STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555245	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Park Post-Acute	2586 Buthmann Ave Tracy, CA 95376

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. Based on observation, interview, and record review, the facility failed to ensure the Resident or Responsible Party (RP, someone who can help the resident and, as necessary, make decisions for the resident) was informed and consented to the use of psychotropic (drugs that affect a person's mind, emotions, and behavior) medications for five of 46 sampled residents (Resident 2, Resident 112, Resident 8, Resident 3, and Resident 19).Resident 2,Resident 112,Resident 8,Resident 3,Resident 19,These failures had the potential for not honoring the resident's right to be informed about his or her medical treatment, including medication side effects or other alternative options.Findings: 1.A review of Resident 2's admission Record, indicated Resident 2 was admitted to the facility with diagnoses which included cognitive communication deficit (difficulty understanding or expressing thoughts), need for assistance with personal care, and unspecified dementia (memory loss and confusion affecting daily functioning). A review of Resident 2's Order Audit Report, dated 1/6/26, indicated the physician ordered olanzapine (a medication used to treat mood and behavior symptoms) 5 milligrams (mg-a unit used to measure medication strength) tablet, one tablet by mouth at bedtime for Resident 2's dementia. A review of Resident 2's Medication Administration Record, (MAR- a document that lists the resident's medications ordered, given, and/or held) dated 1/26, indicated Resident 2 received olanzapine 5mg tablet daily at 8:00 PM from 1/6/26 through 1/28/262. 2.A review of Resident 112's admission Record, indicated Resident 112 was admitted to the facility with diagnoses including radiculopathy of the cervical region (nerve irritation or compression in the neck causing pain, weakness, or numbness). A review of Resident 112's Order Audit Report, dated 1/13/26, indicated that on 1/13/26, the physician ordered mirtazapine (a medication used to treat depression) 15 mg tablet, one tablet by mouth at bedtime for Resident 112's depression. A review of Resident 1122's MAR, dated 1/26, indicated Resident 112 received mirtazapine 15 mg tablet daily at 9:00 PM from 1/14/26 through 1/28/26. During a concurrent interview and record review on 1/29/26 at 2:13 PM with Licensed Nurse (LN) 2, Resident 2's and Resident 112's VERIFICATION OF INFORMED CONSENT FOR PSYCHOTROPIC [informed consent] forms were reviewed. Resident 2's informed consent for olanzapine was signed by Resident 2's representative on 12/31/25 and by the physician on 1/2/26 but did not include olanzapine's drug category, dosage, frequency, duration, administration method, caution and warning summary, reason for use and benefits, probable side effects and significant risks, or alternative treatments, including non-medication approaches. Resident 112's informed consent for mirtazapine (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was signed by Resident 112 on 1/13/26 and by the physician on 1/14/26 but did not include mirtazapine's dosage, frequency, duration, administration method, caution and warning summary, benefits, or alternative treatments, including non-medication approaches. LN 2 stated Resident 2's olanzapine and Resident 112's mirtazapine informed consent forms were not valid because the informed consent forms lacked required information that should have been explained to the resident's representative and the resident. LN 2 further stated Resident 2's representative and Resident 112 did not receive complete education about the medications, which prevented them from making informed treatment decisions. During an interview on 1/29/26 at 2:50 PM with the Director of Nursing (DON), the DON stated psychotropic informed consent had to include the medication dosage, directions, indication, risks, and benefits and had to be clearly explained to the resident or resident's representative. The DON further stated informed consent that lacked required information about the medication was invalid and placed residents at risk for harm. 3. A review of Resident 8's clinical record titled, admission RECORD, indicated Resident 8 was admitted to the facility with diagnosis of, but not limited to schizophrenia (a chronic brain disorder causing distorted thinking, disorganized speech/behavior, and reduced emotional expression), anxiety disorder (a mental condition with experience of excessive, persistent worry, fear or nervousness that doesn't go away and interferes with daily life), depression (a condition causing persistent sadness and loss of interest), and bipolar disorder (a mental health condition that causes extreme mood changes). During a concurrent interview and record review on 1/29/26 at 1:55 PM with the Minimum Data Set Coordinator (MDSC), the MDSC reviewed the electronic health record (EHR) titled, Verification of Informed Consent for Psychotropic Medication, for four psychotropic medications prescribed by the physician to Resident 8. The MDSC stated that obtaining informed consent for psychotropic medications was essential. The MDSC further stated that the administration of these medications could not begin until the resident's attending physician had obtained informed consent. The MDSC reviewed the Verification of Informed Consent for Psychotropic Medication, for the medications prescribed by the physician to Resident 8: Buspirone, ordered 3/22/25 (an antianxiety medication - medicine that helps calm the mind and reduce feelings of anxiety or nervousness), Fluoxetine, ordered 3/21/25 (an antidepressant medication - medicine that helps improve mood and reduce symptoms of depression), Risperdal, ordered 3/22/25 (an antipsychotic medication - medicine that helps calm the mind and reduce symptoms where a person may see, hear, or believe things that aren't real), and Lorazepam, ordered 3/25/25 (an antianxiety medication). The MDSC found that the informed consent for the psychotropic medications Buspirone and Fluoxetine was incomplete. The forms did not include information about the benefits and common side effects, and they lacked the physician's signature who obtained the informed consent. During an interview on 1/30/26 at 8:58 AM with the Director of Nursing (DON), the DON stated that licensed nurses were expected to obtain fully completed informed consent forms for psychotropic medications. The DON stated further that these forms needed to include the medication order, the diagnosis or indication, side effects, beneficial effects, and, most importantly, the doctor's signature. The DON stated that having an incomplete informed consent for psychotropic medications was unacceptable. 4. A review of Resident 3's admission RECORD, indicated Resident 3 was admitted to the facility with diagnoses which included schizophrenia (a chronic brain disorder that disrupts a person's ability to (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	think, feel, and behave clearly, often causing a split from reality. It causes severe symptoms, including hallucinations [sensing things that aren't there], delusions [firmly held false beliefs], and disorganized thinking or behavior). A review of Resident 3's Order Summary Report, dated 1/29/26, the record indicated Resident 3 had an order for Risperidone at bedtime for schizophrenia manifested by auditory hallucinations with a start date of 10/5/25. During a concurrent interview and record review on 1/29/26 at 11:33 a.m. with the Director of Nursing (DON), Resident 3's clinical record for consents was reviewed. The DON confirmed that Resident 3 did not have an informed consent for her risperidone. 5. A review of Resident 19's clinical record titled, admission RECORD, indicated Resident 19 was admitted to the facility with diagnosis which included cognitive communication deficit, dementia (a decline in thinking, memory, and reasoning skills severe enough to disrupt daily life), and Alzheimer's disease (progressive brain disorder that destroys memory and thinking skills). During a concurrent interview and record review on 1/29/26 at 10:30 a.m. with the DON, Resident 3's clinical record titled, Order Summary, dated 11/29/26 was reviewed. The DON confirmed Resident 19 had orders for donepezil (prescription medication used to treat memory loss and confusion associated with Alzheimer's and dementia) daily and memantine (prescription medication used to manage symptoms of moderate-to-severe Alzheimer's disease) twice a day started on 12/1/25. The DON verified Resident 19's or Resident 19's responsible party's (RP) informed consent was not obtained for the donepezil and memantine and stated it was her expectation for licensed nursing staff to obtain informed consent when new orders are given by the provider or upon admission for psychotropic medication. The DON further stated it was important to obtain informed consent so the residents or RP's understand the risks, benefits, and alternatives of the medications that are being prescribed. A review of facility's policy and procedure (P&P) titled, PSYCHOTROPIC MEDICATION USE, dated 6/21, the P&P indicated .All medications used to treat behaviors must have a clinical indication and be used in the lowest possible dose . It is the responsibility of the attending health care practitioner to inform the residents and/or representative of the initiation, reason for use, and the risks associated with the use of psychotropic medications .The informed consent will be obtained by the Prescriber prior to initiation of the psychotropic medication . A review of the facility's policy and procedure (P&P) titled, INFORMED CONSENT POLICY, dated 1/24, indicated, .involve the residents in their care decisions by facilitating information and obtaining consent for the use of psychotropic drugs.which may lead to the inability to regain use of a body function after prolonged use.the licensed nurse verifies with the attending physician that informed consent has been obtained.The licensed nurse documents this verification on the informed consent form.