STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555240	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Turlock Nursing and Rehabilitation Center	1111 E Tuolumne Road Turlock, CA 95380

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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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to ensure Maintenance Director (MAIND) and Dietary [NAME] (DC) were trained to carry out the functions of the food and nutrition services safely and effectively for 136 of 136 residents when:1. MAIND did not sanitize ice bin during cleaning process according to the manufacturer's guidelines.2. DC did not demonstrate correct thermometer calibration during meal preparation.These failures had the potential to place all 136 residents receiving food from the kitchen at risk for cross-contamination (process by which bacteria is transferred from one object or substance to another, with harmful effect) and exposure of foodborne illnesses (a condition where a person becomes sick after consuming contaminated food or beverages. It is caused by the ingestion of harmful microorganisms, such as bacteria, viruses, parasites, or toxins).Findings:1.During a concurrent observation and interview on 3/3/2026 at 10:09 a.m. in the kitchen MAIND took the water curtain (a crucial plastic barrier hung in front of the evaporator to prevent water from splashing out and to maintain proper water flow for consistent ice production) in front of the ice machine out and squeezed cleaning solution into the water trough (usually plastic, reservoir located in the evaporator compartment that holds water to be frozen into ice). MAIND obtained a green scouring pad and scrubbed inside of the ice machine, a black and brown substance was present on the scouring pad after scrubbing the inside of the machine. MAIND obtained a new roll of paper towels and wiped inside the ice machine bin. MAIND did not use sanitizer solution to clean the inside of the ice bin. MAIND stated he used a green scouring pad to clean inside and used hot water to rinse the ice bin. MAIND stated he took apart components from the ice machine and ran it through the dishwasher to clean it. MS stated he cleaned the machine monthly. MAIND stated he was trained at his previous job and was not trained at this facility. MAIND stated he had been cleaning the ice machine like this for 18 years MAIND stated black or brown substances should not have been in the ice machine. MAIND stated the black and brown substances could have gotten into the ice and caused cross-contamination. MS stated residents could have gotten sick from consuming the cross-contaminated ice. During an interview on 3/6/26 at 11:17 a.m., the Registered Dietician stated she expected MAIND to clean and maintain the ice machine monthly. The RD stated she checked the ice machine monthly to make sure it was cleaned. The RD stated she would have the MAIND clean the ice machine again when it was dirty. The RD stated she did not observe the MAIND during the cleaning process. The RD stated the MAIND should have used the manufacturer's guidelines to clean the ice machine. The RD stated the MAIND should have used a sanitizer to clean the ice bin per facility logbook documentation. The RD stated she was not responsible for the training of the MAIND and did not assess his competency or training. The RD stated the ice could have been contaminated from the black and brown substances. The RD stated residents could have gotten sick from foodborne illness from consuming the cross-contaminated ice.During an interview on 3/6/26 at 11:32 a.m., with Administrator (ADM) the ADM stated they have resource training available and there is a step by step process for cleaning in Direct Supply [platform name] (building management platform designed for nursing home and maintenance solutions with instructions to clean the ice machine.). The ADM stated (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	MAIND should have been following the manufacturer's guidelines or facility's logbook documentation guidelines when cleaning. The ADM stated MAIND needed more training. The ADM stated it was not safe for the residents to consume cross-contaminated ice. The ADM stated residents could have gotten ill and had foodborne illnesses from consuming contaminated ice.During an interview on 3/6/26 at 11:41 with the Safety Maintenance Resource (SMR) the SMR stated MAIND should have used a sanitizer to clean the inside of the bin after cleaning the bin. The SMR stated using hot water was not enough to clean the ice machine. The SMR stated MAIND should have more training in cleaning the ice machine. The SMR stated he should have followed the directions that were in TELS and followed the manufacturer's guidelines.During a review of the facility's logbook documentation titled, Ice Machines Deep Cleaning of Ice Machines: interior and Exterior cleaning and Sanitizing undated the logbook indicated, Monthly Deep Cleaning Instructions.4. Clean and Sanitize the system.Sanitize the interior of the ice machine according to the manufacturer's instructions using an approved sanitizer. Clean and sanitize the ice bin.During a review of the manufacturer's guideline titled, [Manufacturer's Name] Preventative and Maintenance, undated, the manufacturer's guideline indicated, Sanitize surface areas of ice machine. Use a clean sanitizer-soaked towel to sanitize ice machine surfaces, including the side walls, base (area above water trough), and the bin or dispenser, spray surfaces with sanitizer solution and wipe down. 2. During a concurrent observation and interview on 3/4/26 at 10:16 a.m. during meal preparation, DC was asked to demonstrate thermometer calibration. DC obtained a cup of ice water. DC put the thermometer inside the cup of ice and allowed the stem to touch the bottom of the cup. DC stated she should have waited till the thermometer reached 32-degree Fahrenheit (F-a temperature scale). DC stated she should have added more ice into the cup to wait until it comes down to 32 F. DC stated she did not know how to calibrate the thermometer when it did not reach 32 F. DC stated she was hired three months ago. DC stated accurate thermometer calibration was important to ensure food was at the right temperature. DC stated inaccurate thermometer calibration could have caused food to be overcooked or undercooked. DC stated residents would not get all the nutrients from overcooked food. DC stated residents could have gotten foodborne illness from consuming undercooked food. DC stated undercooked food such as meat could have contained bacteria such as salmonella ([NAME] of bacteria that causes salmonellosis, a common foodborne illness that affects the intestinal tract) and resident could have gotten sick. DC stated residents could have foodborne illness such as nausea vomiting and diarrhea. DC stated residents in this population were vulnerable and could have been hospitalized During an interview on 3/6/26 at 10:20 a.m. with the Dietary Services Manager (DSM) the DSM stated she expected DC to calibrate the thermometer correctly. The DSM stated it was important to calibrate the thermometer correctly to ensure food was at the correct temperature. The DSM stated inaccurate thermometer calibration was an infection control issue. The DSM stated inaccurate thermometer calibration could have caused foodborne illness. The DSM stated residents could have gotten sick with diarrhea and it could have negatively affected their health. The DSM stated residents could have been hospitalized from consuming undercooked food. The DSM stated DC was new and could use more training. The DSM stated DC was not competent in thermometer calibration.During an interview on 3/6/26 at 11:04 a.m. with the RD. the RD stated the kitchen staff should have been able to calibrate the thermometer. The RD stated the DSM and the Dietary Service Manager Assist should have trained the dietary staff on how to calibrate the thermometer. The RD stated it was important to calibrate the thermometer accurately to ensure the food was at correct temperature. The RD stated not calibrating the thermometer correctly could have caused the food to not be at the right temperature. The RD stated residents could have complained food was not cooked properly and cold. The RD stated food could have been uncooked. The RD stated residents could have gotten foodborne illness from consuming undercooked food. The RD stated, We should have done more training. The RD stated DC was not competent in the thermometer calibration. During a review of the facility's competency check list titled, Verification of Job Competency Demonstration Cooks dated 2023, the (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	competency check list indicated, [competency box] Thermometer calibration and recording process.During a review of the facility's policy and procedures (P&P) titled, Thermometer use and Calibration dated 2003, the P&P indicated, .Food Thermometers can vary in where the temperature is read on the stem and if they can be calibrated or not. Most digital thermometers have temperature sensors within 1/4 [inch] from the probe tip. Bimetal or analog thermometers may have a sensor as far up as 2 [inch] on the probe.checking the accuracy and calibration.fill a large glass with crushed ice and add clean tap water until slush is formed. Stir the mixture well. Put the thermometer's stem into the ice water so that the sensing is completely submerged in the glass. The thermometer steam or probe must remain in the ice water for one minute and during calibration.3. if the thermometer does not read 32 F then the thermometer must be calibrated or discarded.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 safe and sanitary food preparation and storage practices were followed for 136 of 136 residents when:1. A bin containing six bags of stew meat was not labeled with pull-out (a date when items were taken out from the freezer to thaw out in the refrigerator) and use-by date.2. Black and brownish substances were found inside the ice machine.These failures had the potential risk of cross contamination (process by which bacteria is transferred from one object or substance to another, with harmful effect) and exposure of microorganisms (a microscopic organism, especially a bacterium, virus, or fungus) that harbor foodborne pathogens (a bacterium, virus, or other microorganism that can cause disease) from improperly stored and labeled food and could cause foodborne illness (illness that comes from eating contaminated food) to 136 of 136 residents receiving food from the kitchen.Findings:1. During a concurrent observation and interview on 3/3/26 at 9:50 a.m. in the walk-in refrigerator, a bin containing six bags of stew meat for dinner was dated as for dinner 3/3/26. The Dietary Service Manager Assistant (DSMA) stated the bin containing the six bags of stew meat should have been dated with pull- out date 3/3/26 and use- by date 3/5/26. The DSMA stated kitchen staff should have labeled the stew meat when it was pulled out from the freezer. The DSMA stated it was important to label food with the accurate date to ensure food safety. The DSMA stated labeling the food items would prevent residents from consuming food past the use- by date. The DSMA stated residents could have consumed food past it use- by date and could have gotten sick from foodborne illness.During an interview on 3/6/26 at 10:29 a.m. with the Dietary Manager Supervisor (DMS), the DMS stated It's important [to label food] so it does not go bad and everyone in the kitchen knows it is ok to serve. The DMS stated the kitchen staff could have served items past its use-by date when it was not labeled. The DMS stated residents could have gotten sick from foodborne illness and could have been hospitalized .During a record review of the facility's policy and procedures (P&P), titled Policy Thawing of Meats dated 2003, the P&P indicated, .1. In a refrigerator.allow 2 to 3 days to defrost.label defrosting meat with pull and use by date.2. During a concurrent observation and interview on 3/3/26 at 9:57 a.m. in the kitchen, black and brown substances were found inside the ice machine. The DSM stated the dietary staff were responsible for cleaning the outside of the ice machine. The DSM stated the Maintenance Director was responsible for cleaning the inside of ice machine. The DSM stated she was not sure of the cleaning schedule. The DSM stated the ice machine should have been spotless. The DMS stated the ice machine should not have any black and brown substances inside. The DSM stated the black substance could have gotten on the ice and caused cross-contamination. The DSM stated cross-contaminated ice could have caused food borne illness and gotten residents sick and hospitalized . During an interview on 3/3/26 at 10:06 a.m. with the DMSA, the DSMA stated black and brownish substance could have gotten into the ice and caused contamination. The DSMA stated residents could have gotten sick from the ice being cross contaminated from the black and brown substances. The DSMA stated residents in the facility were a vulnerable population and could have gotten sick and were at risk for hospitalization. During a concurrent observation and interview 3/03/2026 at 10:46 a.m. with the Registered Dietician (RD), the RD confirmed there were brown and black substances in the ice machine. The RD stated the black and brown substance could have been dirt and the ice machine was dirty. The RD stated it was not cleaned and it was not acceptable to have the substance in the ice machineDuring an interview on 3/6/26 at 10:56 a.m. with the RD, the RD stated she was not sure what the maintenance supervisor did during his cleaning. The RD stated she was not sure when the Maintenance Director cleaned the ice machine. The RD stated the black and brown substance could have caused the ice to be contaminated. The RD stated residents could have gotten sick from food borne illness from cross-contamination from the ice.During a review of the facility's logbook documentation titled, Ice (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Machines: Deep cleaning of Ice Machines: interior and exterior cleaning and sanitization undated, the logbook indicated, .Monthly deep cleaning.clean and sanitize the ice bin.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 establish and maintain an effective infection prevention and control program to help prevent the development and transmission of infections for 11 of 23 sampled residents (Resident 143, Resident 46, Resident 53, Resident 154, Resident 39, Resident 109, Resident 70, Resident 20, Resident 149, Resident 5 and Resident 111) when:1. Resident 143 had a peripherally inserted central catheter (PICC line- a long, thin, flexible tube inserted into a large vein in the upper arm, with its tip near the heart) dressing that was not changed for nine days, was not labeled accurately during a dressing change, and the insertion site was not visible under the transparent dressing after a dressing change. This failure resulted in Resident 143's PICC line dressing not being changed per provider orders or facility policy and procedures which had the potential to result in infection and illness. 2. The facility failed to ensure a commode containing visible urine and stool (solid waste from the body that left the body during a bowel movement) were cleaned and maintained in a sanitary manner in a shared resident bathroom for four of six sampled Residents, (Resident 46, Resident 53, Resident 154 and Resident 39).This failure had the potential to expose Residents 46, 53, 154 and 39 to bodily fluids from other residents and increase the risk for the transmission of infection. 3. Resident 109, who had documented Methicillin Resistant Staphylococcus Aureus (MRSA-a type of bacteria that could cause an infection and was harder to treat because some antibiotics [medication used to treat infections] did not work against it) wound infection of the left foot wound, was placed in a shared room with Resident 70 who was not identified as having MRSA.This failure placed Resident 70 at risk for exposure to MRSA.4. Licensed Vocational Nurse (LVN) 2 did not perform cleaning and disinfecting (uses chemicals (disinfectants) to kill germs on surfaces and objects) of blood pressure monitor (a medical device used to measure the force of blood against artery walls) and pulse oximeter (an electronic device that measures the saturation of oxygen carried in your red blood cells) when Residents 20 and 149's blood pressure and oxygen saturation level were checked without properly cleaning and disinfecting the equipment between use on both residents on 3/3/26. Resident 149 was on Enhanced Barrier Precautions (EBP- measures used in healthcare settings to prevent the spread of infections) due to presence of wounds. These failures placed Residents 20 and 149 and other residents at an increased risk for cross-contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect), spread of infectious diseases resulting in healthcare associated infections (the invasion and growth of germs in the body), systemic infection control breakdown, and facility outbreak of infection (a sudden increase or clustering of disease cases beyond what's normally expected in a specific time, place, or population, often involving common exposure).5. Two of two licensed nurses (Registered Nurse [RN] 1 and LVN 1) did not properly clean and disinfect a glucometer (a medical device used for determining the amount of sugar in the blood) according to the manufacturer's specifications after use on Resident 5 and Resident 111. This failure had the potential to result in the spread and transmission of communicable (infectious disease - a condition that can be transmitted from one person to another through various means including direct contact and indirect contact) diseases and blood born infections (viruses that are carried in the blood).1. During a concurrent observation and interview on 3/3/26 at 3:25 p.m. with Resident 143, in Resident 143's room, Resident 143's PICC line dressing was observed dated 2/23/26. Resident 143's PICC line dressing indicated it had not been changed in 8 days. Resident 143 stated she refused a PICC line dressing on admission to the facility because it was changed by hospital staff prior to transfer. Resident 143 stated licensed nursing staff had not requested or attempted to change her PICC line dressing since admission. During an observation on 3/4/26 at 10:27 a.m. with Registered Nurse Supervisor (RNS) 1, in Resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	143's room, Resident 143's PICC line dressing was observed dated 2/23/26. Resident 143's PICC line dressing indicated it had not been changed in 9 days. RNS 1 was observed changing Resident 143's PICC line dressing. RNS 1 was observed placing a gauze pad over Resident 143's PICC line insertion site. The insertion site was not visible under the gauze. RNS 1 was observed placing the transparent dressing over the gauze pad. RNS 1 was observed dating the transparent PICC line dressing with the date 3/2/26, the current date was 3/4/26. During an interview on 3/5/26 at 9:42 a.m. with RNS 1, RNS 1 stated PICC line dressing changes needed to be changed per provider orders and facility policy and procedure. RNS 1 stated Resident 143's PICC line dressing needed to be changed every 7 days. RNS 1 stated if Resident 143 refused or was unavailable for her PICC line dressing on day 7 it was expected to be documented in the medical record. RNS 1 stated PICC line dressings needed to be dated the actual date they were changed. RNS 1 stated PICC line insertion sites were observed daily with intravenous medication administration. RNS 1 stated if the insertion site, into the skin, was not visible the site could not be observed for signs and symptoms of infection. RNS 1 stated Resident 143 was at risk for infection when her PICC line dressing was not changed within 7 days from 2/23/26. RNS 1 stated Resident 143 was at risk for infection when she labeled the dressing change 3/2/26 and not 3/4/26 because it could cause discrepancy in the required next dressing change date. During a concurrent interview and record review on 3/5/26 at 10:12 a.m. with RN 2, Resident 143's Medical Record, dated 3/5/26 was reviewed. RN 2 stated Resident 143's PICC line dressing was changed on 2/23/26, at the hospital, and 3/4/26, at the facility. RN 2 stated Resident 143 had an order for PICC line dressing changes on admission, every 7 days, and as needed. RN 2 stated the Medical Record indicated Resident 143 refused the admission PICC line dressing change due to it not being 7 days since hospital staff last changed the dressing. RN 2 stated there was no documentation in the Medical Record to indicate licensed nursing staff attempted to change Resident 143's PICC line dressing 7 days after 2/23/26. RN 2 stated there was no documentation in Resident 143's Medical Record to indicate Resident 143 refused or was unavailable for a PICC line dressing change 7 days after 2/23/26. RN 2 stated provider orders were not followed when Resident 143's PICC line dressing was not changed for 9 days which placed Resident 143 at risk for a systemic infection (a widespread infection that affects the entire body rather than a single organ or area, often spreading through the bloodstream). During a concurrent observation and interview on 3/5/26 at 10:30 a.m. with the Infection Preventionist (IP), Resident 143's PICC line dressing was observed. The IP stated Resident 143's PICC line insertion site was not visible under the transparent dressing. The IP stated it was important PICC line insertion sites were visible under the transparent dressing so signs and symptoms of infection at the insertion site could be identified during daily rounds. The IP stated PICC line dressings needed to be dated the day they were changed. The IP stated Resident 143 was at risk for delayed identification of infection signs and symptoms when the PICC line insertion site was not visible under the transparent dressing. The IP stated Resident 143 was at risk of infection when the PICC line dressing was not changed 7 days after 2/23/26. The IP stated licensed nursing staff were expected to accurately date PICC line dressings on the day they were changed to ensure the next dressing change occurred within 7 days. During a concurrent observation and interview on 3/5/26 at 11:15 a.m. with the Assistant Director of Nursing (ADON), Resident 143's PICC line dressing was observed. The ADON stated facility policy and procedure, and provider orders were not followed when Resident 143's PICC line dressing was not changed for 9 days. The ADON stated Resident 143's PICC line dressing from 3/4/26 was not (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	practice regarding the care and maintenance of central venous catheters.assess the central line daily.assess the site for signs of infection: redness, tenderness, pain or swelling at the insertion site.change dressings routinely.sterile gauze: every other day.sterile, transparent, semipermeable: every 5-7 days. During a review of the facility's education lesson plan titled, Midline/CVAD Dressing Change, dated 8/12/25, 8/13/25, 9/4/25, and 1/15/26, the education lesson plan indicated, .document the procedure accurately (time of dressing change, dressing change refusal and daily monitoring and charting. 