included Abscess of the Liver (localized infection in the liver that forms pus-filled pocket), and Type 2 Diabetes Mellitus (disease that causes blood sugar levels to be high).During an observation on 7/23/2025 at 12:03 p.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 was observed preparing Resident 50's Vancomycin. The label on the Vancomycin bottle indicated, Shake Well. LVN 4 partially tipped Resident 50's Vancomycin solution bottle once and poured the medication into a medication cup for administration. LVN 4 administered Vancomycin solution to Resident 50. During an interview on 7/24/2025 at 2:03 p.m. with Licensed Vocational Nurse (LVN 2), LVN 2 stated medications with Shake Well label should be inverted several times prior to administration.During an interview on 7/24/2025 at 2:17 p.m. with the Pharmacist, the Pharmacist stated Vancomycin solution should be shaken well prior to administration to prevent the solution from separating. The Pharmacist stated the Vancomycin solution bottle should have been fully tilted for a minimum of 2 times.During a review of the facility's policy and procedure (P&P) titled, Specific Medication Administration Procedures, dated June 2021, the P&P indicated, To administer medications in a safe and effective manner. Check MAR (Medication Administration Records) for order.Read medication label three (3) times.prior to removing the medication from the package/container.2. During a review of Resident 39's Face Sheet (Resident Demographics), the Face Sheet indicated Resident 39 was admitted to the facility on [DATE] with diagnoses which included Type 2 Diabetes Mellitus (disease that causes blood sugar levels to be high).During an observation on 7/23/2025 at 3:35 p.m. with Licensed Vocational Nurse (LVN 2) in Resident 39's room, LVN 2 was observed preparing Resident 39's Insulin Aspart. The Insulin Aspart medication label indicated give before meal. LVN 2 administered Insulin Aspart 2 units (unit of measure) via flex pen (inject device) to Resident 39. LVN 2 did not instruct Resident 39 to eat or offer food to Resident 39 after administering the medication. No food items were observed in Resident 39's room.During an observation on 7/23/2025 at 4:46 p.m. in Resident 39's room, Resident 39 was seated in his wheelchair with no food in his room.During a concurrent observation and interview on 7/23/2025 at 5:16 p.m. with Resident 39 in Resident 39's room, Resident 39 was sleeping in his wheelchair. Resident 39 aroused when his name was called. No food or snacks were observed in Resident 39's room. Resident 39 stated he usually gets his insulin before meals and was unsure why his Insulin was administered early. Resident 39 confirmed he had not eaten since his insulin administration. During an interview on 7/23/2025 at 5:25 p.m. with Director of Nursing (DON), the DON stated meals should be given approximately 15-30 minutes after rapid acting insulin administration.During an interview on 7/24/2025 at 1:40 p.m. with LVN 2, LVN 2 stated she administered Resident 39's insulin too early.During a review of Resident 39's Physician Orders dated 6/11/2025, the Physician Orders indicated Insulin Aspart Injection Solution 100 unit/ml (milliliter, unit of measure) inject subcutaneously (under the skin) before meals. During a review of the facility's policy and procedure titled, Specific Medication Administration Procedures, dated June 2021, the P&P indicated, To administer medications in a safe and effective manner. Check MAR (Medication Administration Records) for order.Read medication label three (3) times.prior to removing the medication from the package/container.3. During a review of the Resident 16's Face Sheet (Resident Demographics), [undated], the Face Sheet indicated Resident 16 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD, group of lung diseases that cause ongoing breathing problems) and chronic atrial fibrillation (disorder where upper chambers of heart beat

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of 30 sampled residents (Resident 39) remained free from significant medication error when rapid acting insulin (medication used to decrease blood sugar) was administered at the wrong time.This failure had the potential to result in Resident 39 experiencing adverse complications from hypoglycemia (condition in which blood sugar level drops below normal) including dizziness, sleepiness, passing out or death. Findings:During a review of Resident 39's Face Sheet (Resident Demographics), the Face Sheet indicated Resident 39 was admitted to the facility on [DATE] with diagnoses which included Type 2 Diabetes Mellitus (disease that causes blood sugar levels to be high).During an observation on 7/23/2025 at 3:35 p.m. with Licensed Vocational Nurse (LVN 2), in Resident 39's room, LVN 2 administered Insulin Aspart (rapid acting medication used to decrease blood sugar) 2 units (unit of measurement) via flex pen (injection device). Resident 39's Insulin Aspart medication label indicated give before meals. LVN 2 did not instruct Resident 39 to eat or offer food to Resident 39 after administration. No food items were observed in Resident 39's room.During