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to accommodate the needs of six of 46 sampled residents (Resident 28, Resident 112, Resident 72, Resident 114, Resident 115, and Resident 117) when the following residents did not have access to their call lights (devices used to contact staff for assistance):1.Resident 28,2. Resident 112,3.Resident 72,4.Resident 114,5.Resident 115,6.Resident 117,These failures placed Resident 28, Resident 112, Resident 72, Resident 114, Resident 115, and Resident 117 at increased risk for unmet care needs, delayed staff response, falls, and potential for injury. Findings: 1.A review of Resident 28's admission RECORD, indicated Resident 28 was admitted to the facility with diagnosis of, but not limited to dementia (a condition that affects the brain and causes problems with memory, thinking, and daily activities), seizure (a sudden change in the brain's activity that causes unusual movements, behavior, or awareness), and anxiety disorder (a mental condition where a person can experience excessive, persistent worry, fear or nervousness that doesn't go away and interferes with daily life). During a review of Resident 28's Care Plan Report, revised 5/8/25, in the section titled, Focus, indicated, High risk for falls and injury . and in the section titled, Interventions, initiated 5/8/25, indicated, Have things needed by the resident [Resident 28] within reach including call light . During an observation on 1/27/26 at 10:52 AM in Resident 28's room, Resident 28 was observed sleeping in bed with the call light device and bed remote on the floor, next to the lower right side of her bed. During a concurrent observation and interview on 1/27/26 at 11:05 AM with LN 1 in Resident 28's room, LN 1 confirmed that Resident 28's call light device had fallen to the floor and was not within Resident 28's reach. LN 1 stated that it was unacceptable for Resident 28's call light to be out of reach. LN 1 further stated that if the call light was not within Resident 28's reach, it would put Resident 28 at risk of not having her needs met. 2.A review of Resident 112's admission Record, indicated Resident 112 was admitted to the facility with diagnoses which included discitis of the lumbosacral region (infection of the spinal discs in the lower back), urinary tract infection, diabetes mellitus type II (body cannot control blood sugar levels), and radiculopathy of the cervical (nerve irritation or compression in the neck causing pain, weakness, or numbness). During a concurrent observation and interview on 1/27/26 at 11:12 AM with Certified Nurse Assistant (CNA) 2 in Resident 112's room, Resident 112 was lying in bed with the call light next to Resident 112's left lower leg. Resident 112 yelled and called out for nursing staff and asked for the call light. CNA 2 stated Resident 112 could not reach the call light because it was next to Resident 112's left lower leg. CNA 2 further stated Resident 112 had confusion and the call light should have remained accessible to Resident 112 to help to prevent falls and ensure care needs were met. A review of Resident 112's Care Plan, initiated on 1/14/26, in the section titled, Focus, indicated, . [Resident 112] High risk for falls . In the section titled, Interventions, indicated, .Have things needed by the resident within reach including call light . (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.A review of Resident 72's admission RECORD, indicated Resident 72 was admitted to the facility with diagnosis of, but not limited to major depressive disorder (a serious condition that causes long-lasting feelings of sadness and loss of interest) and quadriplegia (paralysis that affects all four limbs, both arms and both legs). A review of Resident 72's Care Plan Report, revised 9/9/24, in the section titled, Focus, indicated, High risk for falls and injury . and in the section titled, Interventions, initiated 9/11/23, indicated, Leave call light within reach. During a concurrent observation and interview on 1/27/26 at 10:35 AM, Resident 72 was observed sleeping on her back in a low bed without a call light device. Licensed Nurse (LN) 1 confirmed that Resident 72 did not have a call light device to use when Resident 72 needed help. LN 1 stated, I did not know since when Resident 72 did not have a call light. LN 1 further stated that having no call light device for Resident 72 was an emergency. LN 1 stated instead of writing the lack of a call light in the maintenance logbook, LN1 stated that she would communicate it directly with the facility maintenance director or his assistant to address the issue as soon as possible. LN 1 stated that the call light device was very important so Resident 72 could communicate her needs. LN 1 further stated that not having a call light device might lead to not meeting Resident 72's needs. During an interview on 1/27/26 at 10:50 AM with the Assistant Maintenance (AM), AM confirmed that he had received a report that Resident 72 needed a call light device. During an interview on 1/29/26 at 12:16 PM with the Director of Nursing (DON), the DON stated that the expectation was for residents to have a call light device within their reach. The DON stated that the call light device was important for several reasons, including safety, communication of residents' needs, and providing emergency help. 4. A review of Resident 114's admission Record, indicated Resident 114 was admitted to the facility with diagnoses including urinary tract infection, chronic respiratory failure with hypoxia (long-term breathing problem with low oxygen levels), and end-stage renal disease (kidneys no longer function properly). During a concurrent observation and interview on 1/27/26 at 11:45 AM with Certified Nurse Assistant (CNA) 3 in Resident 114's room, Resident 114 was lying in bed, and her call light was caught between the right side of the bed side rail and the bed frame. CNA 3 stated Resident 114's call light was in the wrong position and was not within Resident 114's reach. CNA 3 further stated that when a resident's call light was not within reach, it increased safety risks because it could have delayed staff's response during emergencies, such as fall or choking. A review of Resident 114's Care Plan, initiated on 1/4/26, in the section titled, Focus, indicated . [Resident 114] High risk for falls . In the section titled Interventions, indicated, .Have things needed by the resident within reach including call light . 5.A review of Resident 115's admission Record, indicated Resident 115 was admitted to the facility with diagnoses which included displaced fracture of the right humerus (broken upper arm bone that has moved out of alignment), abnormalities of gait and mobility, Parkinson's disease (a brain disorder that affects movement and balance), and a history of falls. During concurrent observation and joint interview on 1/27/26 at 11:8 AM with CNA 3 and Resident 115 (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in Resident 115's room, Resident 115 sat in her wheelchair next to her bed. Resident 115's call light was attached to Resident 115's bed rail and positioned behind Resident 115's back. Resident 115 stated she could not find her call light. CNA 3 stated Resident 115's call light was not within Resident 115's reach and that when a call light was not within a resident's reach, it was a safety risk. A review of Resident 115's fall care plan, initiated on 1/3/26, in the section titled, Focus, indicated . [Resident 115] High risk for falls . In the section titled Interventions, indicated, .Have things needed by the resident within reach including call light . 6.A review of Resident 117's admission Record, indicated Resident 117 was admitted to the facility with diagnoses which included fracture of the shaft of the left tibia (broken lower leg bone) and urinary retention (inability to empty the bladder completely). During a concurrent observation and interview on 1/27/26 at 4:22 PM with Resident 117 in Resident 117's room, Resident 117 was lying in bed with the call light hanging from the right bed grab rail toward the floor. Resident 117 stated she did not know where the call light was. Resident 117 further stated that whenever she could not find her call light, she yelled for help or attempted to do things without staff assistance. During a concurrent observation and interview on 1/27/26 at 4:30 PM with Licensed Nurse (LN) 6 in Resident 117's room, LN 6 stated Resident 117's call light was not in a proper position because it was hanging from the right side of the bed grab rail toward the floor. LN 6 further stated Resident 117's call light was not within Resident 117's reach and that when a call light was not within resident's reach, residents had no way to call for help. A review of Resident 117's fall care plan, initiated on 1/19/26, in the section titled Focus, indicated, . [Resident 117] High risk for falls . In the section titled Interventions, indicated, .Have things needed by the resident within reach including call light . During an interview on 1/29/26 at 2:50 PM with the Director of Nursing (DON), the DON stated residents' call lights should have remained within the residents' reach. The DON further stated that when residents could not access their call lights, residents would not be able to communicate immediate needs, such as pain or assistance, which would delay staff response and increase residents' risk for injury and other safety concerns. A review of a facility policy and procedure titled, Call Lights: Accessibility and Timely Response, revised 10/25, indicated, Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside . to allow residents to call for assistance. Call lights will directly relay to a staff member . to facilitate appropriate response. Staff should facilitate call light placement within reach of resident and secure it as needed. Call system should be accessible to Residents while in bed .