2. During an observation on 3/3/26 at 9:54 a.m. a bedside commode was observed in the shared bathroom located between resident rooms (X) and (Y). The commode contained a plastic liner with visible urine, stool and used toilet paper inside the basin. A roll of toilet paper was placed on the commode seat. The contents of the commode had not been emptied and remained exposed. The commode was in the shared bathroom accessible to residents from both rooms (X) and (Y) at the time of observation. During a second observation on 3/3/26 at 11:24 a.m. the same bedside commode located in the shared bathroom between resident rooms (X) and (Y) was observed. The commode continued to contain a plastic liner with visible urine, stool and used toilet paper inside the basin. The contents remained present and had not been emptied since the earlier observation at 9:54a.m. The roll of toilet paper was observed placed on the commode seat. The commode was in the shared bathroom accessible to residents from both rooms (X) and (Y) at the time of observation. During an interview on 3/5/26 at 4:50 p.m. with the IP, the IP stated the commode should have been cleaned immediately after use due to the presence of body fluids and the potential for infection transmission. During an interview on 3/6/26 at 9:01 a.m. with the Treatment Nurse (TN), the TN stated the commode should have been cleaned immediately after use. TN stated prompt cleaning was important for infection control and to maintain resident dignity. TN further stated it would not have been appropriate to store a dirty commode in the resident bathroom. During an interview on 3/6/26 at 9:18 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated the commode should have been cleaned immediately after use. CNA 1 stated it was important to maintain resident dignity and infection control practices. CNA 1 further stated it would not have been appropriate for a dirty commode to remain in a shared bathroom for hours without being cleaned. During an interview on 3/6/26 at 2:24 p.m. with the DON, the DON stated the commode should have been cleaned immediately after the resident used it, as this was important for infection control and sanitation. During a review of facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, dated 4/2025, the P&P indicated, the facility personnel will conduct themselves and provide care in a way that minimizes the spread of infection.the facility will use effective methods for storage, transport and disposal of garbage, refuse and infectious waste, consistent with all applicable local, state and federal requirements for such disposal.effective cleaning and disinfecting equipment as needed, to include bathing areas between each resident use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. During an observation on 3/3/26 at 10:18 a.m. the name plaque posted outside Room (Z) was reviewed. The plaque listed the names of the residents assigned to the room as Resident 70 and Resident 109. An orange indicator dot was observed next to Resident 109's name, which facility identified as indicating the resident was placed on Enhanced Barrier Precautions (EBP-infection control steps used in healthcare settings where staff wore protective equipment, such as gloves, and gowns during certain care activities to help prevent the spread of germs). During an interview on 3/3/36 at 10:28 a.m. with Resident 109 in his room, Resident 109 stated he had two wounds, one on each foot, and reported the left foot was connected to a wound vac (a medical device that used gentle suction to remove fluid from a wound to help the wound heal). During a review of Resident 109's AR the admission record indicated, Resident 109 was admitted to the facility on [DATE] with a diagnosis which included cutaneous abscess of left foot (a pocket of pus under the skin on the left foot caused by an infection), and MRSA During a review of Resident 109's MDS, dated 2/26/26, the MDS section C indicated Resident 109 had a BIMS score of 14, which indicated Resident 109 had no cognitive impairment. During a review of Resident 70's AR, the AR, Resident 70 was admitted to the facility on [DATE] with a diagnosis which included fracture of right tibia (a break in the tibia, which was the large bone in the lower part of the right leg), and cellulitis of right lower leg (a skin infection that happened when germs got into the skin through a cut, scrape or sore. It caused the skin to become red, swollen, warm and painful). A diagnosis of MRSA was not included in his history. During a review of Resident 109's Hospitalist Discharge Summary dated 2/3/26, the Hospitalist Discharge Summary indicated Resident 109's wound culture grew MRSA. During a concurrent interview and review of Resident 109's electronic health record on 3/5/26 at 4:27 p.m. with the IP, the IP stated she was unsure if Resident 109 had a history MRSA and would need to review the resident's record. The IP stated as far as she was aware, no residents in the facility currently had MRSA. The IP reviewed the resident's record and identified a diagnosis of MRSA. The IP printed the facility's surveillance log, which indicated Resident 109 was on EBP for a chronic wound and an indwelling medical device. Review of the surveillance log indicated Resident 70 (roommate) was not listed as a resident requiring EBP. The IP stated residents with the same infection may be cohorted together. The IP stated she has a process to ensure appropriate infection control checks are completed when a resident is admitted to the facility. The IP stated she ensures the resident was treated in the hospital with antibiotics and reviews residents who are placed on EBP. The IP further stated Resident 109's current roommate had a diagnosis of cellulitis and should not have been placed in the same room due to the risk of transmission. During an interview on 3/6/26 at 8:43 a.m. with the TN, the TN stated that upon admission, if staff are aware a resident has MRSA, they notify the infection prevention staff and attempt to cohort residents with the same condition or disease. The TN stated it would be inappropriate to place a resident without active MRSA in the same room with a resident who has MRSA, as the roommate could have an open cut or wound and could potentially become contaminated. During an interview on 3/6/26 at 11:33 a.m. with the DON, the DON stated the facility follows Centers for Disease and Control (CDC) guidelines when determining appropriate cohorting of residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of facility's policy and procedure (P&P) titled, IPCP Standard and Transmission-Based precautions, dated 4/2025, the P&P indicated, when private rooms are not available, some residents (e.g., residents with the same pathogen) may be cohorted or per an alternative risk-based approach. Room placement decisions are made balancing risks to other patients. During a review of facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, dated 4/2025, the P&P indicated, The facility uses McGeer's Criteria as the nationally recognized surveillance criteria to define infections. 4. During a concurrent observation and interview on 3/3/26 at 10:40 a.m. with Resident 20, in Resident 20's room, Resident 20 was sitting in a wheelchair awake, alert and oriented to her name and situation with family at bedside. Resident 20 smiled and stated she was okay. During an observation on 3/3/26 at 10:42 a.m. with LVN 2, in Resident 20's room, LVN 2 wrapped the blood pressure cuff (is a medical device consisting of a piece of rubber or similar material that is wrapped around a patient's arm and then inflated in order to measure their blood pressure) around Resident 20's left upper arm and pulse oximeter to left pointer finger. Resident 20's blood pressure was re-checked to Resident 20's right upper arm. LVN 2 went to the medication cart parked in front of Resident 20's room and placed blood pressure cuff and monitor and pulse oximeter on top of medication cart. LVN 2 started administering Resident 20's oral medications. LVN 2 did not perform cleaning and disinfecting of blood pressure monitor and pulse oximeter after checking Resident 20's blood pressure and oxygen saturation level. During a concurrent observation and interview on 3/3/26 at 10:47 a.m. with Resident 149, in Resident 149's room, Resident 149 was sitting in a wheelchair watching a program on television with oxygen on via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen). Resident 149 was pleasant, alert and oriented x 4 (is a term used to describe a patient's level of awareness. It means that the patient is fully aware and can accurately identify four things: person, place, time, situation/event). Resident 149 stated she was okay with a smile on her face. During an observation 3/3/26 at 10:49 a.m. with LVN 2, in Resident 149's room, LVN 2 took the blood pressure cuff and monitor and pulse oximeter (that had just been used on Resident 20) off the top of the medication cart parked in front of Resident 149's room. LVN 2 wrapped the blood pressure cuff around Resident 149's right upper arm and placed pulse oximeter to Resident 149's right pointer finger to check Resident 149's blood pressure and oxygen saturation level. LVN 2 removed the blood pressure cuff and pulse oximeter from Resident 149 and placed it on top of medication cart. LVN 2 started administering Resident 149's oral and inhaler medications. LVN 2 did not perform cleaning and disinfecting of blood pressure monitor (including blood pressure cuff) and pulse oximeter after checking Resident 149's blood pressure and oxygen saturation. During a review of Resident 149's AR, dated 3/6/26, the AR indicated Resident 149 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), chronic kidney disease (a disease characterized by progressive damage and loss of function in the kidneys), type 2 diabetes mellitus (when the blood sugar levels in the body are too high), hypertensive heart disease (refers to heart problems that occur because of high blood pressure that is present over a long time), morbid (severe) obesity (or extreme obesity which is defined as having a body mass index [BMI] of 40 or greater or weighing in excess of 100 pounds of one's ideal weight), and pressure induced deep tissue damage (localized damage to the skin and underlying tissue caused by prolonged pressure, often over bony prominences) of sacral (the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	triangular shaped bone at the base of the back) region and left ankle. During a review of Resident 149's MDS, dated [DATE], the MDS section C indicated Resident 149 had a BIMS score of 13, which suggested Resident 149 was cognitively intact. During a concurrent observation and interview on 3/3/26 at 3:22 p.m. with LVN 2, outside of Residents 20 and 149's room, Resident 149 had an orange sticker by her name. LVN 2 stated an orange sticker beside Resident 149's name indicated that Resident 149 was on EBP. LVN 2 stated Resident 149 was on EBP due to presence of wounds. LVN 2 stated Resident 20 was not on EBP. LVN 2 validated she did not perform cleaning and disinfecting of blood pressure machine and pulse oximeter in between resident use when she checked Resident 20 and 149's blood pressure and oxygen saturation level. LVN 2 stated she used the same blood pressure machine and pulse oximeter for Resident 20 and 149. LVN 2 stated blood pressure monitor (including blood pressure cuff) and pulse oximeter should be cleaned and disinfected using bleach wipes to prevent cross contamination and infection. During an interview on 3/5/26 at 4:17 p.m. with the IP, the IP stated residents shared patient care equipment including blood pressure monitor and pulse oximeter. The IP stated there was no designated blood pressure monitor and pulse oximeter for residents on EBP. The IP stated it was her expectation for all staff to follow and implement facility's Infection Prevention and Control Program (IPCP) in cleaning and disinfecting patient care equipment such as blood pressure cuffs and pulse oximeters in between patient use to prevent the transfer of pathogens (tiny organisms that can make you sick if they get inside your body) from one resident to another resident. The IP stated all staff should be cleaning and disinfecting patient-care equipment using bleach wipes. The IP stated when staff did not perform cleaning and disinfecting of blood pressure monitor and pulse oximeter, the risk of cross contamination was high and stated it was an infection control issue. During an interview on 3/6/26 at 11:33 a.m. with the DON, the DON stated it was her expectation for all staff to follow and implement the facility's policy and procedures (P&P) for Infection Control and Prevention. The DON stated it was a standard of practice to clean and disinfect patient care equipment after use. The DON stated blood pressure machine or monitor, and pulse oximeters being shared with other residents should be cleaned and disinfected in between resident use to prevent transmission of bacteria and cross contamination. During a review of facility's P&P titled, IPCP Standard and Transmission-Based Precautions, revised on 4/2025, the P&P indicated, It is the policy of the facility to implement infection control measures to prevent the spread of communicable diseases and conditions. 1. Standard Precautions are infection prevention practices that apply to the care of all residents, regardless of suspected or confirmed infection or colonization status. They are based on the principle that all blood, body fluids, secretions, and excretions (except sweat) may contain transmissible infectious agents. Standard Precautions include: .f. Reprocessing or reusable medical equipment. 2. Contact Precautions.c. Patient-care equipment (e.g., blood pressure cuffs). It is preferred dedicated or disposable patient-care equipment be used. If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another resident.3. Enhanced Barrier Precaution (EBP): used conjunction with standard precautions. that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident-to-resident. (e.g., residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs) . d. iii. Frequent cleaning/disinfection of shared equipment and environmental surfaces. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. During an observation on 3/3/26 at 11:35 a.m. in the hallway outside Resident 5's room, Licensed Vocational Nurse (LVN) 1 was observed gathering supplies to perform a blood glucose test (a method of measuring the concentration glucose [sugar] in the blood) on Resident 5. After obtaining a blood sample from Resident 5, LVN 1 was observed using a germicidal wipe (a germicidal [kills germs] disposable wipe used for disinfecting surfaces) to disinfect the glucometer. The glucometer was placed on the medication cart and allowed to air-dry. The glucometer was observed to be dry within one minute after being disinfected with the germicidal wipe by LVN 1. During a review of Resident 5's AR, dated 3/3/26, the AR indicated Resident 5 was admitted to the facility from an acute care hospital on [DATE] with diagnoses of type 2 Diabetes Mellitus, pneumonia (an infection that affects one or both lungs, causing the air sacs of the lungs to fill with fluid) and respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood). During an observation on 3/3/26 at 11:51 a.m. outside Resident 111's room, RN 1 was observed gathering supplies to perform a blood glucose test on Resident 111. After obtaining Resident 111's blood sample, RN 1 disinfected the glucometer with a germicidal wipe and placed it on the medication cart to air-dry before placing it back in the medication cart. During an interview on 3/3/26 at 2:47 p.m. with RN 1, RN 1 stated she needed to wipe the glucometer with (brand name) germicidal wipes and let the glucometer air-dry for three minutes after using it on residents. RN 1 stated she did not know what contact or wet time meant. After reviewing the germicidal wipe container indicating a three-minute wet time (the amount of time the item needs to remain visibly wet), RN 1 stated the glucometer did not remain wet for three minutes. During an interview on 3/3/26 at 3:30 p.m. with LVN 1, LVN 1 stated after using the glucometer, nurses were supposed to wipe the glucometer with a germicidal wipe and let the glucometer sit for three minutes. LVN 1 stated it was important to properly clean and disinfect the glucometer to be sure there was no blood on the glucometer and any bacteria that was on the glucometer was killed. After reviewing the germicidal wipe container instructions, LVN 1 stated the glucometer should have stayed wet with the disinfectant for three minutes. LVN 1 stated the glucometer did not stay visibly wet for three minutes after using the germicidal wipe, which was the visibly wet time listed on the container. LVN 1 stated if the wet time was not followed as listed on the germicidal container, there was the possibility of cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) to the resident or to staff. During an interview on 3/3/26 at 4:05 p.m. with the DON, the DON stated nursing staff should have cleaned and disinfected the glucometer by using a germicidal disinfecting wipe to first clean it, then wrapping the glucometer with a clean germicidal wipe, letting it soak for three minutes before letting it air-dry. The DON stated it was important for the glucometer to remain wet for three minutes to be sure it killed germs on the glucometer and did not contaminate the next resident it was used on. During a review of the facility's policy and procedure (P&P) titled, Glucometer Disinfection, dated 8/1/25, the P&amp