an observation on 7/23/25 at 4:46 p.m., Resident 39 was in his room speaking with maintenance staff. No food items were observed in the resident's room.During a concurrent observation and interview on 7/23/2025 at 5:16 p.m. with Resident 39, in Resident 39's room, Resident 39 was sleeping in his wheelchair. Resident 39 aroused when his name was called. No food or snacks were observed in Resident 39's room; two unopened bottles of cola were observed on the resident's bedside table. Resident 39 stated he was tired, and staff usually administered his insulin approximately 30 minutes before he eats. Resident 39 stated I don't know why [nurse] gave it to me so early today. Resident 39 confirmed he had not eaten since his insulin administration.During an interview on 7/23/2025 at 5:25 p.m. with the Director of Nursing (DON), the DON stated meals should be given approximately 15-30 minutes after rapid acting insulin administration. The DON stated LVN 2 should not have administered insulin without feeding Resident 39.During an interview on 7/24/2025 at 1:40 p.m. with LVN 2, LVN 2 stated Resident 39's insulin was administered too early.During an interview on 7/24/2025 at 2:17 p.m. with the Pharmacist, the Pharmacist stated rapid acting insulin should be administered 30 minutes prior to meals. The Pharmacist stated Resident 39 was at risk for hypoglycemia.During a review of Resident 39's Physician Orders, dated 6/11/2025, the physician orders indicated Insulin Aspart Injection Solution 100 unit/ml (milliliters, unit of measurement) inject.subcutaneously (under the skin) before meals.During a review of the facility's policy and procedure (P&P) titled, Specific Medication Administration Procedures, dated June 2021, the P&P indicated, To administer medications in a safe and effective manner. Check MAR (Medication Administration Records) for order.Read medication label three (3) times.prior to removing the medication from the package/container.During a review of the facility's policy and procedure (P&P) titled Insulin Administration dated March 2025, the P&P indicated, Key characteristics of insulin are: Onset of action-how quickly the insulin reaches the bloodstream and begins to lower blood glucose; Peak effects- the time when the insulin is at its maximum effectiveness.Insulin: Rapid acting.Onset within 15 min, Peak 0.5-1.5 hrs.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure a medication cart (a cart that contains medications for residents) was locked while not in use and unattended. This failure had the potential to allow residents, staff and visitors to gain access to the medication cart.Findings:During a concurrent observation and interview on 7/21/2025 at 1:50 p.m. with the Infection Preventionist (IP) on Unit 1A, the medication cart was observed unlocked and unattended. IP stated the medication cart should be locked when not in use.During an interview on 7/22/2025 at 8:47 a.m. with the Director of Nursing (DON), the DON stated the medication carts should be locked at all times when not in use.During a review of the facility's policy and procedure (P&P) titled, Storage of Medications, revised April 2007, the P&P indicated, Compartments .containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.

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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 ensure food was stored in safe and sanitary conditions in the food service department when:1. The walk-in fridge contained food items that were not labeled.2. The walk-in fridge and freezer number #3 contained food items that were expired.These failures had the potential to place residents at risk for developing food-borne illnesses (sickness by consuming contaminated food or drinks) by exposing residents to contaminated food and unsanitary practices.Findings:1.During a concurrent observation and interview on 7/21/2025 at 1:35 p.m. with the Dietary Manager (DM) in the kitchen's walk-in fridge, there was an opened bag of parsley with the date of 7/20/2025, a container with eight red onions with an expiration date of 7/12/2025, and two boxes of fully cooked bacon with no date. The DM stated that the parsley, red onions and fully cooked bacon were expired and should be discarded to prevent food-borne illnesses.During an interview on 7/24/2025 at 8:10 a.m. with the Registered Dietitian (RD), the RD stated the kitchen staff had not been labeling the received date and the expiration date of food items, because the kitchen staff expected the DM to perform this task. The RD stated this was not an acceptable practice and the kitchen staff were also responsible for accurately labeling and dating any food products to prevent cross-contamination and food-borne illnesses. The RD further stated the expiration date was important to ensure the residents consumed a safe food product.During a review of the facility's policy and procedure (P&P) titled, Food Receiving and Storage, dated November 2022, the P&P stated 1. All foods stored in the refrigerator or freezer are covered, labeled and dated (use-by-date). 7. Refrigerated foods are labeled, dated and monitored so they are used by their use-by date.or discarded. 