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a homelike environment for three of 46 sampled residents (Resident 18, Resident 82, Resident 95) when,A bowel movement (BM) was found in the facility's South Hall, In room [ROOM NUMBER], the window blinds were broken and there were floor tiles missing next to Resident 82's bed, In room [ROOM NUMBER], a tall dresser used by Resident 18 was missing knobs on one of the drawers and the bottom drawer had the front panel broken and laying on the bottom of the dresser, andStaff personal belongings were stored in Resident 95's room.These failures could have resulted in the residents not experiencing a clean and well-maintained homelike environment. Findgings: 1.During an observation at 1/26/26 at 9:20 a.m., the facility staff was observed walking around a brown BM on the floor in the South Hall with a noticeable odor. During a concurrent observation and interview on 1/26/26 at 9:26 a.m. with the Social Services Assistant (SSA), the SSA confirmed a noticeable odor and a brown BM in the South Hall. The SSA stated the BM on the floor had an odor that could have been unpleasant for the residents, staff, and visitors. During an interview on 1/29/26 at 2:49 p.m. with the infection preventionist (IP), the IP stated a BM in the hallway presented an uncomfortable odor that was not homelike for the residents. During a review of the facility's policy titled, Quality of Life - Homelike Environment, revised 5/17, the policy indicated, .The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting.Clean, sanitary and orderly environment. Pleasant, neutral scents. 2. During a concurrent observation and interview on 1/27/26 at 11:29 AM with Resident 82 in room [ROOM NUMBER], it was observed that room [ROOM NUMBER] had broken window blinds and missing floor tiles next to bed B. Resident 82 stated that the blinds had been broken for some time and that they looked bad. Resident 82 stated no one had told her when they would be fixed. Resident 82 was unaware that there were floor tiles missing. During a concurrent observation and interview on 1/30/26 at 11:05 AM with the Maintenance Supervisor (MS) in room [ROOM NUMBER], the MS confirmed that the blinds were broken in room [ROOM NUMBER] and that floor tiles were missing next to bed B. 3. During a concurrent observation and interview on 1/27/26 at 11:53 AM with Resident 18 in room [ROOM NUMBER], the tall dresser that was used to store clothing and personal items for Resident 18 was missing the front panel of the bottom dresser drawer, and the panel was laying on the floor of the dresser. The dresser was also missing a knob on one of the other dresser drawers. Resident 18 was unaware if the dresser was scheduled to be fixed or replaced. During a concurrent observation and interview on 1/30/26 at 11:10 AM with the MS in room [ROOM NUMBER], the MS confirmed that the dresser used by Resident 18 was broken and stated it should have been replaced. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/30/26 at 11:20 AM with the MS, a review of the Maintenance log kept at North Station, dated 1/26, was reviewed. The MS confirmed that there were no entries for any repairs needed for room [ROOM NUMBER] or room [ROOM NUMBER]. The MS stated that staff were supposed to write down in the Maintenance log when equipment was in poor repair or needed replacement. The MS stated that a Maintenance log was kept at each station and the MS, or the Assistant Maintenance (AM) were supposed to check the logs at the start of their shift for items that needed their attention. During an interview on 1/30/26 at 11:27 AM with the Director of Staff Development (DSD), the DSD stated that she needed to provide updated training to the nursing staff on the importance of keeping the facility in good repair and how to document items that needed repair. During an interview on 1/30/26 at 11:40 AM with the Administrator (ADM), the ADM stated that the dresser in room [ROOM NUMBER] should have been replaced. The ADM further stated that they were in the process of replacing window blinds with a heavier duty blind, but the blinds that were chosen were on back order. The ADM was unable to provide documents that the blinds were backordered. During a review of the facility's policy and procedure titled, Quality of Life – Homelike Environment, dated 5/17, the policy indicated, .The facility staff and management shall maximize.the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include.clean, sanitary and orderly environment. 4. A review of Resident 95's admission RECORD, indicated Resident 95 was admitted to the facility with diagnosis of muscle weakness, reduced mobility, and dementia (a condition that causes problems with memory, thinking, and daily activities). During an observation on 1/27/26 at 10:58 AM in Resident 95's room, a gray hooded sweater and a fanny pack were observed hung on a white hook on the back of the restroom door. The hook was labeled CNA. During an interview on 1/27/26 at 11:04 AM with Resident 95 in Resident 95's room, Resident 95 stated that staff should have put their clothes or personal belongings in the designated storage location and not in Resident 95's room. Resident 95 stated that staff needed to respect her room space and added that this was now her home. During an interview on 1/27/26 at 11:06 AM with LN 1 in Resident 95's room, LN 1 stated that when staff placed their personal clothes and other belongings in Resident 95's room, it was not acceptable because it did not follow the facility process. LN 1 explained that staff should have put their personal clothes and belongings in the employee break room and not in Resident 95's room. During an interview on 1/27/26 at 11:30 AM with Certified Nurse Assistant (CNA) 1, CNA 1 stated that she often felt cold and found the employee breakroom too far. CNA 1 acknowledged that she should have stored her sweater and fanny pack in the designated storage area in the employee breakroom, which was the correct facility process. CNA 1 stated that storing her sweater and fanny pack in Resident 95's room was not acceptable and stated that she needed to respect Resident 95's private space. During an interview on 1/30/26 at 8:40 AM with the Director of Nursing (DON), the DON stated that it was not acceptable for the staff to store personal belongings, such as sweaters and fanny packs, in (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 95's room. The DON stated that staff needed to store their personal belongings in the designated storage area in the employee breakroom. The DON stated further the importance of respecting Resident 95's space. A review of a facility policy and procedure (P&P) titled, Quality of Life – Homelike Environment, revised 5/17, indicated, Policy Statement – Residents [Resident 95] are provided with a safe, clean, comfortable and homelike environment . The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: . clean, sanitary, and orderly environment . A review of a facility P&P titled, Quality of Life – Dignity, revised 8/09, indicated, Policy Statement – Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Residents' [Resident 95] private space and property shall be respected at all times.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Findings: Based on observation, interview and record review, the facility failed to ensure that three of 46 sampled residents (Resident 7, Resident 39, and Resident 89) had an accurate Minimum Data Set (MDS - a federally mandated resident assessment tool) completed when: 1. Resident 7's MDS was coded as not receiving dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed) services while receiving dialysis three times per week, 2. Resident 39's decreased range of motion (ROM) from contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) in his right shoulder, right arm, and right hand were coded as having no impairment,3. Resident 89's use of oxygen was coded as not in use.These failures had the potential for Resident 7, Resident 36, and Resident 89 to not have received appropriate treatment and services to attain or maintain their health and highest practicable physical needs met.Findings: 1. A review of Resident 7's admission RECORD, (a document used in healthcare settings to compile essential information about a resident, facilitating effective care and communication among healthcare professionals) dated 12/4/24, indicated Resident 7 was admitted to the facility on [DATE] with diagnosis that included but not limited to diabetes (high blood sugar) and CKD (kidney damage), end stage renal disease (End Stage Renal Disease-irreversible kidney failure), and dependence on renal dialysis. A review of Resident 7's Order Summary Report, dated 12/4/24 through 1/30/26, indicated that Resident 7 had a physician's order dated 12/4/24 that indicated Resident 7 was to receive dialysis services at a local dialysis center. The report also indicated that Resident 7 had a physician's order dated, 1/24/25 that indicated, Hemodialysis Schedule: MONDAY, WEDNESDAY, FRIDAY Chair Time: 11am.A review of Resident 7's MDS, dated [DATE], the MDS indicated that in Section O, titled Special Treatments, Procedures, and Programs, the section J1 Dialysis was left blank.During a concurrent interview and record review with the MDSC on 1/29/26 at 4:09 PM, Resident 7's MDS, dated [DATE], was reviewed. The MDSC confirmed that the facility should have indicated that Resident 7 received dialysis while a resident in the facility. The MDSC stated that a correction of the MDS would need to be completed and a review of Resident 7's care plans (a detailed document outlining a person's healthcare needs, goals, and the specific care and support they will receive, including how, when and by whom) to ensure that the dialysis service Resident 7 was receiving was fully identified in Resident 7's clinical record. The MDSC stated the risk of coding dialysis as not being received placed resident 7 at risk for incorrect plan of care development that could affect the services and care Resident 7 received in the facility.2. A