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, interview, and record review, the facility failed to follow policy and procedure (P&P) and professional standards of practice to ensure residents were not prescribed unnecessary medications to treat resident's medical symptoms for three of three sampled residents (Resident 13, Resident 49, and Resident 148), when:1. There were no resident-specific Non-pharmacological Interventions (NPI - any intervention intended to improve the health or the well-being of individuals that do not involve the use of any drugs or medicine) prior to and during administration of antipsychotic (a medication that affects brain activities associated with mental processes and behavior used to treat a collection of symptoms that affect your ability to tell what's real and what is not) and psychotropic (a drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) medications for Residents 13, 49 and 148 and Resident 148 had no behavior monitoring for psychotropic medications lorazepam (a medication used to treat anxiety disorders) and sertraline HCl (a medication used to treat depression and anxiety).2. Resident 148 did not have specified diagnosis of anxiety or depression documented for taking medications lorazepam and sertraline.These failures had the potential for Residents 13,49, and 148 to experience negative physical and psychological side effects by receiving medications that were not administered according to the medications' intended use.Findings:1. During an observation on 3/5/2026 at 11:11 a.m. in Resident 13's room, Resident 13 was observed asleep in bed, covered with blanket to her neck. A fall mat was on the left side of Resident 13's bed, bed in low position, with an air mattress, and pillow on the right side of Resident 13's head.During a review of Resident 13's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 3/5/26, the AR indicated Resident 13 was initially admitted to the facility from an acute care hospital on 9/10/21, with a re-admission on [DATE], with diagnoses of senile degeneration of the brain (dementia - a loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), schizophrenia (a mental illness that affects a person's ability to think, feel, and behave clearly), restlessness (the inability to rest or relax as the result of anxiety [a feeling of fear, dread, and uneasiness] or boredom), pressure ulcer stage 2 (a pink or red open wound, resulting from an injury that causes the first layer of skin to be lost, exposing the dermis[the middle layer of skin]), pain in right upper arm, anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and depression (persistent feelings of sadness, despair, loss of energy, and difficulty dealing with normal daily life).During a review of Resident 13's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 2/12/26, the MDS section C indicated Resident 13 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of three (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 13 was severely cognitively impaired.During a review of Resident 13's MDS, dated 2/12/26, the MDS section B indicated Resident 13 did not speak, rarely or never under stood others, rarely or never understood others and had impaired vision.During a review of Resident 13's MDS, dated 2/12/26, the MDS section E indicated resident did not have hallucinations (perceptual experiences in the absence of real external sensory stimuli), delusions (misconceptions or beliefs that are firmly held, contrary to reality). Resident 13 did not exhibit: .physical behavioral symptoms directed toward others [e.g., hitting, kicking, pushing, scratching, (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	grabbing, abusing others sexually].verbal behavioral symptoms directed toward others [e.g., threatening others, screaming at others, cursing at others].other behavioral symptoms not directed toward others [e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds].During a concurrent interview and record review on 3/5/2026 at 11:15 a.m. with Licensed Vocational Nurse (LVN) 5 Resident 13's Order Summary Report (OSR), dated 3/5/26 was reviewed. The OSR indicated, .buspirone HCl (a medication used to treat generalized anxiety disorder) oral tablet 10 milligrams [MG-a unit of measurement].give 2 tablet by mouth two times a day for anxiety.order date.10/20/25.divalproex sodium (a medication to treat seizures) sprinkles oral capsule delayed release sprinkle 125 MG give 1 capsule by mouth two times a day for mood stabilizer manifested by [m/b] agitation and restlessness.order date.10/20/25.methadone HCl (a medication used to treat moderate to severe pain, also used to help people addicted to opioid drugs such as heroine or prescription drugs) oral concentrate 10 MG/ML.give 0.25 ml by mouth every 8 hours for pain.order date 12/2/25.aripiprazole (an antipsychotic medication used to manage and treat schizophrenia, mania [mental illness marked by periods of abnormally and persistently elevated, expansive, or irritable mood] associated with bipolar 1 disorder, irritability associated with an autism spectrum disorder [a condition related to brain development that affects how people see others and socialize with them], disjunctive therapy in major depressive disorder, and Tourette syndrome [a disorder that involves repetitive movements or unwanted sounds [tics] that can't be easily controlled]) oral tablet 10 MG give 1 tablet by mouth one time a day for schizophrenia m/b restlessness behaviors. At bedtime.order date 3/3/26.start date 3/3/26.aripiprazole oral tablet 5 MG give 1 tablet by mouth one time a day for bipolar behavior m/b screaming and interference with care.order date1/30/26.start date 1/30/26.end date 3/3/26.lorazepam concentrate 2 MG/ML give 0.25 ml orally every 4 hours as needed for anxiety m/b restlessness.order date 10/9/25.start date.10/9/25.end date 3/3/26.lorazepam concentrate 2 MG/ML give 0.25 ml orally every 4 hours as needed for anxiety m/b restlessness for 60 days.order date.3/3/26.start date 3/3/26.quetiapine fumarate [antipsychotic medication]oral tablet 50 MG give 1.5 tablet by mouth one time a day for mood stabilizer.order date.2/27/26.start date 2/28/26.end date 3/3/26.quetiapine fumarate 100 MG give 1 tablet by mouth one time a day for schizophrenia.order date.3/3/26.start date 3/4/26. LVN 5 stated she had been at the facility for two years and had been caring for Resident 13 for two years on and off. LVN 5 stated Resident 13 was on hospice [a program that gives special care to people who are near the end of life and have stopped treatment to cure or control their disease], was a fall risk, developed pressure wounds that were resolved, had diagnoses of schizophrenia and bipolar disorder, yelled and screamed. LVN 5 stated Resident 13 was on routine methadone and lorazepam and as needed trazadone (a drug used to treat depression and anxiety). LVN 5 stated Resident 13 had incidences of delusion (a mental condition with false beliefs or judgment about external reality) with incidences of screaming, talking to God, or talking to no one there and had interference of care from staff. LVN 5 stated Resident 13 mostly slept.During a concurrent interview and record review on 3/5/26 at 11:22 a.m. with LVN 5, Resident 13's Medication Administration Record, dated [DATE] through [DATE] was reviewed. The MAR indicated, .institute non-pharmacological approach prior to administration: [1] reorientation, [2] music/television [TV], [3] re-direction/diversion, [4] reassurance, [5] quiet environment, [6] encourage to vent feelings, [7] food/drink. As needed.order date.9/21/24 . There were no markings that any of the ordered non-pharmaceutical interventions (NPI)s were initiated for Resident 13 prior to administering her antipsychotic or psychotropic medications. LVN 5 stated there were no non-pharmacological interventions documented prior to giving Resident 13 her antipsychotic and psychotropic medications. LVN 5 stated NPIs were important so staff would not give Resident 13 a lot of medications when there were other interventions that might have worked. LVN 5 said giving a lot of medications could have caused Resident 13 to be sedated. LVN 5 stated nurses should have documented initiated prior (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to administration of Resident 13's antipsychotic and psychotropic medications but was unable to find documentation indicating which NPIs were attempted.During a concurrent interview and record review on 3/05/2026 4:52 p.m. with the Director of Nursing (DON), Resident 49's MARs, dated [DATE] through [DATE] were reviewed. The MARs indicated there were no specific NPIs implemented prior to administering psychotropic medications, buspirone, escitalopram oxalate (medication used to treat depression and anxiety)to Resident 49. The DON stated NPIs were important prior to administering any psychotropic medication to be sure Resident 49 was not taking psychotropic medication unless it was absolutely necessary. The DON stated NPIs were important to try and eliminate the medication or administer the medication at the lowest dose possible for Resident 49. The DON stated staff needed to use resident specific NPIs since each resident was unique and not the same. The DON stated her expectation was for nurses to know when to perform NPIs, and the NPIs should have been specific to the psychotropic medications the residents were on and for which behavior.During a review of Resident 49's AR, dated 3/5/26, the AR indicated Resident 49 was admitted to the facility on [DATE] from an acute care hospital with diagnoses of depression, anxiety disorder, chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and insomnia (persistent problems falling asleep and staying asleep).During a review of Resident 148's OSR, dated 3/5/26, the OSR indicated .sertraline HCl oral tablet 25MG give 1 tablet by mouth one time a day for depression m/b sadness.order status.active.order date 3/2/26.start date.3/3/26.lorazepam tablet 0.5 MG give 0.25 tablet by mouth every 12 hours as needed for anxiety m/b restlessness for 7 days.order status.active.order date.3/2/26.start date.3/2/26.During a concurrent interview and record review on 3/05/2026 at 5:14 p.m. with the DON, Resident 148's MAR, dated [DATE] was reviewed. The MAR indicated there were no NPIs implemented prior to initiating Resident 148's psychotropic medications. The DON stated there was no specific behavior monitoring for Resident 148's psychotropic medications listed on the MAR. The DON stated Resident 148 should have had specific NPIs and behavior monitoring to know if the psychotropic medications were working or not. The DON stated there was a risk for Resident 148 having unnecessary medications.During a review of Resident 148's AR, dated 3/5/26, the AR indicated Resident 148 was admitted to the facility on [DATE] from an acute care hospital with diagnoses of hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), aphasia (a disorder that makes it difficult to speak), dysphagia (difficulty swallowing), type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), and history of falling.During an interview on 3/5/26 6:42 p.m. with the Pharmacist Consultant (PC), the PC stated staff should have been monitoring NPIs before giving psychotropic and antipsychotic medications. The PC stated if staff re-directed or repositioned the residents, it could have lowered resident's need for medications and residents could then receive the lowest dose of medications.During a review of the facility's policy and procedure (P&P) titled, Chemical Restraints and Psychotropic Medication Management, dated 4/2025, the P&P indicated, .residents who use psychotropic drugs receive.behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.to ensure residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated.2. During a concurrent interview and record review on 3/5/26 at 5:18 p.m. with the DON, Resident 148's AR dated 3/5/26 was reviewed. The DON stated there were no diagnoses listed for anxiety or depression on Resident 148's AR. The DON stated her expectation was for medical records to update the resident's diagnosis depending on what the doctor put in the resident's medical record and for new admits, the diagnoses should have been updated within 48 hours. During a concurrent interview and record review on 3/5/26 at 5:20 p.m. with the DON, Resident 148's OSR, dated 3/5/26 was reviewed. The OSR indicated .sertraline HCl oral tablet 25MG give 1 tablet by mouth one time a day for depression m/b sadness.order status.active.order date 3/2/26.start date.3/3/26.lorazepam tablet 0.5 MG give 0.25 (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tablet by mouth every 12 hours as needed for anxiety m/b restlessness for 7 days.order status.active.order date.3/2/26.start date.3/2/26. The DON stated there was a risk of not having the right medication for the right diagnosis for Resident 148. The DON stated if Resident 148 did not have the right diagnosis, staff might not know what the medication is treating and staff needed to know what they were giving the medication for. The DON stated Resident 148 did not have documented diagnoses of anxiety or depression and was not receiving lorazepam and sertraline for the appropriate diagnoses documented.During a concurrent interview and record review with the PC on 3/5/26 at 7:08 p.m., Resident 148's AR, dated 3/5/26 was reviewed. The PC stated Resident 148 did not have diagnoses of anxiety or depression and should have had diagnoses that corresponded with the prescribed anti-anxiety medication and anti-depressant medication. During a review of the facility P&P titled, Chemical Restraints and Psychotropic Medication Management, dated 4/2025, the P&P indicated, .it is the policy of this facility to ensure that residents are free from chemical restraints imposed for purposes of discipline or convenience or that are not required to treat a specific condition as diagnosed and documented in the clinical record.the specific condition requiring the use of psychotropic medication[s] is diagnosed and documented in the clinical record.the licensed nurse [LN] shall review the classification of the drug, the appropriateness of the diagnosis, its indication, behavior monitors and related adverse side effects prior to verification of admission orders with the Attending Physician.the facility's Interdisciplinary Team [IDT] will review to ensure.psychotropic medication was prescribed to treat a specific diagnosed condition, as documented in the clinical record.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure professional standards of practice and facility's policies and procedures (P&P) were followed and implemented for two of 13 residents (Residents 78 and 29) when:1. Resident 78 was not assessed by Licensed Nurses for insidious (gradual unintended weight loss) and significant unintentional weight loss of more than five percent from 2/5/26 to 3/2/26.This failure had the potential for Resident 78 to experience unrecognized decline in health conditions and a delay in implementing nutritional interventions and services.2. Resident 29 maintained and self-administered probiotic (live, beneficial bacteria) capsules and probiotic with fiber gummies supplements at bedside with no physician's order. This failure resulted in Resident 29 self-administering supplements without a physician's order which could lead to inadequate monitoring, duplicate therapy and/or adverse effects.1. During a concurrent observation and interview on 3/3/26 at 12:34 p.m. with Resident 78, in the dining room, Resident 78 was sitting in a wheelchair assisted by a certified nurse assistant (CNA) with her lunch meal. Resident 78 was not opening her mouth when being fed by the CNA. Resident 78 had eye contact and was not verbally responsive during the interview. During an interview on 3/4/26 at 11:46 a.m. with the responsible party (RP -is a person (usually a family member or friend) who signs an admission agreement, promising to manage the resident's income and assets to pay for their care) 1, in Resident 78's room. RP 1 stated she was the daughter of Resident 78. RP 1 stated Resident 78 was totally dependent on the staff with activities of daily living (ADLs - routine tasks/activities such as eating, bathing, dressing and toileting a person performs daily to care for themselves). RP 1 stated Resident 78 cannot verbalize her needs and does not know how to use her call light for assistance. RP 1 stated Resident 78 had a decline in oral intake and lost weight since she had brain surgery. RP 1 stated Resident 1 was a slow eater and requires a lot of time when feeding her. RP 1 stated she was concerned about Resident 78's nutrition. During a concurrent interview and record review on 3/5/26 10:29 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 78's medical record titled Weights, dated 2/5/26 to 3/2/26 was reviewed. The weights indicated, 2/5/26 122.8 lbs.(pounds – a unit of weight), 2/6/26 120.4 lbs., 2/9/26 119.8 lbs., 2/16/26 117.6 lbs., 2/23/26 115.2 lbs., and 3/2/26 115.4 lbs. LVN 3 stated Resident 78 had been losing weight since admission with admission weight of 122. 8 lbs. on 2/5/26 and current weight of 115.4 lbs. on 3/2/26. LVN 3 stated Resident 78 had a slow weight loss every week and should have been identified by the Interdisciplinary Team (IDT-a collaborative group of healthcare professionals including doctors, nurses, therapists, and social workers who work together to create and implement a unified plan of care for a resident)) for assessment and interventions. LVN 3 stated Resident 78 has a poor oral intake, and she requires one on one assistance with meals. LVN 3 stated Resident 78 should be on Restorative Nursing Program (a formal, planned and organized program of care which is intended to restore a lost ability or maintain a potentially deteriorating function for a particular resident) for eating to assist Resident 78 with her meals and closely monitor her oral intake to prevent further unintentional weight loss. LVN 3 stated licensed nurses should assess Resident 78 for a change of condition related to significant unintentional weight loss and notify the physician for further evaluation and intervention to prevent weight loss. LVN 3 stated Resident 78 was on health shake supplement which was recently ordered by the Registered Dietitian (RD). LVN 3 stated Resident 78 was admitted to the facility post brain surgery and was totally dependent on staff with all ADLs. During an interview on 3/5/2026 at 10:40 a.m. with CNA 1, CNA 1 stated she fed Resident 78 in her (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room for breakfast today (3/5/26) and Resident 78 consumed 50 percent of her meal. CNA 1 stated Resident 1 was very slow swallowing the food. During a concurrent interview and record review on 3/5/26 at 2:26 p.m. with the Assistant Director of Nursing (ADON), Resident 78's medical record titled Weights, dated 2/5/26 to 3/2/26 were reviewed. The weights indicated, 2/5/26 122.8 lbs., 2/6/26 120.4 lbs., 2/9/26 119.8 lbs., 2/16/26 117.6 lbs., 2/23/26 115.2 lbs., and 3/2/26 115.4 lbs. The ADON stated Resident 78 had been on weekly weights and gradually losing weight, and stated, .about 2 pounds a week.not significant? The ADON stated Resident 78 triggered significant weight loss for monthly weight. The ADON stated she was waiting for the RD's list of residents with significant weight changes before doing a change of condition SBAR (Situation Background Assessment Recommendation) assessment. The ADON stated the facility's policy for significant weight loss or gain is three percent in a week or five percent in a month. During a concurrent interview and record review on 3/6/26 at 9:08 a.m. with LVN 5, Resident 78's weights were reviewed and indicated Resident 78 weights on 3/2/26 had a red flag weight warning of negative six pounds in 30 days. LVN 5 stated Resident 78 had a significant weight loss of six percent in a month. LVN 5 stated a change of condition SBAR should be completed by licensed nurses when weight was recorded in Resident 78's medical records. LVN 5 stated licensed nurses should assess residents with significant weight changes and notify the physician for necessary intervention and treatment to prevent significant unintentional weight loss. LVN 5 stated she was part of IDT skin and weight meeting weekly, and she could not locate the minutes of the meeting in Resident 78's medical records. During an interview on 3/5/26 at 9:31 a.m. with Restorative Nurse Assistant (RNA) 1, RNA 1 stated she was familiar with Resident 78 and had assisted her with meals. RNA 1 stated Resident 78 had poor oral intake and does not open her mouth during meals, and stated, .very picky eater. RNA 1 stated Resident 78 requires one on one assistance with eating. RNA 1 stated Resident 78 was not on RNP for eating because she's still receiving skilled therapy services. During an interview on 3/6/26 at 10:01 a.m. with the ADON, the ADON stated he was responsible for doing and completing the change of condition SBAR for all residents with significant weight changes. The ADON stated he did not identify Resident 78's significant weight loss when weights were reviewed. The ADON stated he should assess Resident 78 and complete a change of condition SBAR for significant unintentional weight loss of six percent in a month to prevent a delay in implementing intervention and treatment as ordered by the physician to prevent further weight loss. The ADON stated a short-term care plan for Resident 78's significant weight loss should be developed upon completion of the change of condition SBAR to reflect Resident 78's current interventions to prevent unintended weight loss. During an interview on 3/6/26 at 11:33 a.m. with the Director of Nursing (DON), the DON stated it was her expectation for licensed nurses to follow the facility's policy and procedures (P&P) for weight monitoring and analysis for weekly and monthly weights. The DON stated a five percent change in weight in one month was considered a significant weight change and requires an assessment by licensed nurses. The DON stated licensed nurses should complete a change of condition SBAR for all significant weight loss and gain. The DON stated she and the ADON review weekly and monthly weights to identify significant weight changes. The DON stated the ADON was responsible for doing the change of condition SBAR assessments for residents with significant weight changes including notification of the physician and RPs. The DON stated the ADON should not wait for RD's assessment and recommendation before initiating a nursing assessment. The DON stated that addressing (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	relative to his/her overall condition and prognosis, such as weight, food/fluid intake, and pertinent laboratory values. 1. A systematic approach is used to optimize each resident's nutritional status: a. Identifying and assessing is used to optimize each resident's nutritional status and risk factors b. Evaluation/analyzing assessment information the assessment information c. Developing and consistently implementing pertinent approaches d. Monitoring the effectiveness of interventions and revising them as necessary. 2. Identification/assessment: a. Nursing staff shall obtain the resident's height and weight upon admission, and subsequently in accordance with facility policy. 3. Evaluation/analysis: a. The assessment shall clarify the resident's current nutritional status and individual risk factors for altered nutrition/hydration. 4. Care plan implementation: a. The residents' goals and preferences regarding nutrition will be reflected in the residents' plan of care. b. Interventions will be individualized to address the specific needs of the resident. 