2. During a concurrent observation and interview on 7/21/2025 at 4:00 p.m., with the Kitchen Aide (KA 2) in the kitchen's freezer number #3, there was a bag of gluten free white bread, unopened, and a used-by-date of 7/6/2025. KA 2 stated this item was expired and should be discarded to prevent food contamination. During an interview on 7/24/2025 at 8:10 a.m. with the Registered Dietitian (RD), the RD stated the kitchen staff had not been labeling the received date and the expiration date of food items, because the kitchen staff expected the DM to perform this task. The RD stated this was not an acceptable practice and the kitchen staff were also responsible for accurately labeling and dating any food products to prevent cross-contamination and food-borne illnesses. The RD further stated the expiration date was important to ensure the residents consumed a safe food product.During a review of the facility's policy and procedure (P&P) titled, Food Receiving and Storage, dated November 2022, the P&P stated 1. All foods stored in the refrigerator or freezer are covered, labeled and dated (use-by-date). 7. Refrigerated foods are labeled, dated and monitored so they are used by their use-by date.or discarded.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to ensure the garbage was disposed of properly, when a garbage can lid and a garbage compactor (a machine that reduces the volume of trash by compacting it), were not closed and the surrounding area had piles of trash bags on the ground.This failure resulted in pest attraction and odor in the garbage disposal area.Findings:During a concurrent observation and interview on 7/23/2025 at 11:50 a.m., with the Housekeeping Supervisor (HS), in the garbage disposal area, the garbage compactor was not closed, the surrounding area had piles of trash bags on the ground with flies and a foul odor. The HS stated the compactor should be covered when not in use to prevent odor and to prevent attracting pests.During a concurrent observation and interview on 7/24/2025 at 7:50 a.m., with Housekeeping (HK), in the garbage disposal area, one of the garbage can lids was opened with birds flying in and out of the garbage can. Housekeeping (HK) stated the garbage can lid needed to be closed to prevent harborage of rodents or pests.During an interview on 7/24/2025 at 8:10 a.m. with the Infection Preventionist (IP), the IP stated the garbage can lid had to be closed at all times and the area around it had to be clean. The IP further stated this was important to prevent attracting rats and pests to the facility.During a review of the Food and Drug Administration (FDA) Food Code 2022, Section 5-501.110 Storage Refuse, Recyclables, and Returnable, dated January 2023, the FDA food code indicated, Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. proper cleaning of garbage storage areas and receptacles so that unsanitary conditions can be eliminated.

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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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a speech therapy evaluation for one of 30 sampled residents (Resident 60) was performed when ordered by the physician.This failure had the potential to result in Resident 60 receiving an inappropriate diet, choking or weight loss.Findings:During a review of Resident 60's Face Sheet (Resident Demographics), the Face Sheet indicated Resident 60 was admitted to the facility on [DATE] with diagnoses which included Myasthenia Gravis (chronic autoimmune disease that causes muscle weakness) and Parkinson's Disease (brain disorder that causes uncontrollable body movements). During a review of Resident 60's Physician Orders, dated 6/11/2025, the physician orders indicated, a speech therapy evaluation was ordered for Resident 60 on 6/11/2025 at 11:13 a.m. There was no documentation in Resident 60's record which indicated the speech therapy consult had been performed (43 days later).During an interview on 7/24/2025 at 2:44 p.m. with the Speech Therapist (ST), the ST confirmed Resident 60's speech therapy evaluation had not been completed. ST stated the order was missed.During an interview on 7/24/2025 at 2:59 p.m. with the Director of Rehabilitation (DOR), the DOR stated speech therapy evaluation orders should be completed within approximately 48 hours. The DOR confirmed Resident 60's speech therapy evaluation order from 6/10/2025 was not completed in a 48-hour time frame.During an interview on 7/25/2025 at 9:05 a.m. with Licensed Vocational Nurse (LVN 2), LVN 2 stated nurses were responsible for verifying speech therapy evaluation consults were completed to ensure residents were receiving the correct diet. LVN 2 stated omitted speech therapy evaluation orders could result in resident choking or receiving the incorrect diet.During a review of the facility's policy and procedure (P&P) titled, Specialized Rehabilitative Services, dated December 2022, the P&P indicated, In addition to rehabilitative nursing care, the facility provides specialized rehabilitative services by qualified professional personnel. Specialized rehabilitative services include the following: Speech pathology/audiology.Therapeutic services are provided only upon the written order of the resident's attending physician.