review of Resident 39's admission RECORD, dated 7/23/21, indicated that Resident 39 was admitted to the facility on [DATE] with diagnosis that included but was not limited to senile degeneration of brain (gradual shrinking and deterioration of brain tissue that occurs with advanced age) and primary osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of the left shoulder.During a concurrent observation and interview on 1/27/26 at 10:03 AM, with Resident 39, Resident 39 demonstrated on his own, his decreased ability to move his right shoulder, elbow, hand, and fingers and stated that he completed exercises to his right upper arm on his own and that he did not want to participate in therapy.During an interview on 1/30/26 at 8:18 AM with CNA 5, CNA 5 stated that Resident 39 had difficulty in moving his left arm for a long time. CNA 5 stated he still used his right hand with difficulty from the contraction in his fingers.A review of Resident 39's Order Summary Report, dated 1/30/26, indicated that Resident 39 had an active physician's order, dated 7/28/22 for Tylenol 325 mg (milligram - a unit of measurement) two tablets once a day for pain management.A review of Resident 39's Encounter Summary, (a physician note that is a concise, structured record outlining a patient's recent health interaction, capturing key clinical details such as diagnoses, procedures, medications, and plan of care) dated 1/2/26, indicated Resident 39 had a right upper extremity contracture that was chronic in nature and caused decreased range of motion. The (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities Based on observation, interview and record review, the facility failed to ensure two of 46 sampled residents (Resident 1 and Resident 8) had properly completed Preadmission Screening and Resident Review (PASRR: required screening done before admission to identify mental illness, intellectual disability, or related conditions and ensure proper placement and services) and received required PASRR Level II (a more detailed evaluation completed when a resident is suspected of having mental illness or intellectual disability to determine needed specialized services) evaluation when;1.Resident 1's diagnosis of developmental disorder of scholastic skills (difficulty learning skills such as reading, writing, or understanding information) was not marked on Resident 1's PASRR screening, 2.Resident 8, who had a diagnosis of schizophrenia, had a PASRR Level II evaluation that was closed because the evaluating agency was unable to contact or obtain required information from the facility.These failures had the potential for Resident 1 and Resident 8 not to be properly evaluated, receive appropriate placement, or obtain specialized services needed to meet their intellectual disability or mental health needs. Findings: 1.A review of Resident 1's admission Record, indicated Resident 1 was admitted to the facility with a diagnosis which included developmental disorder of scholastic skills. A review of Resident 1's Minimum Data Set Assessment (MDS: an assessment tool), Section C-Cognitive Patterns, dated 12/1/25, indicated Resident 1 had short-term and long-term memory problems, impaired recall ability, and severely impaired cognitive skills for daily decision making. A review of Resident 1's PASRR Level I determination letter, dated 10/20/25, the letter indicated .LEVEL II MENTAL HEALTH EVALUATION IS NOT REQUIRED. During a concurrent interview and record review on 1/29/26 at 2:13 PM with Licensed Nurse (LN) 2, Resident 1's two Preadmission Screening and Resident Review (PASRR) Level 1 Screening Document, dated 10/20/25 and 1/17/26, were reviewed. Both PASRR Level 1 Screening documents dated 10/20/25 and 1/17/26 indicated, Section II-Intellectual Disability [ID], Developmental Disability [DD], or Related Condition [RC] Screen.The individual has or is suspected of having primary diagnosis of ID/DD/RC. ID/DD/RC include disabilities that originated before the age of 18 . This includes intellectual disability.autism. Resident 1's two PASRRs indicated, .No in response to the question asking whether Resident 1 had ID, DD, or autism. LN 2 stated Resident 1's two PASRRs should have been marked, yes, because Resident 1 had autism and a diagnosis of developmental disorder. LN 2 further stated that because Resident 1's PASRRs were not completed accurately, Resident 1 did not proceed to a PASSRR Level II evaluation, which placed Resident 1 at risk for unmet developmental service needs. During a concurrent interview and record review on 1/29/26 at 2:50 PM with the Director of Nursing (DON), Resident 1's PASSR, dated 10/20/25 and Resident 1's PASRR, dated 1/17/26, were reviewed. The DON stated Resident 1's PASSR, dated 10/20/25, was completed by another facility prior to Resident 1's admission to the facility. The DON stated the facility completed an additional PASRR dated 1/17/26. The DON stated both PASSRs were completed inaccurately and did not identify Resident 1's developmental disorder. The DON further stated that failure to identify Resident 1's developmental disorder placed Resident 1 at risk for not receiving adequate care and services. A review of facility's policy and procedure (P&P) titled, Resident Assessment – Coordination with PASRR Program, revised on 10/25, the P&P indicated, .ensure that individuals with a mental (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disorder, intellectual disability, or related condition receives care and services in the most integrated setting appropriate to their needs.Applicants to this facility will be screened for serious mental disorder or intellectual disabilities and related conditions.Positive Level I Screen – necessitates a PASRR Level II evaluation prior to admission.PASRR Level II – a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has MD, ID, related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs.The facility will only admit individuals with a mental disorder or intellectual disability who the State mental health or intellectual disability authority has determined appropriate for admission. 2.A review of Resident 8's admission RECORD, indicated Resident 8 was admitted to the facility with diagnosis of, but not limited to schizophrenia (a chronic brain disorder causing distorted thinking, disorganized speech/behavior, and reduced emotional expression), anxiety disorder (a mental condition that causes excessive, persistent worry, fear or nervousness that doesn't go away and interferes with daily life), depression (a condition causing persistent sadness and loss of interest), and bipolar disorder (a mental health condition that causes extreme mood changes). A review of facility provided document titled, Preadmission Screening and Resident Review (PASRR- a service to ensure that individuals with mental illness are able to receive specialized services) Level 1 Screening, dated 3/25/25, under the section titled, Section III – Serious Mental Illness, the document indicated, . Yes . Specify the diagnosis or describe the symptoms: Schizophrenia . Psychotropic Medication: . Yes . Risperdal . Case State: Level II . A review of facility provided document titled, [Name of Department], dated 3/30/25, indicated, . SUBJECT: NOTICE OF ATTEMPTED EVALUATION . Dear [Resident 8] . Re: UNABLE TO COMPLETE LEVEL II EVALUATION FOR SERIOUS MENTAL ILLNESS (SMI) . The [Name of Department] administers the PASRR process when the Level 1 Screening returns a positive result for possible SMI. However, a SMI Level II Mental Health Evaluation was not scheduled for the following reason: Facility staff were unresponsive to two or more attempts of communication within 48 hours of the Level 1 Screening . During an interview on 1/28/26 at 12:12 PM with the Director of Nursing (DON), the DON stated she oversaw the PASRR, but the Minimum Data Set Coordinator (MDSC) oversaw the entire process. The DON stated the importance of prompt follow up with the PASRR process was to avoid the risks associated with delayed assessments. During a concurrent interview and record review on 1/29/26 at 1:55 PM with the MDSC, Resident 8's PASRR Level 1 Screening, submitted on 3/25/25 was reviewed. The MDSC reviewed the EHR and confirmed that the PASRR Level 1 Screening, submitted on 3/25/25, required a Level II Mental Health Evaluation for Resident 8. However, the evaluation was not scheduled because facility staff had not responded to communication attempts. The MDSC stated that PASRR should have been completed for Resident 8 to determine the proper placement or need for a different level of care. A review of a facility policy and procedure titled, Resident Assessment – Coordination with PASRR Program, revised 10/25, indicated, Policy: This facility coordinates assessments in accordance with the preadmission screening and Resident review (PASRR - a service to ensure that individuals with mental illness are able to receive specialized services) program requirements . to ensure that individuals with a mental disorder, intellectual disability . receives care and services in the most integrated setting appropriate to their needs . Any level II Resident . will be referred promptly to the state mental health . for additional Resident [Resident 8] review.