5. Monitoring/revision: Monitoring of the resident's condition and care plan interventions will occur basis c. The care plan will be updated as needed such as when a resident's condition changes, goals are met or the resident changes his or her goals, interventions are determined to be ineffective, or as new causes of nutrition-related problems are identified. D. The physician will be notified of: i. Significant changes in weight, intake, or nutritional status ii. Lack of improvement toward goals. During a review of Nursing World.org Professional Reference titled, The American Nurses Association-Nursing: Scope and Standards of Practice, Third Edition, dated July 2015, (found at https://www.nursingworld.org/~4af71a/globalassets/catalog/book-toc/nssp3e-sample-chapter.pdf) the reference indicated, .The Standards of Practice describe a competent level of nursing care as demonstrated by the critical thinking model known as the nursing process. The nursing process includes the components of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. Accordingly, the nursing process encompasses significant actions taken by registered nurses and forms the foundation of the nurse's decision-making. Standard 1. Assessment The registered nurse collects pertinent data and information relative to the healthcare consumer's health or the situation. 2. During a review of Resident 29's FS, dated 3/5/26, the FS indicated, Resident 29 was admitted to the facility on [DATE] with diagnoses of paroxysmal atrial fibrillation (irregular heart rhythm that starts and stops on its own usually within seven days), aftercare following joint replacement surgery, tremors, unspecified and depression, unspecified. During a review of Resident 29's MDS section C (Cognitive Patterns) indicated, Resident 29's BIMS score was 12 which suggested moderate impairment. During a concurrent observation and interview on 3/3/26 at 2:50 p.m. with Resident 29, in Resident 29's room, two OTC supplements (probiotic capsules and probiotics with fiber gummies) were observed in Resident 29's nightstand. Resident 29 stated she kept the supplements in her nightstand and self-administered the supplements when she remembered to do so. During a concurrent observation and interview on 3/5/26 at 10:38 a.m. with Certified Nursing Assistant (CNA) 2, in Resident 29's room, Two OTC supplements (probiotic capsules and probiotics with fiber gummies) were observed in Resident 29's nightstand. CNA 2 stated she worked with Resident 29 last week (week of February 23rd) and Resident 29 had both of the supplements in the room and on the bedside table at that time. CNA 2 stated she did not notify the nurse at the time because she didn't know the nurse and doctor needed to be aware. During a concurrent observation and interview on 3/5/26 at 10:50 a.m. with LVN 4, in Resident 29's (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room, Two OTC supplements (probiotic capsules and probiotics with fiber gummies) were observed in Resident 29's nightstand. LVN 4 stated she was not aware of the probiotic with fiber gummies and probiotic capsules stored in the unlocked resident's nightstand. LVN 4 stated that all medications including supplements needed to be kept in the locked medication cart and labeled with residents' information (resident name and date of birth) for safety. LVN 4 stated Resident 29 did not have a physician's order to self-administer the supplements and stated the supplements should not have been in the room. LVN 4 stated the medications needed to be entered into the pharmacy system so that any interactions would cause an alert and be flagged for all to see. LVN 4 stated for safety reasons the nurses, Resident 29's doctor etc. should be aware of what supplements/medications Resident 29 is taking because there was a potential for overdose, choking if resident had difficulty swallowing, and drug interactions with the supplements and prescribed medications that could lead to resident harm and possible hospitalization. During a concurrent interview and record review on 3/5/26 at 1:42 p.m. with LVN 4, Resident 29's Order Summary Report (OSR) was reviewed. The OSR indicated, no physician order for probiotic capsules or probiotic with fiber gummies. LVN 4 stated there were no current orders for the probiotic capsules and probiotics with fiber gummies. During a concurrent interview and record review on 3/5/26 at 1:45 p.m. with LVN 4, Resident 29's Self Administration of Medication Assessment ([NAME]) dated 2/26/26 was reviewed. The [NAME] indicated, .Resident may keep meds at bedside.No. LVN 4 stated that according to the [NAME], Resident 29 could not keep medications/supplements at bedside, and the medications/supplements should not have been in the resident's room or nightstand unsecured for safety reasons. During an interview on 3/6/26 at 2:39 p.m. with the DON, the DON stated, her expectation was that if any medications including supplements, were in Resident 29's room, they needed to have a doctors order and be kept under lock to prevent unauthorized access otherwise the medications/supplements should not have been in Resident 29's room. The DON stated it was a safety concern if the nurses, doctors, etc. were unaware of Resident 29 self-administering medications/supplements because there was a potential for overdosing, and safety concern for other residents who could access and take the medications/supplements. The DON stated there was potential for drug interactions with current scheduled medications and a potential for resident harm depending on what medications the resident was taking. The DON stated her expectation was that all medications including supplements Resident 29 was taking and self-administering, needed to have physician orders. During a concurrent interview and record review on 3/6/26 at 2:41 p.m. with the DON, Resident 29's Self Administration of Medication Assessment ([NAME]) dated 2/26/26 was reviewed. The [NAME] indicated, .Resident may keep meds at bedside.No. The DON stated supplements should not have been at the bedside. The DON stated her expectation was if any medications including supplements, were in the resident's room, they needed to have a doctor's order for it and be kept under lock to prevent unauthorized access. During a review of the facility's P&P titled, Self-Administration of Medications, dated 12/01/07, the P&P indicated, .Facility should comply with facility policy, applicable law and the State Operations Manual with respect to resident self-administration of medications.Facility in conjunction with the interdisciplinary care team, should assess and determine.whether self-administration of medications is safe and clinically appropriate.Facility should ensure that orders for self-administration list the specific medication(s) the resident may self-administer.monitor the remaining quantities .to determine if. The resident is taking medications according to physicians/prescriber orders.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** F759 Free of Medication Error Rate of 5% or moreBased on observation, interview and record review, the facility failed to ensure the medication error rate was not five percent or greater for four of eight sampled residents (Resident 136, Resident 143, Resident 40, and Resident 69), when:1. Resident 136 was administered an 800 mg sevelamer tablet, a medication to be taken with meals, before meals were served.2. Staff did not use the measuring stick provided by manufacturer and did not administer the diclofenac gel dose according to prescriber order for Resident 143. 3. Resident 40 was not administered prescribed dose of sennosides when some crushed medication was left in cup unadministered, and Resident 40 was administered docusate sodium gel tablet with a spoon from his crushed medication cup and Resident 40 the chewed medication instead of swallowing the gel tablet whole.4. Resident 69 was administered blood sugar medication almost 2 hours after blood sugar level was checked.These failures had the potential for Resident 136, Resident 143, Resident 40, and Resident 69 to not receive the correct dose of ordered medication, to receive a diluted (weakened or thinned by adding a liquid) or concentrated (strong or condensed substance) dose of medication, or cause an altered (changed or modified) therapeutic response (the specific, desired effects of drug administration) of the medications, which put Residents 136, 143, 40, and 69 at risk of adverse reactions (harmful, undesired effects of a drug or treatment) affecting their health and safety.1. During a concurrent observation and interview on 3/3/26 at 12:19 p.m. in Resident 136's room, with Registered Nurse (RN) 1, RN 1 was observed administering sevelamer HCL (a medication used to control high blood levels of phosphorus [hyperphosphatemia] in people with chronic kidney disease [a gradual loss of kidney function where the kidneys cannot filter the blood as they should]) without receiving his meal. RN 1 stated Resident 136 had an appointment pick up time at 1:20 p.m.During a review of Resident 136's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 3/3/26, the AR indicated Resident 136 was initially admitted to the facility from an acute care hospital on 6/24/24 with diagnoses of type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), severe chronic kidney disease, heart failure (a condition when the heart muscle doesn't pump enough blood to meet the body's needs which can cause fatigue and shortness of breath), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing).During a concurrent interview and record review on 3/3/2026 at 2:50 p.m. with RN 1, Resident 136's Order Summary Report (OSR), was reviewed. The OSR indicated, .[sevelamer HCl] oral tablet 800 milligrams [MG- a unit of measurement] give 1 tablet by mouth three times a day for hyperphosphatemia (high phosphate levels in the blood) with meals.order date 9/19/25. RN 1 stated she did not know what the medication sevelamer was given for. RN 1 stated she was aware Resident 136's medication sevelamer HCl was to be given with meals. RN 1 stated lunch was usually served between 12:00 p.m. and 1:30 p.m.During a review of Resident 136's Medication Administration Record (MAR), dated [DATE], the MAR indicated, .[sevelamer HCl] oral tablet 800 mg give 1 tablet by mouth three times a day for hyperphosphatemia with meals.order date.9/19/2025.During an interview on 3/3/26 at 4:45 p.m. with the Director of Nursing (DON), the DON stated sevelamer HCl was a medication given for chronic kidney disease. The DON stated staff should have administered Resident 136's sevelamer HCl medication when his meal tray was in front of him. The DON stated if the sevelamer HCl medication was not given with meals, the medication would not work.During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated 2025, the P&P indicated, .medications are administered by licensed nurses.as ordered by the physician and in accordance with professional standards of practice.ensure that the six rights of medication administration are followed.right drug.right time.review MAR to identify medication to be administered.compare medication source.with (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MAR to verify resident name, medication name, form, dose, route, and time.refer to drug reference material if unfamiliar with the medication, including its mechanism of action.administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. 2. During a concurrent observation and interview on 3/3/2026 at 11:51 a.m. in Resident 143's room, with RN 1, RN 1 was observed applying diclofenac sodium gel (a topical gel used to treat mild-to-moderate pain) two grams (GM-a unit of measurement) from a medication cup. RN 1 stated there was no measurement in grams identified on the medication cup.During a review of Resident 143's AR, dated 3/3/26, the AR indicated Resident 143 was initially admitted on [DATE] from an acute care hospital with diagnoses of endocarditis (a life-threatening inflammation of the inner lining of the heart's chambers and valves), bacteremia (the presence of bacteria in the blood), abnormalities of gait (walking) and mobility, neuralgia (a sharp, shocking pain that follows the path of a nerve) and neuritis (inflammation of a nerve, usually causing pain).During a concurrent interview and record review on 3/3/2026 at 2:43 p.m. with RN 1, Resident 143's OSR, was reviewed. The OSR indicated, .diclofenac sodium external gel 1% .apply to left forearm topically four times a day for pain 2 GM.order date 2/24/26. RN 1 stated she was not aware of using the measuring stick provided by the medication manufacturer for applying diclofenac sodium gel two grams to Resident 143. RN 1 stated she was aware grams was not measured in the medication cup and always used a medication cup to dose two grams of Diclofenac sodium cream. RN 1 stated it was important to follow the physician's orders, so she did not overdose or underdose resident's medications. RN 1 stated if there was not enough of the medication given, the medication was not effective.During a review of Resident 143's MAR, dated [DATE], the MAR indicated, .diclofenac sodium external gel 1% .apply to left forearm topically four times a day for pain 2 GM.order date 2/24/26.During an interview on 3/3/26 at 4:45 p.m. with the DON, the DON stated staff should have been following the instructions given by the pharmacist on the medication label. The DON stated staff should have been measuring Resident 143's diclofenac gel with the stick and should not have been putting the medicated gel in a cup to measure it. The DON stated the instructions for measuring the gel on the stick and applying the medicated gel were in the medication box provided by the manufacturer. The DON stated if staff were using the medication cup and not the provided stick to measure the diclofenac gel, the measurement would have been incorrect, and Resident 143 would not be receiving the correct dose of the medication ordered by the physician. The DON stated if Resident 143 was not receiving the correct dose of medication, it could have caused Resident 143 to have continued pain and the medication to not be effective.During a review of the facility's P&P titled, Medication Administration, dated 2025, the P&P indicated, .medications are administered by licensed nurses.as ordered by the physician and in accordance with professional standards of practice.ensure that the six rights of medication administration are followed.right drug.right dosage.review MAR to identify medication to be administered.compare medication source.with MAR to verify resident name, medication name, form, dose, route, and time.refer to drug reference material if unfamiliar with the medication, including its mechanism of action.if other than by mouth [PO] route, administer in accordance with facility policy for the relevant route of administration.3. During an observation on 3/03/2026 at 10:14 a.m. in Resident 40's room, Licensed Vocational Nurse (LVN) 2 was observed providing Resident 40 a medication cup containing applesauce and crushed medications which consisted of valsartan (a medication used to treat high blood pressure), metoprolol (a medication used to treat high blood pressure, amlodipine (a medication used to treat high blood pressure), and two sennosides (a laxative medication used to treat constipation [a condition where it is difficult to empty the bowels]) tablets along with a whole medication docusate sodium (a stool softener medication used to treat constipation) gel capsule and a whole acetylsalicylic acid (a drug used to reduce pain or inflammation, fever, and prevent blood clots) tablet. LVN 2 provided Resident 40 spoonfuls of apple sauce mix with his crushed medications, then administered each whole tablet with the same spoon which Resident 40 chewed the docusate sodium gel capsule. Small amounts of applesauce containing powdered substance was observed remaining in the medication cup when LVN 2 exited Resident 40's (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room and discarded the cup.During a review of Resident 40's AR, dated 3/3/26, the AR indicated Resident 40 was admitted on [DATE] from an acute care hospital with diagnoses of fracture of left femur (a break in the bone of the thigh), heart failure, muscle weakness, and difficulty walking.During a review of Resident 40's OSR, dated 3/4/26, the OSR indicated, .docusate sodium oral capsule 100mg.give 1 capsule by mouth one time a day for constipation, hold for loose stools.sennosides.give 2 tablets by mouth two times a day for constipation, hold for loose stools.During a review of Resident 40's MAR, dated [DATE], the MAR indicated, .[acetylsalicylic acid].oral tablet delayed release 81 mg.give 1 tablet by mouth one time a day.During an interview on 3/3/26 at 3:01 p.m. with LVN 2, LVN 2 stated Resident 40 should not have chewed the docusate gel capsule or the acetylsalicylic acid tablet as the medications could have upset Resident 40's stomach if not swallowed whole. LVN 2 stated if Resident 40 did not receive all the crushed medications provided with the applesauce, Resident 40 could not have received the full dosage of ordered medication. LVN 2 stated she was not sure if there were any manufacturer recommendations to not crush the sennosides tablets. LVN 2 stated the medications given to relieve/prevent constipation should have been given with a full glass of water. LVN 2 stated she should have separated the crushed medications from the whole medication so Resident 40 did not get confused about not chewing the medications provided with a spoon.During an interview on 3/3/26 at 4:05 p.m. with the DON, the DON stated nurses should not have placed whole medication tablets in the same container with crushed medications and applesauce and given the whole medications with the same spoon used to administer the crushed medications. The DON stated residents should not have been chewing the docusate sodium due to changing the action of the medication. The DON stated the sennoside tablets should not have been crushed if there was a manufacturer recommendation to not crush the tablets due to bitterness, and the tablets should have been given with a full glass of water.During a review of the During a review of the facility's P&P titled, Medication Administration, dated 2025, the P&P indicated, .medications are administered.as ordered by the physician and in accordance with professional standards of practice.ensure that the six rights of medication administration are followed.administer medication as ordered in accordance with manufacturer specifications.provide appropriate amount of food and fluid.crush medications as ordered. Do not crush medications with [do not crush] instructions.4. During a concurrent observation and interview on 3/3/26 at 9:40 a.m. in Resident 69's room, with LVN 2, LVN 2 administered insulin aspart (a fast-acting form of insulin used to treat high blood sugar) to Resident 69. LVN 2 stated Resident 69's insulin aspart was to be given before meals and Resident 69's blood sugar level was taken earlier the same day at 7:26 a.m.During a review of Resident 69's AR, dated 3/3/26, the AR indicated Resident 69 was admitted to the facility from an acute care hospital on [DATE] with diagnoses of type 2 Diabetes Mellitus, atrial fibrillation (an irregular heartbeat), and acute kidney failure (a condition when the kidneys suddenly are unable to filter waste products from the blood).During a concurrent interview and record review on 3/3/26 at 3:05 p.m. with LVN 2, Resident 69's Medication Administration Record (MAR), dated [DATE] was reviewed. The MAR indicated, .insulin aspart injection solution 100 unit (unit of measurement)/milliliter (ML - unit of liquid measurement).inject as per sliding scale.subcutaneously (under the skin) before meals.hours.0630. LVN 2 stated she checked Resident 69's blood sugar on 3/3/26 at 7:30 a.m., which was before Resident 69 was scheduled for her breakfast meal. LVN 2 stated Resident 69's insulin aspart was administered at 9:40 a.m. which was after Resident 69 ate her meal. LVN 2 stated Resident 69's insulin aspart medication was a fast-acting insulin and should have been given within 15 to 30 minutes before Resident 69 ate her meal. LVN 2 stated it was important for Resident 69's insulin aspart to be given before meals to work effectively and bring Resident 69's blood sugar level down. LVN 2 stated if the medication was given without checking Resident 69's blood sugar level within the time frame ordered before meals, Resident 69's blood sugar level could have gone up and the insulin aspart would have been an inaccurate dose.During an interview on 3/3/26 at 4:05 p.m. with the DON, the DON stated nurses should have administered insulin ordered before meals no later than 15 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	minutes from checking the resident's blood sugar level, or when they saw the meal trays in the hallway being delivered to residents. The DON stated that short acting insulin could have dropped the resident's blood sugar level and caused a change of condition in the resident. the DON stated nurses should have followed the physician's orders to give the insulin aspart before meals and not after meals. The DON stated the administration of resident's insulin aspart should not have been two hours after checking the resident's blood sugar level. During a review of the facility's P&P titled, Medication Administration, dated 2025, the P&P indicated, .medications are administered.as ordered by the physician and in accordance with professional standards of practice.ensure that the six rights of medication administration are followed.right time.administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician.