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow and implement infection control practices and maintain a sanitary environment when:1. A contact precaution order was not in place when Resident 125 was identified to have a multidrug resistance organism (MDRO, a bacteria that have developed resistance to multiple antibiotics).2. Dirty items were found stored in the clean shower.3. An unlabeled urinal was found stored in a bathroom sink next to oral hygiene items in room [ROOM NUMBER]. Unlabeled oral hygiene items were found stored on top of a toilet lid in room [ROOM NUMBER].4. Enhanced Barrier Precautions (EBP- safety measures in place for residents with wounds or indwelling devices) was not implemented for one of 30 sampled residents (Resident 7) with a wound vac (medical device that heals slow-healing wounds by using gentle suction).These failures had the potential to result in the spread of infectious diseases amongst residents, staff, and visitors.Findings: 1. During a review of Resident 125’s “admission Record,” dated 7/22/2025, the admission record indicated Resident 125 was admitted to the facility on [DATE] with diagnosis of facial weakness following a cerebral infarction (when blood supply to part of the brain is blocked or reduced). During a review of Resident 125’s “Progress Notes,” dated 5/12/2025 at 1:25 p.m., the progress notes indicated a wound was noted with MRSA (Methicillin-Resistant Staphylococcus Aureus, a type of bacteria that has become resistant to many of the antibiotics used to treat an ordinary staph infection) and contact isolation precautions were started. The progress notes further indicated the IP nurse was updated on the new orders and culture results. During a review of Resident 125’s Contact Precautions Order, dated 6/12/2025, the order indicated an order for contact precautions related to MRSA in wound. During an interview on 7/21/2025 at 5:17 p.m., with the Infection Preventionist (IP), the IP stated Resident 125 was on contact precautions (infection control measures used to prevent the spread of infectious agents that can be transmitted through direct or indirect contact with a patient or their environment), because Resident 125 had a wound on his scrotum which tested positive for MRSA. During a concurrent observation and interview on 7/21/2025 at 5:42 p.m., a “Contact Precautions” sign was posted on the outside of Resident 125’s room. The “Contact Precautions” sign indicated that everyone must clean their hands, including before entering and when leaving the room. The “Contact Precautions” sign further indicated providers and staff must also put on gloves before room entry, discard gloves before room exit, put n gown before room entry, and discard gown before room exit. During an interview on 7/23/2025 at 11:34 a.m., with the Director of Nursing (DON), the DON stated when a culture was received and the culture indicated a MDRO requiring contact precautions, then contact precautions would be initiated right away and there should be an order for contact isolation in place at that time. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility’s policy and procedure (P&P) titled, “Isolation-Initiating Transmission-Based Precautions,” dated September 2024, the P&P indicated, “Transmission-Based Precautions will be initiated when there is reason to believe that a resident has a communicable infectious disease. 4. Transmission-Based Precautions shall remain in effect until the Attending Physician or Infection Preventionist discontinues them, which should occur after pertinent criteria for discontinuation are met.” 2. During a concurrent observation and interview on 7/21/2025 at 1:59 p.m. with the Infection Preventionist (IP) in the shower room on Unit 1A, two dirty linen barrels and one rolling commode were found stored in the clean shower. IP stated the dirty linen barrels and rolling commode should be stored in the dirty utility area, not the clean shower area. The facility was unable to provide a policy regarding the storage of dirty items at the time requested. 3. During a concurrent observation and interview on 7/22/2025 at 12:14 p.m. with Certified Nursing Assistant (CNA 3), in room [ROOM NUMBER]’s shared bathroom, an unlabeled urinal was observed in the sink next to oral hygiene items (toothbrush and toothpaste) that were uncovered and left open to the air. CNA 3 stated that the urinal should not be kept in the bathroom. CNA 3 further stated that the urinal should be stored at the resident's bedside. CNA 3 confirmed that the urinal was not labeled, and that the urinal should have been labeled with the resident's name. During a concurrent observation and interview on 7/23/2025 at 11:15 a.m. with Licensed Vocational Nurse (LVN 5), in room [ROOM NUMBER]’s shared bathroom, an unlabeled emesis basin containing a toothbrush, mouth wash, toothpaste, and a razor was observed sitting on top of the toilet tank and left uncovered and open to the air. LVN 5 stated she did not know which resident the hygiene items belonged to and confirmed the items were unlabeled. LVN 5 stated that the hygiene items should have been labeled and stored in the bedside cabinet and should not be stored on top of the toilet. During a review of the facility’s policy and procedure (P&P) titled, “Cleaning and Disinfecting Non-Critical Resident-Care Items,” dated June 2022, the P&P indicated, “Single resident use items are for single resident use only. [NAME] with the resident’s name and/or room number. Bedpans…Return the bedpan or urinal to resident’s bedside cabinet.” 