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review, the facility failed to ensure that oxygen and nebulizer breathing treatment tubing were changed, stored and kept off the floor for 4 of 31 residents (Resident 54, Resident 89, Resident 97, and Resident 115) whom received oxygen therapy when:1.Resident 54's oxygen tubing was not stored in a protective bag and was not labeled with the date of first use;2. Resident 89's oxygen tubing was not stored in a protective bag and had a date of first use of 1/19/26;3. Resident 97's oxygen tubing was not stored in a protective bag, was undated, and was lying on the floor; and4. Resident 115's breathing treatment tubing was not stored in a protective bag and was not labeled with the date of first use.These failures placed Resident 54, Resident 89, Resident 97, and Resident 115 at risk for pulmonary (lung) infections.Findings:1. During a review of Resident 54's clinical record, titled admission RECORD, the record indicated that Resident 54 was admitted to the facility in 2025 with diagnoses that included but not limited to heart failure (a condition where the heart can't pump enough blood to meet the body's needs) and acute pulmonary edema (a life-threatening medical emergency where sudden, rapid fluid buildup occurs in the lungs' air sacs, making it feel like drowning or suffocating).During an observation on 1/27/26, at 11:23 AM, Resident 54 was noted to be in bed, with a nasal cannula (NC - a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) in place and delivering oxygen at 4L (liters - a unit of measurement) per minute. The nasal cannula tubing was undated and there was no protective bag available to place the tubing in when not in use.During a concurrent observation and interview on 1/27/26, at 11:45 AM with LN 7, LN 7 confirmed that the oxygen tubing for Resident 54 was undated and that there was no storage bag to place the tubing in when not in use.During a review of Resident 54's clinical record, titled Order Summary Report, dated 1/1/26 through 1/31/26, the report indicated that Resident 54 had an active physician's order dated 12/20/25 that resident was to have oxygen at 4 liters via NC as need for shortness of breath.2. During a review of Resident 89's clinical record titled admission RECORD, dated 1/7/25, the record indicated that Resident 89 was admitted to the facility in 2025 with diagnoses that included but not limited to chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and heart failure (a condition where the heart can't pump enough blood to meet the body's needs).During a concurrent observation and interview on 1/27/26, at 11:02 AM, Resident 89 was noted to be in bed, with a NC in place and delivering oxygen at 2L per minute. The tubing was dated as first used on 1/19/26 and there was no protective bag available to place the tubing in when not in use. The resident stated he was not sure when the tubing was changed and further stated he had never seen a storage bag to place the tubing in when he was not using it. During a concurrent observation and interview on 1/27/26, at 11:45 AM with LN 7, LN 7 confirmed that Resident 89's oxygen tubing had a sticker on the tubing that was dated 1/19/26 (nine days since dated date and observation of tubing) and there was no bag attached to the concentrator to store the tubing in when not in use.During a review of Resident 89's clinical record, titled Order Summary Report, dated 2/6/26, the Order Summary Report indicated that Resident 89 had a physician's order dated 2/5/26 for oxygen at 2-5L per minute via NC continuously every shift for SOB (shortness of breath).During a review of a facility provided document, titled Order Listing Report, dated 1/30/26, the report indicated that resident oxygen cannula tubing was to be changed every week on Sunday and as needed for soilage.3. During a review of Resident 97's clinical record, titled admission RECORD, dated 8/27/25, the record indicated that Resident 97 was admitted to the facility in 2025 with diagnoses that included but not limited to personal history of pulmonary embolism (PE -a sudden, dangerous blockage in one of the lung's arteries, usually caused by a blood clot that travels from the legs to the lungs) and hypertension (high blood pressure).During a concurrent observation and interview on 1/27/26, at 11:11 AM, Resident 97 was noted to be in bed, with an oxygen concentrator (helps people with breathing problems by taking in room air, removing nitrogen, and delivering purified, concentrated oxygen (about 90-95% pure) through a tube, mask, or nasal (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cannula) next to the bed. The concentrator was not on, the oxygen tubing was lying on the floor, undated and there was no protective bag available to place the tubing in when not in use. Resident 97 stated that sometimes the oxygen tubing was stored in a bag and sometimes it was not, and he became frustrated at times when he was not able to reach the tubing or it was on the floor.During a review of Resident 97's clinical record, titled MEDICATION ADMINISTRATION RECORD, dated 1/1/26 through 1/31/26, the report indicated that Resident 97 had a physician order dated 1/21/26 for oxygen at 2L per minute via NC as need to maintain O2 saturations above 90%.During a concurrent observation and interview on 1/27/26, at 11:45 AM with LN 7, LN 7 confirmed that Resident 97's oxygen tubing was lying on the floor, was not dated, and there was no protective bag attached to the concentrator to store the tubing in when not in use. LN 7 stated that the oxygen tubing was supposed to be changed every Sunday on the night shift for all resident's that had oxygen orders, but that all licensed nurses should check every shift that the oxygen tubing had a correct date and had a storage bag to put the tubing in when not in use.During an interview on 1/29/26 at 10:54 AM with the Director of Nurses (DON), the DON stated that the night shift was assigned to change the oxygen tubing, change the storage bag, and label the tubing and the bag with a date on Sunday nights. The DON stated the facility policy indicated that the tubing and storage bag will be changed at least every seven days and as needed if soiled. The DON further stated that there should be an order in the clinical record for residents who have oxygen orders that prompts the licensed nurse to change the oxygen tubing every seven days, but there has not been an audit to see if those orders were present for all resident's that have a physician's order for oxygen.During a review of a facility policy and procedure titled Respiratory Therapy - Prevention of Infection, dated 11/15/23, the policy indicated .Change the oxygen cannulae and tubing every seven (7) days, or as needed.Keep the oxygen cannulae and tubing used PRN [as needed] in a plastic bag when not in use.4. A review of Resident 115's admission RECORD, indicated Resident 115 was admitted to the facility with diagnoses including Parkinson's disease (a brain disorder that affects movement, balance, and muscle control), pneumonia (a lung infection that causes swelling in the lungs and makes breathing hard), and pleural effusion (a buildup of fluid around the lungs that makes breathing difficult).A review of Resident 115's Order Audit Report, dated 1/2/26, indicated Resident 115 had a physician's order for albuterol sulfate nebulization 0.083% (a breathing treatment medication to open the airways and help breathing), three (3) milliliter (ml - a unit of measure) inhaled via nebulizer (a device used to deliver breathing treatment) every four hours as needed for shortness of breath.A review of Resident 115's Medication Administration Record, (MAR, a document that indicated medications ordered, given and/or held) dated 1/26, the MAR indicated nursing staff administered albuterol nebulizer treatment to Resident 115 last on 1/25/26 at 7:50 AM.During a concurrent observation and interview on 1/27/26 at 11:45 AM with Licensed Nurse (LN) 8 in Resident 115's room, LN 8 stated Resident 115 had a nebulizer device on her bedside table with breathing treatment tubing that was unlabeled and not stored in a protective bag. LN 8 stated when the breathing treatment tubing that was not labeled with the first-use date, it prevented staff from knowing when the tubing should be replaced, which increased the risk of bacterial growth (germs) and infection. LN 8 further stated failure to store the breathing treatment tubing in a protective bag when not in use increased the risk of cross-contamination (spread of germs from one person, surface, or object to another) between residents and staff. During an interview on 1/29/26 at 2:50 PM with the Director of Nursing (DON), the DON stated nursing staff were required to label breathing treatment tubing with the first-use date and store the tubing in a protective bag to prevent the spread of infection. Review of facility's policy and procedure (P&P) titled, Respiratory Therapy - Prevention of Infection, dated 11/15/23, the P&P indicated, .Infection Control Considerations Related to Medication Nebulizers.Obtain equipment (i.e., administration set-up, plastic bag.).Take care not to contaminate internal nebulizer tubes.Store the circuit [the breathing treatment tubing and connected parts used to deliver breathing treatment medication] in plastic bag, marked with date and resident's name, between uses.Discard the administration set-up every seven (7) days.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, and serve food per safety standards when:Two pans that were worn were not replaced; andA rusted scraper was stored with clean utensils in a drawerThese failures had the potential to lead to cross contamination and food borne illness (nausea, vomiting, diarrhea) for a facility census of 94 residents eating facility prepared meals.Findings:1.During the initial kitchen tour on 1/27/26 at 9:15 a.m., with the certified dietary manager (CDM), the CDM verified two pans that were worn in appearance were stored in the food prep area.During an interview on 1/28/26 at 3:10 p.m., with the registered dietitian (RD), the RD stated worn pans should not have been kept in the kitchen. The RD further stated the use of worn pans when cooking food could have caused cross contamination (accidental transfer of harmful germs, bacteria, or allergens from one surface, food, or person to another) in the food that was prepared by kitchen staff.During an interview on 1/29/26 at 9:21 a.m. with the CDM, the CDM stated worn pans in the kitchen could potentially have caused cross contamination of food. The CDM further stated the worn pots and pans should not have been in the kitchen.2.During the initial kitchen tour on 1/27/26 at 9:23 a.m., with the CDM, the CDM verified a rusted paint scraper was stored with clean utensils in a drawer.During an interview on 1/28/26 at 3:10 p.m. with the RD, the RD stated the rusted paint scraper could have caused cross contamination with the clean utensils when it was stored together and potentially could have affected the food prepared in the kitchen.During an interview on 1/29/26 at 9:21 a.m. with the CDM, the CDM stated the rusted paint scraper was a cross-contamination risk. The CDM further stated it was stored with clean utensils and could have been potentially used by kitchen staff.A review of the facility policy and procedure (P&P) titled, Sanitization, dated 10/08, the P&P indicated, .all utensils, counters, shelves and equipment shall be kept clean maintained in good repair and shall be free from breaks, corrosions, open seems, cracks and chipped areas that may affect their use or proper cleaning A review of the FDA Food Code 2022 Chapter 4 Equipment, Utensils, and Linens section 4-601.11 on Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, indicated (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. Pf (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. It further indicated that The objective of cleaning focuses on the need to remove organic matter from . surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate and insects and rodents will not be attracted.