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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 drugs and biologicals (a substance such as vaccines or drugs derived from a living organism used for treatment) were stored and labeled in accordance with currently accepted professional standards and practice when:1. The facility failed to ensure medications for one of one Resident (Resident 69's) Inhaler (medications used to treat respiratory disease with a mist or spray that the patient breathes in through the nose or mouth) dispenser was labeled with Resident 69's name and medication expiration date and Resident 69's insulin aspart (a fast-acting form of insulin used to treat high blood sugar) injectable pen was not labeled with the medication expiration date.2. The facility failed to remove discontinued medications from active medications in medication and treatment carts for four of four residents (Resident 19, Resident 45, Resident 57 and Resident 155.These failures had the potential for residents to receive expired and/or wrong medications, which put Resident 69, Resident 19, Resident 45, Resident 57, and Resident 155 at risk for medication adverse (resulting in negative or harmful effect) reactions.3. The facility failed to ensure the medication refrigerator containing vaccines had the temperature monitored two times per day.This failure had the potential to result in medications and vaccines becoming ineffective (not producing any significant or desired effect) and placed residents at risk of medication adverse (resulting in negative or harmful effect) reactions.1. During an observation on 3/03/2026 at 9:21 a.m. outside Resident 69's room, Licensed Vocational Nurse (LVN) 2 was observed obtaining Resident 69's fluticasone and salmeterol (medication to treat asthma [a condition in the lungs that caused the airways to swell, narrow and fill with mucus, causing difficulty breathing] and chronic obstructive pulmonary disease [COPD-a chronic lung disease causing difficulty in breathing]) inhaler from the medication box and insulin aspart (a fast-acting form of insulin used to treat high blood sugar) injectable pen from the medication cart. LVN 2 entered Resident 69's room with the medications, leaving the medication box and injection cap on the medication cart. There was no label with Resident 69's name or medication expiration date on the inhaler dispenser, and no label with the medication expiration date on the injection syringe. During a review of Resident 69's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 3/3/26, the AR indicated Resident 69 was admitted to the facility from an acute care hospital on [DATE] with diagnoses of type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), atrial fibrillation (an irregular heartbeat), acute kidney failure (a condition when the kidneys suddenly are unable to filter waste products from the blood), shortness of breath (uncomfortable feeling of running out of air or not able to breathe deeply enough) and cough.During an interview on 3/3/26 at 3:39 p.m. with LVN 2, LVN 2 stated Resident 69's insulin aspart cap had Resident 69's name and expiration date, but the syringe did not have a label, Resident 69's fluticasone/salmeterol had a label on the medication box, but the inhaler dispenser was not labeled with Resident 69's name and expiration date. LVN 2 stated Resident 69's syringe and inhaler dispenser could have gotten mixed up with another resident's medication and Resident 69 could have been given the wrong medication. LVN 2 stated it was important to have the resident's name and expiration date on the medications so residents would not get the wrong medication or expired medications. During an interview on 3/4/26 at 3:45 p.m. with the Director of Nursing (DON), the DON stated Resident 69's insulin pen and inhaler were not labeled appropriately. The DON stated the insulin syringe and inhaler dispenser should have had their own label to be sure the medication was given to the right resident and the medication was not expired.During a review of the facility's policy and procedure (P&P) titled, Labeling of Medications and Biologicals, dated 2025, the P&P indicated, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.all medications and biologicals will be labeled in accordance with applicable federal and state requirements and current accepted pharmaceutical principles and practices.medication labels must be legible at all times.labels for individual drug containers must include.the resident's name.the expiration date.labels for medications designed for multiple administrations [such as inhalers].the label will identify the specific resident for whom it was prescribed. 2. During an observation on 3/4/26 at 10:27 a.m. at station 5/6, Medication Cart 6 was reviewed. Resident 57's Hydrocodone-acetaminophen 5-325 (a medication used to treat pain) pill blister packet (a form of temper-evident packaging where an individual pushes individually sealed tablets through the foil in order to take the medication) was reviewed. The medication label indicated Resident 57's hydrocodone-acetaminophen 5-325 was ordered to be taken every six hours for 14 days.During a concurrent interview and record review on 3/4/26 at 10:30 a.m. with LVN 3, Resident 57's Order Listing Report (OLR), dated 3/4/26 was reviewed. The OLR indicated, .hydrocodone-acetaminophen oral tablet 5-325 mg [a unit of measurement] give 1 tablet by mouth every 6 hours as needed for moderate to severe pain [4-10 on pain scale] for 14 days.start date 02/15/2026.end date.03/01/2026. LVN 3 stated Resident 57's Hydrocodone-acetaminophen was ordered for 14 days and was completed on 3/1/26. LVN 3 stated discontinued medications needed to be pulled out of the medication cart and the log for controlled medications needed to be taken out of the binder. LVN 3 stated the discontinued controlled medications, and the medication log should have been given to the DON for review and destruction.During a review of Resident 57's AR, dated 3/4/26, the AR indicated Resident 57 was admitted to the facility from an acute care hospital on 2/15/26 with diagnoses of displaced fracture of right femur (a break in the bone of the thigh), acute respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), and history of falling.During an observation on 3/04/2026 at 10:52 a.m. at Station 5/6, Station 5 Treatment Cart was reviewed. The treatment cart contained clotrimazole (an antifungal medicine that treats certain fungal infections) 1% 30 grams (gm - a unit of measurement) for Resident 155.During a concurrent interview and record review on 3/4/26 at 11:00 a.m. with RN 3, Resident 155's OLR, dated 3/4/26 was reviewed. The OLR indicated, .clotrimazole .external cream 1% .apply to left [Lt] and right [Rt] feet topically [on the skin] every day and evening shift for wound care for 14 days. start date.1/15/2026.end date.1/29/2026. RN 3 stated Resident 155 was discharged and his clotrimazole medicated cream was discontinued .During a review of Resident 155's AR, dated 3/4/26, the AR indicated Resident 155 was admitted from an acute care hospital on 1/14/26 with diagnoses of tinea pedis (Athlete's foot - a skin infection caused by fungi), candidiasis (a fungal infection caused by the overgrowth of the yeast Candida) of skin and nail, arthropathic psoriasis (Psoriatic arthritis - a progressive inflammatory condition of the joints and the places where tendons and ligaments attach to bones). Resident 155 was discharged from the facility on 2/6/26.During an observation on 3/4/26 at 11:00 a.m. at Station 5/6, Station 5 Treatment cart was reviewed. The treatment cart contained two bottles of nystatin (a medication used to treat fungal or yeast infections of the skin) topical powder for Resident 45 and one tube of clotrimazole cream for Resident 45. The label on Resident 45's nystatin topical powder indicated, .apply to breast folds topically every day and evening shift for wound care for 14 days. Resident 45's clotrimazole cream label indicated, .apply to Lt and Rt feet topically every day and evening shift for wound care for 14 days.During a concurrent interview and record review on 3/4/26 at 11:05 a.m. with RN 3, Resident 45's Order Summary Report (OSR), dated 3/4/26 was reviewed. The OSR indicated, .nystatin external powder 1000000 unit/gm.apply to breast folds topically every day and evening shift for blanchable redness with dry flakey scaley skin for 14 days.order date.2/9/2026.end date 2/22/2026.clotrimazole.external cream 1% .apply to Lt and Rt feet topically every day and evening shift for wound care for 14 days. RN 3 stated Resident 45's nystatin powder and clotrimazole medications were discontinued. RN 3 stated nurses needed to look at the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician's orders. If a medication was discontinued, the nurse needed to take it out of the medication or treatment carts. RN 3 stated if the medication was not active anymore, someone could have used the medication if it remained in the cart.During a review of Resident 45's AR, dated 3/4/26, the AR indicated Resident 45 was admitted on [DATE] from an acute care hospital with diagnoses of metabolic encephalopathy (a condition where brain function is disturbed due to different diseases or toxins [poisons] in the blood), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), heart failure (a condition when the heart muscle doesn't pump enough blood to meet the body's needs which can cause fatigue and shortness of breath), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), candidiasis (a fungal infection caused by the overgrowth of the yeast Candida), and tinea pedis (Athlete's foot - a skin infection caused by fungi).During a concurrent observation and interview on 3/4/2026 at 11:03 a.m. with LVN 3 at station 5/6, LVN 3 was observed removing Resident 19's silver sulfadiazine external cream 1% (a medication used to prevent manage, and treat burn wound infections), two tubes and collagenase external ointment (a medication that removes dead tissue from wounds so they can start to heal), medications from treatment cart 6 to put in treatment cart 4. LVN 3 stated Resident 19 was moved to another room. The medication label on Resident 19's collagenase ointment indicated , .collagenase.250unit/1 gm.60 gm.apply to bilateral buttocks topically every day shift for wound care for 14 days.expiration date [exp] 1-28. The box was marked Opened 2/2/26. The label of a second tub of collagenase for Resident 19 was removed from Treatment Cart 6 and reviewed. The label indicated, .collagenase.250 unit/1 gm.30 gm.apply to bilateral buttocks topically every day shift for. unstageable tissue damage [UTD- unstageable full thickness (extend beyond both layers of the skin into subcutaneous tissue, sometimes reaching bone or tendon) skin or tissue loss, depth unknown] for 14 days.exp: 1-28. The box was marked, Opened 2/12/26. The label for a tube of silver sulfadiazine 1% cream indicated, .apply to right lower extremity [RLE] and left lower extremity [LLE] topically every day shift forwound care for 14 days.85 gm.exp: 1/27. The tube was marked, Opened 2/2/26. The label of a second tube of silver sulfadiazine 1% cream for Resident 19 indicated, .apply to right lower extremity [RLE] and left lower extremity [LLE] topically every day shift for wound care for 14 days.50 gm.exp: 1/28. The box was marked Opened 2/20/26.During a concurrent interview and record review on 3/4/26 at 11:08 a.m. with LVN 3, Resident 19's OLR, dated 3/4/26 was reviewed. The OLR indicated, .[collagenase].250 unit/gm.apply to bilateral buttocks topically every day shift for wound care for 14 days.start date 2/12/26.end date.2/26/26.[collagenase] .external ointment.250 unit/gm.apply to bilateral buttocks topically every day shift for UTD for 14 days.start date.2/19/26.end date.3/5/26.[silver sulfadiazine] external cream 1% .apply to RLE and LLE topically every day shift for wound care for 14 days.start date.2/12/26.end date.2/26/26.[silver sulfadiazine] external cream 1% .apply to RLE and LLE topically every day shift for wound care for 14 days.start date 2/19/26.end date 3/5/26. LVN 3 stated one tube of each of Resident 19's collagenase and silver sulfadiazine creams was discontinued.During a review of Resident 19's AR, dated 3/4/26, the AR indicated Resident 19 was admitted on [DATE] from an acute care hospital with diagnoses of cellulitis (a deep infection of the skin caused by bacteria) right lower limb and left lower limb, Methicillin Resistant Staphylococcus Aureus (MRSA - a bacteria that does not get better with the type of antibiotics [a medication that inhibits or destroys infections caused by bacteria] that usually cure staph infections), pressure ulcer/injury Stage 4 (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and tinea pedis (Athlete's foot - a skin infection caused by fungi).During an interview on 3/4/26 at 3:45 p.m. with the DON, the DON stated discontinued medications in the medication and treatment carts should have been separated from active medications. The DON stated if medications were discontinued, they should have been removed and put in the medication room to avoid being given to the residents.During an interview on 3/05/26 at 6:42 p.m. with the Pharmacist Consultant (PC), the PC stated if medications were expired, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they should have been removed from the treatment and medication carts and the medication rooms and put in a designated area for destruction. The PC stated discontinued medications should have been removed before the expiration date, and discontinued orders should have been removed by the end of the shift. The PC stated expired and discontinued medications should have been separated from regular medications, so the medications were not accidentally given to the residents.During a review of the facility's P&P titled, Medication Storage, dated 8/1/25, the P&P indicated, .the pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our [Destruction of Unused Drugs Policy].During a review of the facility's pharmacy P&P titled, Disposal/Destruction of Expired or discontinued Medication, dated 12/1/07, the P&P indicated, .facility should destroy discontinued or outdated medications in accordance with facility policy or applicable state law.3. During a concurrent observation and interview on 3/4/26 at 10:00 a.m. with Registered Nurse (RN) 1 in Station 3 and 4's medication room, the medication refrigerator was observed to contain two boxes of 20 shingles (a viral [virus] infection that causes a painful rash with fluid-filled blisters on the body) vaccine vials. RN 1 stated the temperature of the medication refrigerator was monitored once a day. The current temperature of the refrigerator was 42 degrees Fahrenheit (F - a unit of temperature measurement).During a review of the Temperature Log for Refrigerator - Fahrenheit (Temp Log), dated 3/2026, the Temp Log indicated, .other identification number [ID #] vaccines.monitor temperatures closely! if using temperature monitoring device [TMD]that does not record minimum/maximum temps, document current temps twice, at beginning and end of each workday.take action if temp is out of range - too warm [above 46 degrees F] or too cold [below 36 degrees F].day of month.1.exact time.AM 700/PM 1830.Minimum/Maximum [Min/Max] temp in unit [since previous reading] 70 [degrees F]/70 [degrees F].day of month.2.exact time.AM700/PM 1600.Min/Max temp in unit.72[degrees F]/70 [degrees F].day of month.3.exact time AM 530/PM 1800.Min/Max temp in unit.72 [degrees F/70 [degrees F].day of month.4.exact time530.Min/Max temp in unit.72 [degrees F].Danger! Temperatures above 46 degrees F are too warm! Write any out-of-range temps and room temp on the lines below and call your state or local health department immediately .acceptable temperatures aim for 41 degrees F. boxes for days of the month one through three had check marks without any temperature readings documented.During a review of the Medication Room Temperature Station 3-4 (Room Temp Log), dated March 2026, the Room Temp Log indicated .[day] 1.72 degrees F.[day] 2.70 degrees F.[day] 3.70 degrees F.[day]4.70 degrees FDuring a concurrent interview and record review on 3/4/26 at 3:45 p.m. with the Director of Nursing (DON), the Temp Log for the medication refrigerator in Station 3/4 was reviewed. The DON stated the temperatures for the medication refrigerator containing the vaccines was not monitored appropriately. The DON stated her expectation was for nurses to open the refrigerator, check the refrigerator thermometer, and document the refrigerator temperature at that moment on the Temp Log form. The DON stated staff should have checked the medication refrigerator temperature two times a day between a.m. and p.m. shifts.During a review of the facility's policy and procedure (P&P) titled, Medication Storage, dated 8/1/25, the P&P indicated, .all drugs and biologicals will be stored in locked compartments.[refrigerators].under proper temperature controls.all medications requiring refrigeration are stored in refrigerators located in the pharmacy and at each medication room.temperatures are maintained within 36-46 degrees F.During a review of the facility P&P titled, Temperature Recording Log for Vaccines Form No. 670 & 670 F, undated, indicated, .all refrigerator and freezers, used to store vaccine, must use a thermometer that has an external display of the current temperature and be capable of recording the minimum and maximum temperature o a recording period.measurements shall be recorded twice a day; one at the beginning of the workday and one prior to the end of the work day.record current vaccine storage unit temperature in Fahrenheit.record minimum and maximum temperatures in Fahrenheit.the internal temperature of refrigerator units should be between 36 degrees Fahrenheit and 46 degrees Fahrenheit.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an effective pest control program that ensured the facility was free of pests for three of six sampled residents (Residents 11, 145, and 147) when ants were observed on Resident 11, 145, and 147's nightstands.This failure resulted in the potential for disease transmission, food contamination, and secondary infections due to ant bites.During a review of Resident 11's Face Sheet (FS - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 3/5/26, the FS indicated, Resident 11 was admitted to the facility on [DATE] with diagnoses of acute posthemorrhagic anemia (a condition where a low number of red blood cells occurs because of significant blood loss), Type 2 diabetes mellitus with diabetic polyneuropathy (long-term high blood sugar has damaged multiple nerves, causing pain, numbness, tingling, or weakness, usually starting in the feet and legs), Cirrhosis of liver (when scar tissue replaces healthy liver tissue), and history of falling.During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes of thinking, learning and understanding] and physical functional level assessment), dated 2/21/26, the MDS section C (Cognitive Patterns) indicated, Resident 11 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1 to 15) Resident 11's BIMS score was 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested cognitively intact.During a concurrent observation and interview on 3/3/26 at 11:51 a.m. with Resident 11 in Resident 11's room, three ants were observed on Resident 11's nightstand. Resident 11 stated she had seen one or two ants in her room intermittently (occasionally) on her nightstand since moving into the facility a couple of months prior.During an observation on 3/4/26 at 1:36 p.m. in Resident 11's room, two ants were observed on Resident 11's nightstand. One ant was observed under the lid of Resident 11's white denture cup and another was observed on the nightstand near Resident 11's lipstick. During a review of Resident 145's FS, dated 3/5/26, the FS indicated, Resident 145 was admitted to the facility on [DATE] with diagnoses of encounter for surgical aftercare following surgery on the nervous system (made up of the brain, spinal cord, and nerves), fusion of spine (surgery to permanently join together two or more bones in the spine so there is no movement between them)- lumbar region (lower back), neuralgia (nerve pain) and neuritis (inflammation of one or more nerves)- unspecified, and depression(mood disorder that causes a persistent feeling of sadness and loss of interest)-unspecified.During a review of Resident 145's MDS, dated [DATE], the MDS section C indicated, Resident 145 had a BIMS score of 13 which suggested cognitively intact.During a concurrent observation and interview on 3/3/26 at 10:24 a.m. with Resident 145 in Resident 145's room, five ants were observed on Resident 145's nightstand near the television control, a cup, and surrounding food in a zip locked bag along with other resident items. Resident 145 stated she was not aware there were ants on her nightstand. During a review of Resident 147's FS, dated 3/5/26, the FS indicated, Resident 147 was admitted to the facility on [DATE] with diagnoses of urinary tract infection-site not specified, Parkinsons disease (a progressive movement disorder of the nervous system) without dyskinesia (uncontrolled involuntary movements), muscle weakness-generalized, and history of falling.During a review of Resident 147's MDS, dated [DATE], the MDS section C indicated, Resident 147 had a BIMS score of 6 which suggested severe cognitive impairment.During a concurrent observation and interview on 3/3/26 at 10:50 a.m. with Resident 147 in Resident 147's room, one ant was observed on Resident 147's nightstand. Resident 147 responded with No when asked if he was aware there were ants on his nightstand. During a concurrent observation and interview on 3/4/26 at 9:34 a.m. with Certified Nursing Assistant (CNA) 1 in Resident 145's room, CNA 1 stated the bugs on Resident 145's nightstand were ants and stated she would inform maintenance right away. CNA 1 (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated there should not be ants in the resident rooms because ants could get into the residents' food and that would be unhygienic (unclean). CNA 1 stated if ants were to bite the residents, it could cause red spots and lumps on the resident's skin that could cause skin changes and would require immediate notification to the nurse. CNA 1 stated an ant bite could cause an infection.During a concurrent interview on 3/5/26 at 9:45 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated there was an ant on resident 147's nightstand. LVN 3 stated she had received a complaint of ants recently from a resident in a different room, and she followed the usual process and put in a Tells (a system to notify maintenance of issues per LVN) order for it. LVN 3 stated ants should not be in residents' rooms and stated it's an infection precaution and not sanitary. LVN 3 stated ants could get on the residents, residents could get bitten and it could cause an infection.During a concurrent interview and record review on 3/5/26 at 9:49 a.m. with Licensed Vocational Nurse (LVN) 3, the facility's policy and procedure (P&P) titled, Pest Control Program, undated, was reviewed. The P&P indicated, .It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests.Definition: Effective pest control program is defined as measures to eradicate and contain common household pests (e.g., bed bugs, lice, roaches, ants, mosquitos. LVN 3 stated the pest control program was not effective if there were ants in resident's rooms.During a concurrent interview and record review on 3/6/26 at 3:54 p.m. with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Pest Control Program, undated, was reviewed. The P&P indicated, .It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests.Definition: Effective pest control program is defined as measures to eradicate and contain common household pests (e.g., bed bugs, lice, roaches, ants, mosquitos. The DON stated there should not be ants in the resident rooms. The DON stated ants should not be in the facility at all for infection control and for resident safety. The DON stated there was a potential residents could eat the ants and get bitten by the ants. The DON stated if a resident got bit by an ant there was a potential the bite could cause a change of condition that required notification to the doctor and possibly sending the resident to the hospital. The DON stated the P&P was not followed if there were ants in the resident's rooms.During a review of the facility's Work Order (facility's process of addressing needs/problems found) #9846, dated 2/2/26, the Work Order indicated, there is ants and spiders.During a review of the facility's Work Order #9866, dated 2/3/26, the Work Order indicated, aunts(ants) and spiders.During a review of Work Order #10112, dated 3/2/26, the Work Order indicated, ants in room.