4. During a review of Resident 7’s Minimum Data Set (MDS, a health status screening and assessment tool), dated 7/24/2024, the MDS indicated, Resident 7 was admitted on [DATE] with diagnoses that included unspecified fracture of left pubis (anterior bone of the pelvis). During a review of Resident 7’s Physician Orders, dated 6/10/2025, the physician orders indicated, an order for a wound vac was placed on 6/10/2025 for Resident 7. During a review of Resident 7's Physician Orders, dated 7/22/205, the physician orders indicated, an order for Enhanced Barrier Precautions on 7/22/2025 (42 days later), indication: Wound Vac, with PPE (personal protective equipment, specifically gown and gloves) required for high resident contact care activities. During an observation on 7/21/2025 at 2:50 p.m. in Resident 7’s room, the door was observed as having no notable signage present. (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 7/22/2025 at 8:51 a.m. with Resident 7, in Resident 7’s room, a new sign on Resident 7’s door indicated Enhanced Barrier Precautions were in place directing staff to wear gowns and gloves for high-contact resident care activities, such as dressing, transferring, providing hygiene, device care and wound care. A dispenser stocked with isolation gowns and gloves was observed on the front of Resident 7’s door for staff use. Resident 7 stated that she had a wound vac and confirmed that staff have not consistently worn isolation gowns when providing hygiene or wound care to her in the last month. During an interview on 7/23/2025 at 2:30 p.m., with Licensed Vocational Nurse (LVN 2), LVN 2 stated Enhanced Barrier Precautions (EBP) requires that a gown and gloves are worn for resident care tasks when a resident is on EBP. LVN 2 stated, EBP was for the protection of the residents. LVN 2 further stated, when staff members provide care to residents on EBP without wearing gowns and gloves, they put the residents at increased risk for infection. During an interview on 7/24/2025 at 3:08 p.m., with the Director of Nursing (DON), the DON stated a staff member responding to a call light is not likely to know that a resident requires Enhanced Barrier Precautions if EBP signage is not in place on the resident’s door. The DON stated, a possible consequence of not implementing EBP was infection and EBP is for the protection of residents. During a review of the facility’s policy and procedure (P&P) titled “Enhanced Barrier Precautions,” revised December 2024, the P&P indicated, “Enhanced barrier precautions (EBPs) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organisms (MDROs) during high contact resident care activities. Enhanced Barrier Precautions apply when; a resident is not know to be infected or colonized with any MRDO, has a wound or indwelling medical devices. EBP are in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that place that resident at higher risk. Signs are posted on the door or wall outside the residents' rooms which communicate the type of precautions and PPE required…with personal protective equipment and alcohol-based hand-rub…readily accessible to staff.”

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a sanitary and comfortable environment when the Stop sign banners in Hallway 3A had hair and lint on the velcro areas of the banners. This failure had the potential to negatively affect the residents' homelike environment. Findings:During a concurrent observation and interview on 7/21/2025 at 2:45 p.m., with the Director of Staff Development (DSD), three Stop sign banners were hanging on Hallway 3A rails next to rooms [ROOM NUMBER]. The Stop sign banners had hair and lint on the velcro areas. The DSD stated the Stop sign banners are put on the door to prevent wandering residents from going into residents room. The DSD confirmed the hair and lint on the velcro areas on the three Stop sign banners.During a concurrent observation and interview on 7/21/2025 at 3:25 p.m., with Housekeeping (HK), HK confirmed the hair and lint on the velcro areas on the three Stop sign banners hanging on Hallway 3A rails next to rooms [ROOM NUMBER]. HK stated the Stop sign banners were sanitized and replaced, but the facility did not have the tools to remove the hair and lint on the velcro area. HK stated the Stop sign banners did not look clean with the hair and lint on the velcro areas. During a review of the facility's policy and procedure (P&P) titled, Policies and Practices-Infection Control, dated October 2018, the P&P indicated, 2. The objective of our infection control policies and practices are to: . b. maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public.