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to practice appropriate infection prevention and control measures for 3 of 46 sampled residents (Resident 103 and Resident 127, and Resident 128) when1.Resident 103 had unlabeled perishable food (food that can spoil or go bad if not stored properly) on the bedside table; and2. Residents 128 and Resident 127 was observed without the required Enhanced Barrier Precaution signage posted at the door.These failures could result in food borne illnesses for Resident 103 and increased risk of transmission of multidrug-resistant organisms (germs that are very hard to kill because many antibiotics don't work on them) or other infectious pathogens (germs that can cause disease) to Residents 128 and 127, other residents, staff, and visitors. Findings: 1.A review of Resident 103's admission RECORD, indicated Resident 103 was admitted to the facility with diagnoses which included sepsis (a serious body infection), diabetes mellitus type II (a condition that causes high blood sugar), muscle weakness, hypo-osmolality, and hyponatremia (low sodium levels in blood), primary central nervous system lymphoma (a type of cancer in the brain or spinal cord). During an interview on 1/27/26 at 8:43 AM with the Certified Diet Manager (CDM), the CDM stated a refrigerator was available at the nursing station for residents to store food brought in from outside sources. The CDM further stated residents' perishable food from outside sources must be labeled with the resident's name, resident's room number, date received, and discard date, and must be discarded within 72 hours of preparation or receipt. During a concurrent observation and interview on 1/27/26 at 3:02 PM with Resident 103, in Resident 103's room, multiple small containers of perishable food were on Resident 103's bedside table. Resident 103 stated the food in the containers on her bedside belonged to her. During a concurrent observation and interview on 1/27/26 at 3:05 PM with Licensed Nurse (LN) 8. in Resident 103's room, LN 8 stated that the four small containers of perishable food brought by family for Resident 103 were on Resident 103's bedside table and were not labeled with the resident's name or date the food was prepared or received. LN 8 further stated food left in a resident's room without refrigeration must be consumed within two hours or be discarded to prevent foodborne illness (illness caused by contaminated or spoiled food), and without a date on perishable food, staff would not know when it must be discarded. During an interview on 1/29/26 at 2:50 PM with the Director of Nursing (DON), the DON stated perishable food from outside sources must be labeled with the resident's name, room number, the date received or prepared, and the date the food was to be discarded. The DON further stated staff must store perishable food in the resident's refrigerator if the resident cannot finish the food to ensure safe handling (to prevent bacteria growth that could cause infection or food poisoning). A review of facility's policy and procedure (P&P) titled, Use and Storage of Food Brought in by Family or Visitors, revised on 10/25, the P&P indicated .food must be handled and stored in a way to facilitate safety.Prepared food items brought in from outside sources should generally be labeled and dated.Facility may refrigerate labeled/dated prepared [food] items in designated unit or pantry refrigerator.As a general guideline, prepared food is recommended to be consumed within 3 days of preparation.Perishable food left at bedside for extended period (e.g. beyond approximately 2 hours) shall be discarded to reduce risk of spoilage . (continued on next page)

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North Park Post-Acute	2586 Buthmann Ave Tracy, CA 95376

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident 128's clinical record titled, admission RECORD, the record indicated Resident 128 was admitted to the facility with diagnosis of but not limited to displaced fracture (a broken bone where the pieces are no longer lined up correctly) of left lower leg and heart failure. During an observation on 1/27/26 at 12:30 PM in Resident 128's room by the door, a safety cone facility marker (image) was next to Resident 128's room name label. During an interview on 1/27/26 at 12:39 PM with Licensed Nurse (LN) 2, LN 2 explained that the safety cone marker next to Resident 128's name meant Resident 128 was on enhanced barrier precaution (EBP – extra safety steps used to stop the spread of germs during close care). LN 2 stated that staff needed to have an EBP signage on Resident 128's door to alert residents, staff, and family members not to enter the room without protective gear. LN 2 further stated that this signage reminded everyone that staff had to wear personal protective equipment (PPE – protective clothing or gear worn to keep people safe from germs) during close contact or direct care to keep safe from germs. LN 2 stated that Resident 128's door did not have an EBP signage, which put everyone at risk of infection and the spread of germs. During an interview on 1/27/26 at 12:42 PM with the Infection Preventionist (IP), the IP stated that the orange-white colored safety cone next to Resident 128's name indicated that staff who cared for Resident 128 and/or visitors needed to be aware of the EBP. The IP explained that the door signage was important so that everyone knew and followed the necessary precautions. The IP stated that if staff or visitors did not know which PPEs to wear, there was a risk of spreading the infection. During an interview on 1/27/26 at 1:02 PM with Resident 128's family member, the family member stated that there had been no marker beside Resident 128's name label before, and they did not know what the marker meant. A review of Resident 127's clinical record titled, admission RECORD, the record indicated Resident 127 was admitted to the facility with diagnosis of, but not limited to gout (a type of arthritis that causes sudden, severe joint pain and swelling), chronic ulcer (a wound or sore that does not heal for a long time) of right foot and left foot, chronic venous hypertension (long-term high pressure in the veins of the legs) with ulcer (an open sore that does not heal easily) of left lower extremity. During an observation on 1/27/26 at 12:58 PM in Resident 127's room by the door, a safety cone facility marker was next to Resident 127's room name label. During an interview on 1/27/26 at 12:59 PM with the Director of Staff Development (DSD) in front of Resident 127's room door, the DSD confirmed that there was an orange-white safety cone marker beside the name label for Resident 127, but no EBP signage was posted by the door. The DSD stated that without the EBP signage, there was a risk of infection control issues and potential spread of infection. During an interview on 1/30/26 at 8:44 AM with the Director of Nursing (DON), the DON stated that it was unacceptable for residents with a facility marker for Enhanced Barrier Precautions (EBP) not to have EBP signage by the door. The DON stated further that if staff found only the facility marker without the EBP signage by the door, they were expected to bring it to the attention of nursing leadership, management, or the infection preventionist to address the issue. A review of a facility policy and procedure (P&P) titled, Infection Prevention& Control Program Policy, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revised 10/25, indicated, Policy Statement: An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Prevention of Infection . Important facets of infection prevention include: . Instituting measures to avoid complications or dissemination . implementing appropriate isolation precautions when necessary . A review of a facility P&P titled, Enhanced Barrier Precaution, dated 6/20/24, indicated, Policy: To reduce the transmission and spread of . important multi-drug resistant organism (MDRO – germs that are hard to kill because many antibiotics no longer work on them) causing infection when contact precautions do not apply . Enhanced Barrier Precautions (EBP – extra safety steps used to stop the spread of germs during close care) used in conjunction with standard precautions and expand the use of PPE [personal protective equipment – protective clothing or gear worn to keep people safe from germs] to donning of gown and gloves during high-contact resident care activities and in situations of expected exposure to blood, body fluids, skin breakdown . that provide opportunities for transfer of MDROs to staff hands and clothing . PROCEDURE: Facility staff shall post a visual alert by the resident's door [Resident 127 and Resident 128] indicating the high-contact resident care activities requiring the use of gowns and gloves .