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications were stored safely and securely for one of six sampled residents (Resident 29) when Resident 29 had been assessed as not capable of keeping medications at bedside for self-administration and two over the counter (OTC) supplements (probiotic -live, beneficial bacteria) capsules and probiotic with fiber gummies) were found in Resident 29's unlocked bedside table. This failure resulted in Resident 29 self-administering OTC supplements without a physician order, Resident 29's supplements being accessible to residents, visitors and staff and the potential for unintended use. During a review of Resident 29's Face Sheet (FS - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 3/5/26, the FS indicated, Resident 29 was admitted to the facility on [DATE] with diagnoses of paroxysmal atrial fibrillation (irregular heart rhythm that starts and stops on its own usually within seven days), aftercare following joint replacement surgery, tremors, unspecified and depression, unspecified.During a review of Resident 29's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes of thinking, learning and understanding] and physical functional level assessment), dated 01/25/26, the MDS section C (Cognitive Patterns) indicated, Resident 29 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1 to 15) Resident 29's BIMS score was 12 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested moderate impairment.During a concurrent observation and interview on 3/3/26 at 2:50 p.m. with Resident 29, in Resident 29's room, two OTC supplements (probiotic capsules and probiotics with fiber gummies) were observed in Resident 29's nightstand. Resident 29 stated she kept the supplements in her nightstand and self-administered the supplements when she remembered to do so.During a concurrent observation and interview on 3/5/26 at 10:38 a.m. with Certified Nursing Assistant (CNA) 2, in Resident 29's room, Two OTC supplements (probiotic capsules and probiotics with fiber gummies) were observed in Resident 29's nightstand. CNA 2 stated she worked with Resident 29 last week (week of February 23rd) and Resident 29 had both of the supplements in the room and on the bedside table at that time. CNA 2 stated she did not notify the nurse at the time because she didn't know the nurse and doctor needed to be aware.During a concurrent observation and interview on 3/5/26 at 10:50 a.m. with Licensed Vocational Nurse (LVN) 4, in Resident 29's room, Two OTC supplements (probiotic capsules and probiotics with fiber gummies) were observed in Resident 29's nightstand. LVN 4 stated she was not aware of the probiotic with fiber gummies and probiotic capsules stored in the unlocked resident's nightstand. LVN 4 stated that all medications including supplements needed to be kept in the locked medication cart and labeled with residents' information (resident name and date of birth) for safety. LVN 4 stated the supplements should not have been kept in the resident's room or stored unlocked, for safety reasons.During a concurrent interview and record review on 3/5/26 at 1:42 p.m. with Licensed Vocational Nurse (LVN) 4, Resident 29's Order Summary Report (OSR) was reviewed. The OSR indicated, no physician order for probiotic capsules or probiotic with fiber gummies. LVN 4 stated there were no current orders for the probiotic capsules and probiotics with fiber gummies.During a concurrent interview and record review on 3/5/26 at 1:45 p.m. with Licensed Vocational Nurse (LVN) 4, Resident 29's Self Administration of Medication Assessment ([NAME]) dated 2/26/26 was reviewed. The [NAME] indicated, .Resident may keep meds at bedside.No. LVN 4 stated that according to the [NAME], Resident 29 could not keep medications/supplements at bedside, and the medications/supplements should not have been in the resident's' room or nightstand unsecured for safety reasons.During a concurrent interview and record review on 3/6/26 at 2:41 p.m. with the Director of Nursing (DON), Resident 29's [NAME] dated 2/26/26 was reviewed. The [NAME] (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated, .Resident may keep meds at bedside.No. DON stated supplements should not have been at the bedside and any medications/supplements at the bedside needed to be in a locked compartment and they were not. DON stated Resident 29's supplements stored unlocked at the bedside were a safety concern for the resident. DON stated there was a potential for other residents to access those medications/supplements. DON stated her expectation was if any medications including supplements, were in the resident's' room, they needed to have a doctor's order for it and they should be kept under lock at all times to prevent unauthorized access.During a concurrent interview and record review on 3/6/26 at 2:55 p.m. with the DON, the facility's policy and procedure (P&P) titled, Self Administration of Medications, dated 12/1/07 was reviewed. The Self Administration of Medications P&P indicated, .Facility.should assess and determine. whether Self-Administration of medications is safe and clinically appropriate. To ensure safe and appropriate Self-Administration, Facility should educate residents to ensure that a resident is able to. Correctly store his/her medications in a locked compartment. The DON stated the P&P was not followed.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure respect and dignity for two of 13 sampled residents (Resident 147 and Resident 40) when:1. Resident 147's lunch tray on 3/3/26 was delivered 24 minutes after all other residents received their meals in the Tuolumne dining room due to his dining location on his meal ticket not being updated for 4 days. 2. Resident 40 gave his lunch tray to Resident 58 and staff did not check residents' lunch trays to ensure all residents received their correct lunch tray at the same timeThis failure resulted in Resident 147 and Resident 40 having to observe other residents eating without being able to participate which led to Resident 147 eating his meal alone and could result in a non-dignified social dining experience with the potential to cause feelings of exclusions or isolation. 1.During a review of Resident 147's admission Record (AR -a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 3/5/26, the AR indicated Resident 147 was admitted to the facility on [DATE] with diagnoses of urinary tract infection (infection in urinary system), Parkinson's disease (movement disorder of the nervous system), and right hand fracture (break in the hand bones). During a review of Resident 147's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 1/25/26, the MDS indicated Resident 147 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 6 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 147 was severely cognitively impaired. During a concurrent dining observation and interview on 3/3/26 at 12:18p.m., in the Tuolumne dining room, Resident 147, Resident 77, and Resident 81 were observed seated at a table together. The Tuolumne dining room had a total of 12 residents. Certified Nursing Assistant (CNA) 3 distributed all meals in the dining cart to residents in the room. Resident 147 was observed with no meal. The dining cart was observed with no more lunch trays inside. CNA 3 stated Resident 147 had been transferred from the Olive room to the Tuolumne room [ROOM NUMBER] days prior and his trays had been late since. CNA 3 stated the Tuolumne room was for independent residents who could feed themselves. CNA 3 stated the Director of Staff Development (DSD) and dietary staff were responsible for updating meal tickets to reflect dining locations. Resident 147 stated he was hungry and tired of his food being late since transferring to the Tuolumne dining room. Resident 147 stated he was frustrated. Resident 77 stated Resident 147's meals had been late every day since he transferred. During a concurrent dining observation and interview on 3/3/26 at 12:42 p.m., in the Tuolumne dining room, Resident 147's meal was delivered. Resident 147's meal was delivered 24 minutes after all other residents received their meals in the Tuolumne dining room. Resident 147's meal ticket stated his dining location was Olive room. The meal ticket indicated Resident 147's dining location had not been updated. During an interview on 3/3/36 at 12:45 a.m., in the Tuolumne dining room, Resident 77 and Resident 81 stated they were done eating. Resident 77 stated Resident 147 now had to eat alone and it was unfair. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/3/36 at 12:47 p.m., in the Tuolumne dining room, Resident 77 stated she was done eating and was observed exiting the Tuolumne dining hall. Resident 81 stated she would stay with Resident 147 so he didn't have to eat alone. During an observation on 3/3/36 at 12:55 p.m., in the Tuolumne dining room, Resident 81 left the Tuolumne dining room. Resident 147 was observed eating his meal alone at the table. The dining room had five residents left in the dining room. During an observation on 3/3/26 at 1:03 p.m., in the Tuolumne dining room, Resident 147 was observed eating alone at his table. The dining room had 2 residents left, waiting to return to their room. During a concurrent interview and record review on 3/6/26 at 8:57 a.m. with the DSD, Resident 147's Nursing/Dietary Communication card, dated 2/26/26, and Meal Ticket, dated 3/3/26, were reviewed. The DSD stated on 2/26/26 she was approached by the Director of Rehabilitation (DOR) with verbal recommendations to advance Resident 147 from the Olive room to the Tuolumne room for dining. The DSD stated the Olive room was for assisted dining and the Tuolumne room was for independent dining. Resident 147's Nursing/Dietary Communication indicated on 2/26/26 the DSD completed Resident 147's dining room change to the Tuolumne room starting for 2/27/26. The DSD stated, based on Resident 147's Meal Ticket the request had not been processed. The DSD stated Resident 147's Meal Ticket had not been updated to reflect his Tuolumne dining location. The DSD stated Nursing/Dietary Communication cards were brought to the kitchen and dietary staff updated the Meal Ticket. The DSD stated Resident 147's meals were being delivered to the wrong dining room since 2/27/26. The DSD stated this resulted in Resident 147's meals being delivered late which resulted in an undignified dining experience. The DSD stated having to watch others eat and not being able to dine with others was a dignity issue. The DSD stated she expected dietary staff to fulfill Nursing/Dietary Communication requests when submitted and facility staff to identify why trays were late and review Meal Tickets for accuracy. During a concurrent interview and record review on 3/6/36 at 9:12 a.m. with the Director of Rehab (DOR), Resident 147's Medical Record, dated 3/6/26, was reviewed. The DOR stated on 2/25/26 she attended Resident 147's interdisciplinary team meeting (IDT) and verbally discussed increasing Resident 147's dining independence in preparation for discharge. During an interview on 3/6/26 at 10:12 a.m. with the Dietary Service Manager (DSM), the DSM stated Nursing/Dietary Communication cards were brought to her and then she updated resident meal tickets. The DSM stated she had not received a Nursing/Dietary Communication card for Resident 147. The DSM stated she was aware Resident 147 recently switched from dining in the Olive room to the Tuolumne room. The DSM stated it was important Meal Tickets were updated with the correct dining room to ensure residents received their meals timely. The DSM stated it was important residents in the Tuolumne room were served and dined at the same time to ensure dignity. During an interview on 3/6/26 at 11:16 a.m. with the Director of Nursing (DON), the DON stated all meals in dining rooms were expected to be served at the same time to ensure residents had a dignified dining experience and ate at the same time. The DON stated Resident 147's meal ticket was not updated when the Nursing/Dietary Communication card was completed. The DON stated she expected facility staff to follow up with late trays and ensure meal tickets were updated and accurate to reflect dining needs. The DON stated Resident 147 was at risk for frustration, lack of social dining and an undignified social dining experience when his meal was delivered late and he had to eat alone. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON stated facility policy and procedure was not followed when Resident 147's meal ticket was not updated per the Nursing/Dietary Communication for 4 days and he had to watch other residents eat before his tray was delivered which resulted in him dining alone. 2. During a concurrent observation and interview on 3/3/26 at 12:35 p.m. in the Olive dining room Resident 40 was sitting next to Resident 58. Resident 40 did not have his lunch tray in front of him. Resident 40 stated he was waiting for his food. All other residents in the dining room had their lunch tray and CNAs were assisting other residents with their meals. During an observation on 3/3/25 at 12:45 p.m. RNA 1 arrived to the Olive dining room after assisting another resident to his room. RNA 1 retrieved Resident 40's lunch tray from the top of the cart. RNA 1 gave Resident 40 his lunch tray. During an interview on 3/3/25 at 12:54 p.m. with CNA 3, CNA 3 stated she gave Resident 40 his lunch tray. CNA 3 stated Resident 40 gave his lunch tray to Resident 58 when Resident 58's lunch tray was not brought to her. CNA 3 stated she had to assist another resident with his lunch and did not check to see if Resident 58 had her lunch tray. CNA 3 stated all CNAs were responsible to ensure all residents got their trays. CNA 3 stated We all should have checked to ensure all the residents got their tray at the same time. CNA 3 stated it was important to pass all the lunch trays to ensure residents were not given the wrong lunch tray and residents could dine together. CNA 3 stated residents could have choked when given the wrong lunch tray if the food was not the consistency ordered by the physician. CNA 3 stated residents should have gotten their lunch trays at the same time to promote dignity. CNA 3 stated residents could have felt left out if not served at the same time. During an interview on 3/5/26 at 9:07 a.m. with CNA 1, CNA1 stated CNAs should have served residents at the same time. CNA 1 stated all residents should be treated equally with respect and dignity. CNA 1 stated there was no nurse on that day to check residents' lunch trays to ensure right diet was served for the right resident. CNA 1 stated residents were at potential risk for choking and aspiration if given the wrong lunch tray. During an interview on 3/5/26 at 9:31 a.m. with Restorative Nursing Assistant (RNA) 1, RNA 1stated residents at each table must be serve at the same time with the rest of the residents sitting at the dining table for respect. RNA 1 stated all staff in the dining room should have checked residents' lunch trays. RNA 1 stated CNAs should be checking that all residents have their trays served. RNA 1 stated nurses should be checking resident's lunch trays to ensure right diet was prepared and being served for the residents. RNA 1 stated it was important to check all residents had the correct tray to prevent residents from getting the wrong lunch tray. RNA 1 stated residents could have choked and aspirated if given the wrong lunch tray when it was not in their diet. RNA 1 stated it was important to ensure everyone was served on time for dignity. During an interview on 3/6/26 at 2:54 p.m. with the DON, the DON stated, My expectation is for the CNAs to give the residents their lunch tray at the same time. The DON stated CNAs should have checked to make sure the lunch tray was given at the same time. The DON stated residents could have been given food against their diet. The DON stated it was a safety concern. The DON stated staff should have ensured all residents had their lunch and the right lunch tray to promote resident's rights and dignity. During a review of Resident 40's AR dated 3/6/26 the AR indicated, Resident 40 was admitted to the facility on [DATE] with diagnoses which included fracture (a partial or complete break in a bone) of (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	neck of left femur, atherosclerosis (the buildup of fats, cholesterol and other substances in and on the artery walls), atrial fibrillation (A-fib- an irregular and often very rapid heart rhythm), muscle weakness, dementia (a progressive disease resulting in memory loss, language difficulties, and poor judgment that interferes with daily life) and heart failure (chronic, progressive condition where the heart muscle cannot pump blood efficiently, often causing fluid buildup in the lungs and legs). During a review of Resident 40 's MDS, dated [DATE], indicated BIMS score was 8 out of 15, which indicated Resident 40 was moderately impaired. During a review of Resident 40's Physician order (PO) tilted, Order Details dated 2/23/26, the PO indicated, Order Summary: No added Salt diet (NAS- often called a low-sodium or salt-restricted diet) is an eating plan that limits the amount of sodium you consume to manage health conditions like high blood pressure, heart failure, or kidney disease): soft and bite sized . During a review of Resident 58's AR dated 3/6/26 the AR indicated, Resident 58 was admitted to the facility with diagnoses of diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic kidney disease (CKD- the slow, progressive loss of kidney function over months or years, often caused by diabetes or high blood pressure), dysphagia (difficulty in swallowing), hemiplegia (a severe form of one-sided, often permanent, paralysis or significant weakness caused by brain damage (e.g., stroke, tumor, infection) or spinal cord injury) and hemiparesis (weakness on one side of the body following a stroke, brain injury or tumor) and dementia. During a review of Resident 58 's MDS, dated [DATE], indicated BIMS score was 11 out of 15, which indicated Resident 58 was moderately impaired. During a review of Resident 58's PO dated 1/20/26, the PO indicated, Order Summary: [Consistent or Controlled Carbohydrate] CCHO NAS diet (is a therapeutic meal plan that combines Consistent Carbohydrate (CCHO) management with No Added Salt (NAS) restrictions) soft and bite sized level 6 texture [food designed for safe swallowing, featuring tender, moist foods that require chewing but can easily be broken apart with a fork or spoon) thin liquids During a review of the facility's policy and procedure (P&P) titled, Serving Meals, undated, the P&P indicated, .the presentation of the meal directly affects how much the resident eats. Presentation includes the dining environment.be accurate in serving of meals. During a review of the facility's P&P titled, The Dietary Profile, dated 2023, the P&P indicated, .a nutritional profile will include.need for special timing of tray. During a review of the facility's P&P titled, Dignity- Promoting/Maintaining Dignity, undated, the P&P indicated, .it is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life.provide equal access to quality of care.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement a comprehensive person-centered care plan for one of seven sampled residents (Resident 149) when Resident 149's care plan for Stage 3 pressure ulcers (a deep, full-thickness skin loss injury where subcutaneous fat is visible, but muscle, tendon, or bone are not exposed) to coccyx (the last bone at the bottom [base] of your spine) was not implemented.This failure resulted in Resident 149 not receiving necessary care and treatment in promoting wound healing and placed Resident 149 at increased risk of an avoidable worsening of pressure ulcers (areas of damaged skin caused by staying in one position for too long), developing new pressure ulcers and wound infection (an invasion of the body by bacteria or viruses that cause disease).During a concurrent observation and interview on 3/3/26 at 10:47 a.m. with Resident 149, in Resident 149's room, Resident 149 was sitting in a wheelchair watching a program on television. Resident 20 had oxygen on at two liters per minute (lpm -oxygen flow rates) per nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen). Resident 149 was pleasant, alert and oriented x 4 (a term used to describe a patient's level of awareness. It means that the patient is fully aware and can accurately identify four things: person, place, time, situation/event). Resident 149 stated she was okay with a smile on her face. Resident 149 stated she was admitted to the facility from acute care hospital. Resident 149 stated she's been at the facility for almost a week. Resident 149 stated she was receiving therapy services and treatment for her wounds (pointing to her bottom).During a concurrent observation and interview on 3/3/26 at 10:58 a.m., in Resident 149's room, Resident 149 was sitting in a wheelchair at bedside. Resident 149 was sitting on a folded facility's blanket (with a rough texture) on her wheelchair. Resident 149 stated she had no cushion on her wheelchair.During a concurrent observation and interview on 3/3/26 at 12:20 p.m. with Resident 149, Resident 149 was sitting in a wheelchair waiting for her lunch. Resident 149 stated she's been sitting in her wheelchair since after breakfast, and she was up in a wheelchair every day. Resident 149 stated she usually sits in her wheelchair for more than two to three hours and stated, .sometimes longer. Resident 149 stated she cannot reposition herself while sitting in a wheelchair. Resident 149 stated she was dependent on nursing staff for wheelchair repositioning. Resident 149 stated she stayed in one position when sitting up in wheelchair and staff were not repositioning her.During a concurrent observation and interview on 3/5/26 at 8:57 a.m. with Resident 149, in Resident 149's room, Resident 149 was laying in bed in a low air loss mattress (a mattress designed to prevent and treat pressure wounds). Resident 149's wheelchair was parked facing her closet, there was a standard pillow on top of wheelchair seat. Resident 149 stated she needed help with bed and wheelchair repositioning.During a concurrent observation and interview on 3/5/26 at 10:17 a.m. with Licensed Vocational Nurse (LVN) 3, in Resident 149's room, Resident 149's wheelchair and closet were checked. LVN 3 stated there was no cushion on wheelchair and could not find the wheelchair cushion in Resident 149's closet. LVN 3 stated Resident 149 had pressure ulcer on her coccyx and should have a wheelchair cushion available to prevent worsening of the pressure ulcer and promote wound healing. LVN 3 stated Resident 149 should be repositioned every two hours by the CNAs when up in a wheelchair to prevent the progression or worsening of the wounds. During an interview on 3/5/26 12:03 p.m. with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 149 was assisted in her wheelchair at 11:30 a.m. using a stander lift (a mobility device designed to safely lift individuals from a seated position to a standing position). CNA 1 stated there was no cushion in her wheelchair. CNA 1 stated she should have a cushion in a wheelchair because Resident 149 has wounds. CNA 1 stated Resident 149's wounds on her bottom could worsen.During a concurrent observation and interview 3/5/26 at 2:14 p.m. with Occupation Therapy Assistant (OTA) 1, OTA 1 was pushing out the stander lift towards the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible for doing weekly rounds with the wound specialist. LVN 5 stated physician order for repositioning should be implemented to prevent worsening of the wounds and developing of new pressure ulcers.During a concurrent interview and record review on 3/2/26 at 9:30 a.m. with LVN 5, Resident 149's medical records titled Braden Scale- for Pressure Ulcer Risk Evaluation, dated 2/26/26 was reviewed and indicated, 1. Braden Scale for Predicting Pressure Ulcer Risk. 1. Use the Braden Scale to assess the resident's level of risk for development of pressures ulcers. The evaluation is based on six indicators: sensory perception, moisture, activity, mobility, nutrition, and friction of shear. 8. Scoring: Total score of 12 or less represents HIGH RISK. LVN 5 indicated Resident 149's score was 16 and stated Resident 149 was high risk for developing pressure ulcers. LVN 5 stated Resident 149 should be repositioned every two hours by the CNAs when up in wheelchair to prevent worsening of existing pressure ulcers and developing new pressure ulcers. LVN 5 stated it was her expectation for CNAs to follow facility's protocol and care plan to reposition residents every two hours not only in bed but also when up in a chair.During an interview on 3/6/26 at 11:33 a.m. with the Director of Nursing (DON), the DON stated it was her expectation for licensed nurses to develop and implement a person-centered care plan based on residents' assessment and needs. The DON stated Resident 149's care plan for pressure ulcers should be implemented by nursing staff to prevent developing and worsening of pressure ulcers. The DON stated Resident 149 should be repositioned by nursing staff every two hours and as needed when in bed and in chair and provide a gel cushion in her wheelchair for wound healing and prevent worsening of wounds or developing an acquired avoidable pressure ulcer. The DON stated Resident 149 was admitted with pressure ulcer on coccyx and should not be up in wheelchair for more than two hours.During a review of facility's P&P titled Skin and Wound Monitoring and Management, revised on 4/2025, the P&P indicated, It is the policy of this facility that: 2. A resident having pressure injury(s) receives necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing. The purpose of this policy is that the facility provides care and services to: 1. Promote interventions that prevent pressure injury development; 2. Promote the healing of pressure injuries that are present (including prevention of infection to the extent possible); and 3. Precent the development of additional, avoidable pressure injury. Procedure. a. Resident Assessment: The nurse responsible for assessing and evaluating the resident's condition on admission and readmission is expected to take the following actions: a. Complete Initial admission Record and Braden Scale to identify risk and to identify any alterations in skin integrity noted at that time. c. Identify risk factors which relate to the possibility of skin breakdown and/or the development of pressure injury which include but are not limited to: Impaired/decreased mobility and decreased functional ability e. Develop an individualized person-centered care plan based on the assessment and designed to minimize the possibility of skin breakdown. 3. Prevention: In order to prevent the development of skin breakdown or prevent existing pressure injuries from worsening, nursing staff shall implement the following approaches as appropriate and consistent with the resident's care plan: c. Reposition the resident. d. Use pressure relieving/reducing and redistributing devices (including but not limited to low air loss mattresses, wedges, pillows, etc.) . 5. Treatment. a. Continue preventive measures as appropriate, including but not limited to: Pressure reduction, Continence care, Mobility.During a review of National Library of Medicine.org Professional Reference titled, Nursing Process, dated 4/10/23, (found at https://www.ncbi.nlm.nih.gov/books/NBK499937/) the reference indicated, . Planning: The planning stage is where goals and outcomes are formulated that directly impact patient care based on guidelines. These patient-specific goals and the attainment [the level of knowledge, skills, or qualifications a learner has acquired at a specific point in time] of such assist in ensuring a positive outcome. Nursing care plans are essential in this phase of goal setting. Care plans provide a course of direction for personalized care tailored to an individual's unique needs. Overall condition and comorbid conditions play a role in the construction of a care plan. Care plans enhance communication, documentation, reimbursement, and continuity of care across the healthcare continuum. vital to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	positive patient outcomes. the nursing process to guide care is clinically significant going forward in this dynamic, complex world of patient care. Aging populations carry with them a multitude of health problems and inherent risks of missed opportunities to spot a life-altering condition.