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to treat a resident with dignity and respect by not honoring her preferred form of address for 1 of 46 sampled residents (Resident 95), when CNA 1 addressed Resident 95 as Honey.This deficient practice had the potential to negatively affect Resident 95's dignity and emotional well-being.Findings:During a review of Resident 95's clinical record titled, admission RECORD, the record indicated Resident 95 was admitted to the facility with diagnosis of, but not limited to muscle weakness, reduced mobility, and dementia (a condition that causes problems with memory, thinking, and daily activities).During an observation on 1/27/26 at 10:56 AM in Resident 95's room, Certified Nurse Assistant (CNA) 1 addressed Resident 95 as Honey three times while providing bedside care.During an interview on 1/27/26 at 10:58 AM with Resident 95 in Resident 95's room, Resident 95 was asked if she was okay being called Honey. Resident 95 stated no and added that she preferred to be called by her name. Resident 95 stated further that Honey was not part of her name, and she didn't like being called that.During an interview on 1/27/26 at 11:23 AM with CNA 1, CNA 1 stated that she had called Resident 95 Honey multiple times while providing care. CNA 1 stated that she should have treated Resident 95 with respect and dignity, like any other human being. CNA 1 stated that she had since stopped calling Resident 95 Honey and used Resident 95's name instead.During an interview on 1/30/26 at 8:37 AM with the Director of Nursing (DON), the DON stated that when Resident 95 was called Honey, that was not acceptable, especially if that name was not her preference. The DON stated the importance of addressing residents by their names to ensure their dignity remains intact.A review of the facility's policy and procedure titled, Quality of Life - Dignity, revised 8/09, indicated, Policy Statement - Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Residents shall be treated with dignity and respect at all times. Staff shall speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that a federally required comprehensive assessment (an in-depth, interdisciplinary evaluation of a resident's physical, functional, psychosocial, and cognitive status, typically conducted upon admission and after significant changes in condition) was completed within the required timeframe for two (2) of 46 sampled residents (Resident 18 and Resident 54) when:1. Resident 18's required Minimum Data Set (MDS -a federally mandated, standardized, and comprehensive assessment tool used in long term care facilities to evaluate a resident's functional, medical, and psychosocial status) annual assessment was not completed within the required 14 days of the assessment reference date (ARD - the specific endpoint of the observation or look back period, serving as the common reference point for assessing a resident's status).2. Resident 54's required MDS admission comprehensive assessment was not completed within the required 14 days from Resident 54's admission date of 12/19/25.These failures had the potential impact on the development of a comprehensive plan of care addressing the residents' needs, strengths, goals, life history and preferences for Resident 18 and Resident 54. Findings: 1. During a review of Resident 18's admission RECORD (a document that contains demographic information), the document indicated that Resident 18 was admitted to the facility on [DATE] with diagnosis that included but not limited to type 2 diabetes mellitus (a chronic condition where the body resists the effects of insulin or fails to produce enough, causing high blood sugar [glucose] levels), reduced mobility, hypertension (heart problems that arise from prolonged high blood pressure), chronic kidney disease stage 3 (moderate kidney damage), chronic pain syndrome, anxiety (a mental health condition characterized by ongoing, overwhelming fear that interferes with daily life, going beyond normal temporary worry), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), dementia (a decline in mental ability severe enough to interfere with daily life), and a history of venous thrombosis and embolism (a dangerous, sometimes fatal, condition caused by blood clots forming in the veins). A review of Resident 18's MDS assessment calendar, dated 1/28/26, indicated Resident 18's annual (otherwise known as a comprehensive assessment) MDS had an Assessment Reference Date of 12/18/25 and the MDS calendar indicated the assessment was in progress and 28 days past due for completion.During a concurrent interview and record review on 1/29/26 at 10:34 AM with the Minimum Data Set Coordinator (MDSC), Resident 18's MDS assessment calendar, dated 1/28/26, was reviewed. The MDSC stated that Resident 18's annual comprehensive MDS assessment was late due to staffing difficulties within the department. MDSC confirmed that Resident 18's annual comprehensive MDS assessment indicated it was in progress. The MDSC confirmed that the annual comprehensive MDS assessment for Resident 18 should have been completed by 1/1/26 and was 28 days past the required completion date.2. During a review of Resident 54's clinical document titled, admission RECORD, the document indicated that Resident 54 was admitted to the facility on [DATE] with diagnosis that included but not limited to heart failure (a condition where the heart can't pump enough blood to meet the body's needs), type 2 diabetes mellitus with diabetic chronic kidney diseases (slow-progressing, chronic condition where the kidneys gradually lose their ability to remove waste products and extra fluids from the body), hepatic encephalopathy (a temporary, reversible brain dysfunction caused by severe liver disease), and vascular dementia (a decline in thinking, memory, and reasoning caused by reduced blood flow to the brain, often following a stroke or damaged blood vessel).During a review of Resident 54's MDS assessment calendar, dated 1/28/26, indicated Resident 54's admission comprehensive MDS had an Assessment Reference date of 12/30/25 and the MDS calendar indicated the assessment was in progress and 27 days past the required completion date.During a concurrent interview and record review on 1/29/26 at 10:40 AM with the MDSC, (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 54's admission comprehensive MDS assessment was reviewed. The MDSC stated that Resident 54's admission comprehensive MDS assessment was late because the facility was waiting for a completed Certification of Terminal Illness (CTI - a mandatory document for Medicare hospice eligibility, affirming a patient's life expectancy of 6 months or less to live) from the hospice provider. When asked if MDSC had requested and documented those attempts to obtain the document from Resident 54's hospice provider, MDSC stated she had requested the information, but had not documented it. The MDSC confirmed that Resident 54's admission comprehensive MDS assessment indicated it was in progress. The MDSC confirmed that the admission comprehensive MDS assessment for Resident 54 should have been completed by 1/2/26 and was 27 days past the required completion date.During an interview on 1/29/26 at 10:45 AM with the MDSC, the MDSC stated that not having the annual and admission comprehensive MDS assessments completed as required for Resident 18 and Resident 54 affected the development of the comprehensive care plans for Resident 18 and Resident 54. The MDSC further stated that not having a comprehensive care plan had the potential to affect care provisions in several areas that included activities of daily living (ADLs - refer to the basic self-care tasks essential for independent living like bathing, dressing, eating and toileting), communication, cognitive function, mood and behaviors, medication, skin care, activity preferences, and discharge goals.