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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 observation, interview, and record review, the facility failed to ensure necessary care and treatment in promoting wound healing, preventing infection (an invasion of the body by bacteria or viruses that cause disease), developing new pressure ulcers (areas of damaged skin caused by staying in one position for too long) and preventing worsening of existing pressure ulcers were implemented for one of seven sampled residents (Resident 149) when Resident 149 had no pressure relieving device when sitting in a wheelchair and was not repositioned by the nursing staff while sitting in a wheelchair for more than two hours. Resident 149 had a Stage 3 pressure ulcers (is a deep, full-thickness skin loss injury where subcutaneous fat is visible, but muscle, tendon, or bone are not exposed) to coccyx (is the last bone at the bottom [base] of your spine).These failures had placed Resident at increased risk of an avoidable worsening of pressure ulcers, developing new pressure ulcers and wound infection.During a concurrent observation and interview on 3/3/26 at 10:47 a.m. with Resident 149, in Resident 149's room, Resident 149 was sitting in a wheelchair watching a program on television. Resident 20 had oxygen on at two liters per minute (lpm -oxygen flow rates) per nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen). Resident 149 was pleasant, alert and oriented x 4 (a term used to describe a patient's level of awareness. It means that the patient is fully aware and can accurately identify four things: person, place, time, situation/event). Resident 149 stated she was okay with a smile on her face. Resident 149 stated she was admitted to the facility from acute care hospital. Resident 149 stated she's been at the facility for almost a week. Resident 149 stated she was receiving therapy services and treatment for her wounds (pointing to her bottom).During a concurrent observation and interview on 3/3/26 at 10:58 a.m., in Resident 149's room, Resident 149 was sitting in a wheelchair at bedside. Resident 149 was sitting on a folded facility's blanket (with a rough texture) on her wheelchair. Resident 149 stated she had no cushion on her wheelchair.During a concurrent observation and interview on 3/3/26 at 12:20 p.m. with Resident 149, Resident 149 was sitting in a wheelchair waiting for her lunch. Resident 149 stated she's been sitting in her wheelchair since after breakfast, and she was up in a wheelchair every day. Resident 149 stated she usually sits in her wheelchair for more than two to three hours and stated, .sometimes longer. Resident 149 stated she cannot reposition herself while sitting in a wheelchair. Resident 149 stated she was dependent on nursing staff for wheelchair repositioning. Resident 149 stated she stayed in one position when sitting up in wheelchair and staff were not repositioning her.During a concurrent observation and interview on 3/5/26 at 8:57 a.m. with Resident 149, in Resident 149's room, Resident 149 was lying in bed in a low air loss mattress (a mattress designed to prevent and treat pressure wounds). Resident 149's wheelchair was parked facing her closet, there was a standard pillow on top of wheelchair seat. Resident 149 stated she needed help with bed and wheelchair repositioning.During a concurrent observation and interview on 3/5/26 at 10:17 a.m. with Licensed Vocational Nurse (LVN) 3, in Resident 149's room, Resident 149's wheelchair and closet were checked. LVN 3 stated there was no cushion on wheelchair and could not find the wheelchair cushion in Resident 149's closet. LVN 3 stated Resident 149 had pressure ulcer on her coccyx and should have a wheelchair cushion available to prevent worsening of the pressure ulcer and promote wound healing. LVN 3 stated Resident 149 should be repositioned every two hours by the CNAs when up in a wheelchair to prevent the progression or worsening of the wounds. During an interview on 3/5/26 12:03 p.m. with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 149 was assisted in her wheelchair at 11:30 a.m. using a stander lift (a mobility device designed to safely lift individuals from a seated position to a standing position). CNA 1 stated there was no cushion on her wheelchair. CNA 1 stated she should have a cushion on the wheelchair because Resident 149 has wounds. CNA 1 stated Resident 149's wounds on her bottom could worsen.During a concurrent observation and interview 3/5/26 at 2:14 p.m. with Occupation Therapy Assistant (OTA) 1, OTA 1 was (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pushing out the stander lift towards the door of Resident 149's room. OTA 1 stated she was assisting and giving instructions while the two CNAs were transferring Resident 149 from wheelchair to bed. OTA 1 stated Resident 149 had no cushion on her wheelchair. OTA 1 stated Resident 149 should have a gel cushion (designed to reduce the risk of skin breakdown and prevent the development of pressure ulcers caused by prolonged sitting) on her wheelchair to prevent worsening of pressure ulcer in her coccyx and developing new pressure ulcers. OTA 1 stated Resident 149 should be repositioned by staff when sitting in wheelchair to help with circulation and wound healing.During a review of Resident 149's Face Sheet (FS - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 3/6/26, the AR indicated Resident 149 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), chronic kidney disease (a disease characterized by progressive damage and loss of function in the kidneys), type 2 diabetes mellitus (when the blood sugar levels in the body are too high), hypertensive heart disease (refers to heart problems that occur because of high blood pressure that is present over a long time), morbid (severe) obesity (or extreme obesity which is defined as having a body mass index [BMI] of 40 or greater or weighing in excess of 100 pounds of one's ideal weight), and pressure induced deep tissue damage (localized damage to the skin and underlying tissue caused by prolonged pressure, often over bony prominences) of sacral (the triangular shaped bone at the base of the back) region and left ankle.During a review of Resident 149's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 3/5/26, the MDS section C indicated Resident 149 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 13 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 149 was cognitively intact.During an interview on 3/6/26 at 8:22 a.m. with CNA 1, CNA 1 stated she did not reposition Resident 149 when sitting up in a wheelchair yesterday (3/5/26). CNA 1 stated she only asked Resident 149 if she wanted to go back to bed. CNA 1 stated Resident 149 requires assistance with Activities of Daily Living (ADLs- routine tasks/activities such as repositioning, transferring, bathing, dressing and toileting a person performs daily to care for themselves). CNA 1 stated Resident149 should be repositioned when up in wheelchair every two hours for wound healing and not to develop new pressure ulcers.During a concurrent interview and record review on 3/6/26 at 9:09 a.m. with LVN 5, Resident 149 medical records titled Order Summary Report (OSR), dated 3/6/26 and Care Plan Report, dated 2/27/28 were reviewed. The OSR indicated, .Stage 3 Pressure Ulcer to Coccyx. The Care Plan report indicated, Has Stage 3 pressure ulcer to coccyx upon admission.Goal: Pressure Ulcer will show signs of healing and remain free from infection.Interventions: .frequent repositioning. LVN 5 stated Resident 149 was admitted with pressure ulcer to her coccyx. LVN 5 stated Resident 149 is at risk for pressure ulcers related to presence of pressure ulcers, diagnoses of morbid (severe) obesity and type 2 Diabetes Mellitus. LVN 5 stated Resident 149 requires assistance with bed mobility and repositioning in wheelchair. LVN 5 stated frequent repositioning applies to bed and in wheelchair and should be implemented by nursing staff every two hours and as needed. LVN 5 stated a gel cushion should be provided for Resident 149 on admission and applied on wheelchair seat when Resident 149 was sitting in a wheelchair. LVN 5 stated providing and implementing wound preventive interventions such as pressure relieving device and turning and repositioning will promote wound healing and prevent worsening of pressure ulcers.During a concurrent interview and record review on 3/6/26 at 9:20 a.m. with LVN 5, Resident 149's wound care visit report, dated 3/4/26 was reviewed, and indicated, .Wound Assessment.Wound Details: . Wound location-bilateral buttocks, wound type-pressure ulcer. Wound Description: Stage-3 Pressure Injury.Additional Orders: Offload wound and reposition per facility protocol. LVN 5 stated Resident 149's pressure ulcer to coccyx was assessed by the wound specialist on 3/4/26 and (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented bilateral (both sides) buttocks instead of coccyx. LVN 5 stated physician's order for repositioning should be implemented. LVN 5 stated she was responsible for doing weekly rounds with the wound specialist.During a concurrent interview and record review on 3/2/26 at 9:30 a.m. with LVN 5, Resident 149's medical records titled Braden Scale- for Pressure Ulcer Risk Evaluation, dated 2/26/26 was reviewed and indicated, 1. Braden Scale for Predicting Pressure Ulcer Risk. 1. Use the Braden Scale to assess the resident's level of risk for development of pressures ulcers. The evaluation is based on six indicators: sensory perception, moisture, activity, mobility, nutrition, and friction of shear. 8. Scoring: Total score of 12 or less represents HIGH RISK. LVN 5 indicated Resident 149's score was 16 and stated Resident 149 was at high risk for developing pressure ulcers. LVN 5 stated Resident 149 should be repositioned every two hours by the CNAs when up in wheelchair to prevent worsening of existing pressure ulcers and developing new pressure ulcers. LVN 5 stated it was her expectation for CNAs to follow facility's protocol to reposition residents every two hours not only in bed but also when up in a chair.During an interview on 3/6/26 at 11:33 a.m. with the Director of Nursing (DON), the DON stated it was her expectation for licensed nurses to follow and implement the policy and procedures (P&P) for wound management to prevent developing and worsening of pressure ulcers. The DON stated Resident 149 was admitted with pressure ulcer on coccyx and should not be up in wheelchair for more than two hours. The DON stated Resident 149 should be repositioned by nursing staff every two hours and as needed when in bed and in chair and provided a gel cushion in her wheelchair to promote wound healing and prevent worsening of wounds and developing an acquired avoidable pressure ulcer. The DON stated the Interdisciplinary Team (IDT) meets weekly for skin and wound meetings but there was no documentation of the meeting being done.During a review of facility's P&P titled Skin and Wound Monitoring and Management, revised on 4/2025, the P&P indicated, It is the policy of this facility that: 2. A resident having pressure injury(s) receives necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing. The purpose of this policy is that the facility provides care and services to: 1. Promote interventions that prevent pressure injury development; 2. Promote the healing of pressure injuries that are present (including prevention of infection to the extent possible); and 3. Precent the development of additional, avoidable pressure injury. Procedure. a. Resident Assessment: The nurse responsible for assessing and evaluating the resident's condition on admission and readmission is expected to take the following actions: a. Complete Initial admission Record and Braden Scale to identify risk and to identify any alterations in skin integrity noted at that time. c. Identify risk factors which relate to the possibility of skin breakdown and/or the development of pressure injury which include but are not limited to: Impaired/decreased mobility and decreased functional ability e. Develop an individualized person-centered care plan based on the assessment and designed to minimize the possibility of skin breakdown. 3. Prevention: In order to prevent the development of skin breakdown or prevent existing pressure injuries from worsening, nursing staff shall implement the following approaches as appropriate and consistent with the resident's care plan: c. Reposition the resident. d. Use pressure relieving/reducing and redistributing devices (including but not limited to low air loss mattresses, wedges, pillows, etc.) . 5. Treatment. a. Continue preventive measures as appropriate, including but not limited to: Pressure reduction, Continence care, Mobility.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents receive appropriate services to maintain or improve mobility with the maximum practicable independence for one of seven sampled residents (Resident 35) when Resident 35's Restorative Nursing Program (RNP- a formal, planned and organized program of care which is intended to restore a lost ability or maintain a potentially deteriorating function for a particular resident. RNP is initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy services) was not developed and implemented after completion and discharge from skilled Occupational Therapy services on 1/30/26.This failure resulted in Resident 35 not receiving RNP to maintain or improve her mobility and placed Resident 3 at an increased risk of decline in range of motion and functional mobility such as transfers and ambulation.Based on concurrent observation and interview on 3/3/26 at 12:03 p.m. with Resident 35, in Resident 35's room, Resident 35 was laying in bed awake. Resident 35 was pleasant, alert and oriented x 4 (a term used to describe a patient's level of awareness. It means that the patient is fully aware and can accurately identify four things: person, place, time, situation/event). Resident 35 stated she wanted to walk. Resident 35 stated she was walking prior to hospitalization. Resident 35 stated she could stand for a short period and could take a few steps in her room. Resident 35 stated she could manage to go to the bathroom and dress herself, but she needed some assistance. Resident 35 stated she was getting weaker and was at risk for falls. Resident 35 stated she uses a wheelchair as her primary mode of locomotion. Resident 35 stated physical therapist (PT) should be walking her yesterday (3/2/26) and today 3/3/26). During a concurrent interview and record review on 3/5/26 at 9:31 a.m. with Restorative Nurse Assistant (RNA) 1, the current list of residents on RNP was reviewed and indicated Resident 35 was not on the list. RNA 1 stated she remembered Resident 35 being on RNP, but she needed to look for Resident 35's RNP record. RNA 1 stated the Director Staff Development (DSD) was overseeing the RNPs.During a concurrent interview and record review on 3/5/26 at 9:35 a.m. with RNA 1, Resident 35's RNP titled RNA Monthly Summary, dated 7/1/25 to 10/25/25 were reviewed. The RNA Monthly Summary indicated, Treatment Provided: Ambulation.Goals addressed: maintain mobility Assistive devices: FWW (Front Wheeled Walker) Distance: Ambulation 100-150. RNA 1 stated Resident 35 can ambulate with FWW from her room to the front lobby. RNA 1 stated Resident 35 had multiple refusals in participating with RNP ambulation. RNA 1 stated Resident 35 was receiving RNP for ambulation before she went to acute care hospital.During a concurrent interview and record review on 3/5/26 at 2:14 p.m. with the Director of Rehabilitation (DOR), Resident 78's medical records titled, Occupational Therapy -OT Discharge summary, dated [DATE] - 1/30/26 was reviewed. The OT Discharge Summary indicated, .Discharge Recommendations and Status.Restorative Transfer Program: RNA program sit to stand.to be trained on Monday.Prognosis to maintain CLOF (Current Level of Function) .electronically signed by: name of Occupational Therapist 1/30/26. The DOR stated Resident 35 was referred for RNP sit to stand. During an interview on 3/6/26 at 11:05 a.m. with the DSD (Director of Staff Development), the DSD stated Resident 35 was not currently on RNP and there was no order for RNP. The DSD stated she did not receive RNP referral from the therapy department. The DSD stated Resident 35 was previously on RNP for ambulation but had episodes of refusals. The DSD stated Resident 35 was transferred to acute care hospital and was placed on therapy services. The DSD stated she will develop a process of ensuring RNP referrals will be implemented. The DSD stated Resident 35 should have been on RNP when completed skilled therapy services to prevent the risk of decline in her functional mobility like ambulation. The DSD stated the implementation of RNPs was important to maintain and restore current level of function, prevent a decline in mobility, and maximize residents' potential abilities. During an interview on 3/6/26 at 11:16 a.m. with Occupational Therapist (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(OT) 1, OT 1 stated she was the therapist who treated and provided OT services to Resident 35. OT 1 stated she remembered filling out a restorative nursing referral for Resident 35 and stated, .it could have been missed. OT 1 stated Resident 35 should be receiving RNP. OT 1 stated implementing RNP for the residents was important in maintaining their CLOF and prevent a decline in their mobility. During an interview on 3/6/26 at 11:33 a.m. with the Director of Nursing (DON), the DON stated Resident 35's RNP should be implemented when discharged from OT services. The DON stated RNPs were nursing services provided to residents in maintaining residents' functional mobility and preventing decline in their mobility. During an interview on 3/6/26 at 3:45 p.m. with the DOR, the DOR stated Resident 35 was not evaluated by PT. The DOR stated Resident 35 received OT services and did not receive PT services from recent hospitalization.During a review of Resident 35's care plan report , initiated date 1/2/26 and 1/3/26, indicated, Resident is at risk for falls related to impaired mobility due to weakness. Self-Care Performance Deficit related to impaired/limited mobility due to weakness. Goal: Will maintain current level of function in bed mobility, transfers, eating, dressing, grooming, toilet use and personal hygiene.will improve to highest practicable level with activities of daily living (ADLs - routine tasks/activities such as eating, bathing, dressing, transferring, and toileting a person performs daily to care for themselves)performance.During a review of Resident 35's Face Sheet (FS - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 3/6/26, the FS indicated Resident 35 was readmitted to the facility on [DATE] (original admission date of 8/17/24) with diagnoses of pneumonia (an infection that affects one or both lungs, causing the air sacs of the lungs to fill with fluid), mild dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and heart failure (a condition when the heart muscle doesn't pump enough blood to meet the body's needs which can cause fatigue and shortness of breath).During a review of Resident 35's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 1/31/26, the MDS section C indicated Resident 35 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 13 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 35 was cognitively intact.During the review of facility's policy and procedures (P&P) titled Restorative Nursing Program, revised 7/2022, the P&P indicated, .1. Develop a plan of nursing care services based upon nursing assessment, physical therapy, occupational therapy, or speech recommendations of resident needs. 2. Provide direct Restorative nursing services that will maintain optimum physical and mental health for the residents and meet his/er medical treatment needs. 3. Apply restorative nursing measures and ensure the safety and comfort of the resident in his/her environment. 6. Provide health teaching and training that will meet the needs of the individual resident and his family. The resident will be evaluated on his/her ability to carry out activities of daily living (ADL). These activities include: the ability to use the toilet; the ability to transfer from bed to a chair; the ability to stand walk. Evaluation of resident's skin, his/her safety, in addition to ADL's, is an ongoing process. The staff, along with the resident, will formulate goals, interventions to meet goals, and continually re-evaluate the resident's progress.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview and record review the facility failed to ensure the daily nurse staffing information posted for public viewing accurately identified the actual number of Registered Nurses (RNs), Licensed Vocational Nurses (LVNs) and Certified Nursing Assistants (CNAs) providing direct care for each shift. Review of the facility's posted staffing sheets indicated staffing was reported under the categories of Licensed and Unlicensed staff, which combined RN and LVN hours under licensed staff and combined CNA and Restorative Nursing Assistant (RNA) hours under unlicensed staff.This failure had the potential to affect 136 of 136 residents residing in the facility, as the inaccurate posting of daily nurse staffing information had the potential to prevent residents, visitors and the public from clearly determining the number and type of nursing staff providing direct care in the facility.Findings:During an observation on 3/6/26 at 10:51 a.m. the facility's posted nurse staffing information was observed in a common area accessible to residents and visitors. The posting indicated a resident census of 133 (current census is 136). The staffing information was posted by shift as follows: Day shift (6:00a.m.-2:30p.m.) reflected 11 licensed staff and 18 unlicensed staff totaling 88 licensed hours and 144 unlicensed hours. Evening shift (2:00p.m.-10:30p.m.) reflected nine licensed staff and 14 unlicensed staff totaling 72 licensed hours and 112 unlicensed hours. Night shift (10:00p.m.-6:30a.m.) reflected four licensed staff and seven unlicensed staff totaling 32 licensed hours and 56 unlicensed hours. The posting indicated staff included RN's and LVN's and unlicensed staff included CNA's and RNAs. The total direct care hours posted equaled 504 hours, with a handwritten calculation of 3.78 nursing hours per resident day.During a concurrent interview and record review on 3/6/26 at 11:27 a.m. the posted daily nurse staffing information dated 3/6/26 was reviewed with Staff Coordinator (SC) and Payroll Representative (PR). PR stated he reviewed the staffing schedule from the previous day, reconciled the hours per patient day (HPPD). PR stated he then provided the information to SC. SC stated she received the document and verified the hours prior to posting. SC stated the hours included all staff involved in direct resident care. SC stated she posted the daily HPPD information. SC stated the unlicensed HPPD reflected 1.44 hours for the day shift and 1.12 hours for the evening shift. SC stated she would need to perform a manual calculation to determine the specific hours worked by CNA's and RNA's because the hours were grouped together. SC further stated she would also need to calculate the RN hours separately from LVN hours because the licensed staff hours were combined. SC stated the RNA primarily performed restorative duties but could also respond to call lights and pass snacks. SC stated the projected staffing hours were posted during the day, and PR verified the hours the following morning, after which the document was filed and not reposted. SC stated that because the staffing categories were grouped together, a resident or family member reviewing the posting would not be able to determine the exact hours worked by each nursing staff category.During a record review on 3/6/26 at 1:30 p.m. the facility's posted daily nurse staffing information for March 1, 2026, through March 5, 2026 indicated the facility's posted staffing sheets identified staffing under the categories of Licensed and Unlicensed staff providing direct care. The posted staffing information combined RN and LVN hours under the licensed category and combined CNA and RNA hours under the unlicensed category. The posted staffing information did not identify the specific number of RN, LVN, CNA and RNA's providing direct care for each shift.During an interview on 3/6/26 at 2:24 p.m. with the Director of Nursing (DON), the DON stated the RNA had an assigned schedule of residents and primarily performed restorative therapy services for those residents. The DON stated she did not have a clear picture of the number of hours the RNA worked performing restorative duties versus performing CNA duties. The DON stated the LVN and RN hours were combined on the staffing posting, and the form used by the facility reflected only licensed and unlicensed staff categories. The DON stated the posted hours reflected projected staffing hours. The DON further stated it was important for residents and visitors to clearly understand how many nurses and CNAs were working in the facility and that more specific (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	information would provide a clearer understanding of the staffing present.During a review of the facility's policy and procedure (P&P) titled, Staffing, undated, the P&P indicated, our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment.During a follow up email correspondence on 3/11/26 at 8:56a.m. with the DON, The DON stated she had consulted with a resource person regarding additional policies related to staff. The DON stated there were no additional policies beyond the staffing policy previously provided to the surveyor.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were free of significant medication errors, when one of one resident (Resident 69) was administered the incorrect dose of Dulaglutide (an injectable medication used to improve blood sugar levels in the blood) that was prescribed by the physician from January 27 2026 to March 3 2026, which resulted in continued high blood sugar levels requiring the increase and addition of medications to help regulate Resident 69's blood sugar levels.This failure put Resident 69 at risk of developing hypoglycemia (when the level of glucose [sugar] in the blood drops below the range that is healthy) which had the potential to cause, seizures (a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements, behaviors, sensations, or states of awareness), confusion (a situation in which people do not understand what is happening, what they should do or who someone or something is), trouble walking or seeing clearly, weakness and loss of consciousness.Findings:During an observation on 3/3/26 at 9:58 a.m. in Resident 69's room, Licensed Vocational Nurse (LVN) 2 was observed to administer dulaglutide. The manufacturer's label on the medication injection indicated, .dulaglutide injection 0.75milligrams [mg- a unit of measurement]/0.5milliliters [ml- a liquid unit of measurement]. The pharmacist's printed label that was on Resident 69's dulaglutide medication indicated, . [brand name] 0.75mg/0.5ml pen injector. generic for dulaglutide.inject 1.5mg subcutaneously [under the skin] one time a day.During a review of Resident 69's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 3/3/26, the AR indicated Resident 69 was admitted to the facility from an acute care hospital on [DATE] with diagnoses of type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), atrial fibrillation (an irregular heartbeat), and acute kidney failure (a condition when the kidneys suddenly are unable to filter waste products from the blood).During a review of Resident 69's Medication Administration Record (MAR), dated [DATE], the MAR indicated, .[brand name] solution auto-injector [a device for injecting a single, preloaded dose of a drug] 0.75 mg/0.5 ml dulaglutide inject 0.75 mg subcutaneously one time a day every Tuesday for DM 2.order date 01/19/2026.discontinue [d/c] date 01/26/2026.administered Tuesday [DATE].[brand name medication] subcutaneous solution auto-injector 0.75mg/0.5ml dulaglutide inject 1.5 mg subcutaneously one time a day every Tuesday for DM 2.order date 01/26/2026.d/c/ date.03/03/2026.administered Tuesday [DATE].During a review of Resident 69's MAR, dated [DATE], the MAR indicated, .[brand name medication] subcutaneous solution auto-injector 0.75mg/0.5ml dulaglutide inject 1.5 mg subcutaneously one time a day every Tuesday for DM 2.order date 01/26/2026.d/c/ date.03/03/2026.administered Tuesday [DATE].[DATE].[DATE].[DATE].During a review of Resident 69's MAR, dated [DATE], the MAR indicated, .[brand name medication] subcutaneous solution auto-injector 0.75mg/0.5ml dulaglutide inject 1.5 mg subcutaneously one time a day every Tuesday for DM 2.order date 01/26/2026.d/c/ date.03/03/2026.administered Tuesday [DATE].During a review of Resident 69's Dulaglutide Pharmacy Dispense Report (Report), dated 3/3/26, the Report indicated, .fill date 1/20/26. [dulaglutide] 0.75mg/0.5ml inject 0.75mg subcutaneously one time a day every Tuesday.labeled.1/20/26.manifested [information about the contents of a shipment].1/20/26.Fill date 2/10/26.[dulaglutide] 0.75mg/0.5ml inject 1.5 mg subcutaneously one time a day every Tuesday.labeled.2/10/26.manifested.2/10/26.fill date 2/18/26.[dulaglutide] 0.75mg/0.5ml inject 1.5 mg subcutaneously one time a day every Tuesday.labeled 2/18/26.manifested.2/18/26.During a concurrent interview and record review on 3/3/26 at 3:05 p.m. with LVN 2 and the Director of Nursing (DON), Resident 69's Order Summary Report (OSR), undated was reviewed. The OSR indicated, .[brand name medication] subcutaneous solution auto-injector 0.75mg/0.5ml . inject 0.75 mg (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	subcutaneously one time a day every [Tuesday] for Diabetes Mellitus 2 [DM 2]. discontinued.order date 1/19/2026 start date 1/20/26. (brand name medication) subcutaneous solution auto-injector 0.75mg/0.5ml . inject 1.5mg subcutaneously one time a day every Tuesday for DM 2. order date 1/26/26.start date 1/27/26. The DON acknowledged Resident 69's dulaglutide was a 0.75 mg single dose pre-filled syringe and not 1.5 mg as ordered by the physician. LVN 2 also acknowledged Resident 69's dulaglutide syringe was a pre-filled, single dose syringe. LVN 2 stated Resident 69's physician order was for 1.5 mg dulaglutide subcutaneously every Tuesday. LVN 2 acknowledged she administered the wrong dose of dulaglutide medication to Resident 69. LVN 2 stated Resident 69 should have received 1.5 mg of dulaglutide medication not 0.75 mg which was the manufacturer's dose indicated on the dulaglutide pre-filled single dose syringe she administered.During an interview on 3/5/2026 at 4:47 p.m. with the Medical Director (MD), the MD stated Resident 69's dulaglutide dose was increased from 0.75 mg to 1.5 mg. The MD stated his expectation was for staff to administer the correct dose of medication ordered. The MD stated it looked like Resident 69's blood sugar was not controlled on dulaglutide 1.5 mg, so insulin glargine injection (a long-acting man-made-insulin used to control high blood sugar) and pioglitazone (a prescription tablet used to control blood sugar levels) was added to Resident 69's medications. The MD stated if the pharmacy had sent the right dose of Resident 69's dulaglutide in addition to the other diabetes medications that were added (in February and March), Resident 69's blood sugar could have dropped, and Resident 69 could have experienced hypoglycemic symptoms. During a review of Resident 69's MAR dated [DATE], the MAR indicated, .insulin glargine.subcutaneous solution 100 unit [unit of measurement for insulin medication]/ml.inject 37 units subcutaneously one time a day for hyperglycemia.order date 2/13/26.d/c date 3/2/26 [evening dose].insulin glargine.subcutaneous solution 100 unit/ml.inject 52 unit subcutaneously in the morning for DM.order date 2/3/26.dc date.2/5/26.insulin glargine. subcutaneous solution 100 unit/ml.inject 56 unit subcutaneously one time a day for DM.order date 2/5/26.d/c date.2/13/26 [morning dose].insulin glargine.subcutaneous solution 100 unit/ml.inject 60 unit subcutaneously one time a day for DM.order date 2/13/26.d/c date.3/2/26.[morning dose]. Resident 69's morning dose of insulin glargine was increased 52 units to 60 units during the month of February 2026.During a review of Resident 69's MAR dated [DATE], the MAR indicated, .pioglitazone 15 mg.give 1 tablet by mouth one time a day for DM 2.order date 3/2/26. insulin glargine.subcutaneous solution 100 unit/ml.inject 65 unit subcutaneously one time a day for DM.order date 3/3/26 [morning dose]. insulin glargine.subcutaneous solution 100 unit/ml.inject 41 unit subcutaneously one time a day for hyperglycemia.order date 3/2/26 [evening dose].insulin glargine.subcutaneous solution 100 unit/ml.inject 65 unit subcutaneously one time a day for DM.order date 3/2/26 [morning dose]. Resident 69's evening dose of insulin glargine increased from 37 units to 41 units and the morning dose of insulin glargine increased from 60 units to 65 units for elevated blood sugar levels during the first week of March 2026. Resident 69 was also ordered the oral medication pioglitazone for elevated blood sugar levels in addition to the insulin glargine injections for elevated blood sugar levels in March 2026. During a telephone interview on 3/5/26 at 6:42 p.m. with the Pharmacist Consultant (PC), the PC stated the physician changed Resident 69's dulaglutide medication to a higher dose and the pharmacist who dispensed the medication was not notified of the change in dose. The PC stated the medication label that was on the dulaglutide injector pen was put on the medication by the pharmacist. The PC stated the facility should have discontinued the dulaglutide 0.75 mg order and placed a new order for a 1.5 mg dose. The PC stated the Pharmacist should have checked the label before putting it on the dulaglutide medication. The PC stated Resident 69 could have become hypoglycemic.During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated 2025, the P&P indicated, .ensure that the six rights of medication administration are followed.right drug.right dosage.review MAR to identify medication to be administered.compare medication source.with MAR to verify resident name, medication name, form, dose.During a review of the facility's P&P titled, Medication Reconciliation, dated 2025, 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, .this facility reconciles medication frequently throughout a resident's stay to ensure that the resident free of any significant medication errors.refers to the process of verifying that the resident's current medication list matches the physician's orders for the purposes of providing the correct medications to the resident at all points throughout his or her stay.daily processes.verify medication labels match physician orders and consider [rights] of medication administration each time a medication is given.order medications from pharmacy in accordance with facility procedures.verify medications received match the medication orders.weekly processes.perform medication crossmatch of medications to verify medications on hand match physician orders.During a review of the facility's P&P titled, Medication Orders, the P&P indicated, when a new order changes the dosage of a previously prescribed medication, discontinue previous entry by writing [DC'd] and the date, or discontinue the order as per the electronic software instructions and retype the new order.enter the new order on the MAR or ensure the new order is in the electronic MAR.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure and maintain complete medical records for one of seven sampled residents (Resident 4) when Resident 4's Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) was not signed by the physician. Resident 4's POLST was prepared by qualified staff and signed by Resident 4 on 1/27/26.This failure had the potential for Resident 4 not to receive necessary care and treatment according to her wishes as stated in her POLST during emergency or significant change of conditions.During a concurrent observation and interview on 3/3/26 at 11:50 a.m. with Resident 4, in Resident 4's room, Resident 4 was laying in bed with oxygen on at two liters per minute via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen). Resident 4 was awake, alert and oriented x 4 (is a term used to describe a patient's level of awareness. It means that the patient is fully aware and can accurately identify four things: person, place, time, situation/event). Resident stated she was admitted to the facility from the hospital after she had surgery at the hospital. During a concurrent interview and record review on 3/5/26 at 12:13 p.m. with Licensed Vocational Nurse (LVN) 3, Resident 4's medical record titled POLST, dated 1/27/26 was reviewed and indicated Resident 4 signed the POLST on 1/27/26 when she was admitted to the facility on [DATE] but it was not signed by a physician. LVN 3 stated Resident 4's POLST should be signed by the physician within 48-72 hours when Resident 4 signed the POLST on 1/27/26. LVN 3 stated the facility usually faxes the POLST to the physician for review and signature. LVN 3 stated it was important that resident's POLST form was complete to be valid. LVN 3 stated resident's POLST is a legal document stating the care and treatment based on resident or responsible party's wishes. LVN 3 stated resident's POLST was guiding the staff in identifying if resident is needing a CPR - cardiopulmonary resuscitation (an emergency lifesaving procedure performed when the heart stops beating) or not in times of emergency and change of condition. LVN 3 stated the POLST form was in bright colored pink paper.During an interview on 3/5/26 at 12:30 p.m. with Resident 4, in Resident 4's room, Resident 4 stated she remembered signing a pink form, but she cannot remember what it was. During a review of Resident 4's Face Sheet (FS - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 3/6/26, the FS indicated Resident 4 was admitted to the facility on [DATE] with diagnoses of Urinary Tract Infection (UTI - an infection in the bladder/urinary tract), encounter for surgical aftercare following surgery on the digestive system (is a group of organs that work together to digest and absorb nutrients from the food you eat), Type 2 diabetes mellitus (when the blood sugar levels in the body are too high), chronic pulmonary edema (is the long-term, gradual buildup of fluid in the lung's air sacs), essential (primary) hypertension (abnormally high blood pressure [the amount of force the heart uses to pump blood through the arteries] that is not the result of a medical condition), atherosclerotic heart disease (when the blood vessels that carry oxygen and nutrients from the heart to the rest of the body become thick and stiff), and presence of cardiac pacemaker (is a small, battery-operated device that helps the heart beat in a regular rhythm).During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 2/2/26, the MDS section C indicated Resident 4 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 11 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 4's cognition was moderately impaired.During an interview on 3/5/26 at 2:07 p.m. with the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical Records Manager (MRM), the MRM stated Resident 4's POLST was not signed by the physician and was faxed to the physician today (3/5/26). The MRM stated Resident 4's POLST was not valid if not signed by the physician, and stated, it's incomplete. The MRM stated she was responsible for auditing residents' POLST form for completeness of residents' medical records. The MRM stated the POLST form should be signed by the physician within 5 days. During an interview on 3/6/26 at 8:36 a.m. with the Social Services Director (SSD), the SSD stated resident's POLST should be signed by the physician, resident or legally recognized decision maker to be considered valid. The SSD stated the MRM reviews residents' medical records including POLST to ensure completeness. During an interview on 3/6/26 at 11:33 a.m. with the Director of Nursing (DON), the DON stated it was her expectation that residents' POLST must be signed by the physician within 48 hours from admission of resident to the facility. The DON stated it was not acceptable that Resident 4's POLST was not signed by the physician since admission on [DATE]. The DON stated it was important to complete POLST with signatures from physicians and residents/responsible party to appropriately provide the necessary care and treatment as stated in residents' POLST. The DON stated the POLST is a legal physician's order. During a review of facility's policy and procedures (P&P) titled, Promoting the Right of Self-Determination for Healthcare Decisions and Advance Healthcare Directives, undated, the P&P indicated, Each resident will receive the necessary care and services to attain or maintain the highest practice physical, mental, and psychosocial wellbeing, accordance with comprehensive assessments and plan of care. Each resident and/or legal healthcare decision maker will be provided a mechanism for reaching decisions concerning preferred intensity or of care, including the right to forego or withdraw life sustaining treatment. To provide guidelines and principles to assist residents and/or legal healthcare decision maker, physicians and facility personnel in implementing decisions concerning a residents' preferred intensity of care and the process for creating and implementing advanced healthcare directives including the withholding of life support and the foregoing or withdrawal of life sustaining treatment. Standing physician order form (MOST/POLST/POST) are physician orders, typically documented on a brightly the end of life. Decisions documented on these orders include choices for CPR, antibiotics and IV fluids, use of intubation and mechanical ventilation, and artificial nutrition. The form is used to compliment an Advanced Directive or Living Will and is not intended to replace those documents. A completed, fully executed form is a legal physician order and is immediately actionable.