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure three (3) of 46 sampled residents (Resident 2, Resident 7, and Resident 54) were kept free from the potential for injury when,1.A regular bed mattress was stored upright against the wall in Resident 2's room,2. Resident 54's order for floor pads next to both sides of the bed was not followed,3. room [ROOM NUMBER] had a metal strip, 6 inches in length and 1/4 inch in width, noted to be protruding at knee height out of the wall in a loop type fashion (coming out of the wall at top and back into the wall at the bottom) next to the bathroom door near Resident 7's bed.These failures placed Resident 2, Resident 7 and Resident 54 at increased risk for sustaining an injury.Findings: 1.A review of Resident 2's admission Record, indicated Resident 2 was admitted to the facility with diagnoses which included encounter for surgical aftercare following surgery on the circulatory system, other abnormalities of gait and mobility, cognitive communication deficit (difficulty understanding or expressing thoughts), need for assistance with personal care, unspecified dementia (memory loss and confusion affecting daily function). During a concurrent observation and interview on 1/27/26 at 10:48 AM with Licensed Nurse (LN) 8 in Resident 2's room, a regular bed mattress was stored upright against the wall in Resident 2's room pathway. LN 8 stated the regular bed mattress was used as a fall mat (a cushion placed on the floor next to the bed to help reduce injury if a resident falls) for Resident 2 because Resident 2 was at high risk for falls. LN 8 stated having the mattress stored upright against the wall created a safety hazard and the mattress could have tipped or fallen and caused an injury to a resident or others. During a concurrent observation and interview on 1/27/26 at 10:48 AM with the Infection Preventionist (IP) in Resident 2's room, the IP stated when the mattress was placed against the wall in Resident 2's room, the pathway was unsafe because the mattress was unstable and not secured. The IP further stated Resident 2 wheeled himself in his wheelchair and could have accidentally bumped the mattress, which placed Resident 2 at higher risk for injury if the mattress tipped or fell onto Resident 2. During a concurrent observation and interview with Resident 2 in Resident 2's room, Resident 2 stated the regular bed mattress was placed on the floor next to his bed at night while he slept and that he called staff to remove the mattress before he safely got out of bed. During an interview on 1/29/26 at 2:04 PM with the Rehabilitation Director (RHD), the RHD stated a regular mattress was not appropriate for use as a fall mat. The RHD further stated using a regular mattress as a fall mat created a trip hazard and increased the risk of resident injury. During an interview on 1/29/26 at 2:50 PM with the Director of Nursing (DON), the DON stated Resident 2's regular bed mattress was not stored in a proper location because when it was placed against the wall inside Resident 2's room, it created a safety concern. The DON further stated it was unsafe for Resident 2 to use a regular bed mattress as a fall mat. A review of Resident 2's Care Plan, initiated on 1/1/26, in the section titled, Focus, indicated . [Resident 2] High risk for fall and injury related to Poor judgement, Poor safety awareness, attempting to get out of bed unassisted, Limitation of mobility . In the section titled Interventions, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated .Keep room and common areas free from clutter . A review of the facility's policy and procedure (P&P) titled, Hazardous Areas, Devices and Equipment, revised on 7/17, the P&P indicated .A hazard is defined as anything in the environment that has a potential to cause injury .Examples of environmental hazards include .Irregular floor surfaces .Furniture that is unstable or positioned at an improper height .Any element of the resident environment that has the potential to cause injury and that is accessible to a vulnerable resident is considered hazardous . 2. A review of Resident 54's clinical document titled, admission RECORD, dated 12/19/25, indicated Resident 54's diagnosis included heart failure (a condition where the heart can't pump enough blood to meet the body's needs) and vascular dementia (a decline in thinking, memory, and reasoning caused by reduced blood flow to the brain, often following a stroke or damaged blood vessel). During an observation on 1/27/26 at 11:23 AM, Resident 54's name tag positioned on the outside of the room indicated a safety cone sticker next to Resident 54's name. Upon entering the room, Resident 54 was observed to be in bed with a fall mat placed next to the left side of the bed. During an interview on 1/27/26 at 2:30 PM with Certified Nursing Assistant (CNA) 5, CNA 5 stated that Resident 54 was at risk of falls and was dependent on activities of daily living (ADLs - refer to the basic self-care tasks essential for independent living, like bathing, dressing, eating and toileting). CNA 5 stated that Resident 54 became anxious (feeling uneasy, nervous, or worried about what might happen, often accompanied by physical tension) at times and tried to get out of bed unassisted. CNA 5 confirmed that there was a fall mat to the left of the bed. CNA 5 was unable to state if there should be a fall mat on the right side of the bed as well. During an interview on 1/29/26 at 10:14 AM with CNA 4, CNA 4 stated that the safety cone sticker on the name tag outside of Resident 54's room meant that Resident 54 was at risk for falls. CNA 4 stated the fall mat was used to prevent injury and it should have been placed to the right of the bed and CNA 4 stated he was unaware of why it had been placed on the left side of the bed prior to that day. During a concurrent interview and record review on 1/29/26 at 9:35 AM, with Licensed Nurse (LN) 7, LN 7 confirmed that there was a fall mat to the right side of Resident 54's bed. LN 7 stated the purpose of the fall mat was to help decrease risk of injury if the resident fell from the bed. LN 7 stated that the fall mat had previously been on the left side of the bed, but because Resident 54 had fallen from the right side of the bed on 1/28/26, the fall mat was moved to the right side of the bed. LN 7 stated that Resident 54 was only to have one fall mat next to the bed. During a concurrent interview and record review on 1/29/26 at 2:35 PM with LN 7, Resident 54's clinical document titled Order Summary Report, dated 12/30/25 and Resident 54's clinical document titled, Care Plan Report (a detailed document outlining a person's healthcare needs, goals, and the interventions), dated 1/29/26, were reviewed. LN 7 confirmed Resident 54 had a physician's order dated 12/30/25 for fall mats on both sides of bed and a physician's order dated 12/30/25 that the nurse was to confirm placement of the fall mats every shift. LN 7 stated that currently Resident 54 only had a fall mat on the right side of the bed, and that LN 7 should have ensured one was placed on the left side of the bed. LN 7 confirmed that the care plan identified Resident 54 as a risk for falls related to confusion, gait and balance problems, incontinence (the involuntary or accidental leakage of urine or stool due to a loss of physical control), poor communication, and was unaware of safety needs. LN 7 confirmed that Resident 54's care interventions (specific actions nurses take to address (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a patient's health needs and work towards achieving desired outcomes) for being at risk for falls did not include an intervention for fall mats on both sides of the bed. LN 7 stated that the risk of not having fall mats on both sides of bed could have increased Resident 54's risk of injury and that the LNs did not follow the physician's orders for Resident 54. During a record review of Resident 54's clinical document titled, Morse Fall Risk Screen (The Morse Fall Risk Scale is a quick, easy-to-use checklist used by healthcare providers to determine how likely a patient is to fall) dated 12/19/25, indicated, Resident 54 had a moderate risk for falling. The same assessment was completed again and dated 1/28/26 and indicated Resident 54's risk had increased and was now considered a high risk of fall. During a concurrent interview and record review on 1/29/26 at 11:10 AM with the Director of Nurses (DON), Resident 54's clinical documented titled, TREATMENT ADMINISTRATION RECORD, (TAR -a daily, signed record of all treatments provided for a specified resident) dated 1/1/26 through 1/31/26 and Resident 54's fall care plans were reviewed. The DON confirmed that the TAR included the physician's order, dated 12/31/25 that the LN was to check placement of fall mats on every shift and that every nurse that had worked from 1/1/2026 through 1/29/26 had initialed that the floor pad was in place. The DON stated that the LN always had access to fall mats, and if one was missing, they should have replaced it. The DON stated that by not ensuring the fall mats were in place they were not following a physician's order and placed Resident 54 at an increased risk for injury if a fall occurred from the bed onto the floor that was without a fall mat. Resident 54's care plan for at risk for falls was reviewed with the DON. The DON stated that the lack of having the fall mats on the care plan as an intervention meant that the intervention would not be seen on the CNA Kardex (a concise, centralized, and easily accessible record of essential resident information, used by staff to quickly summarize resident care and guide daily actions) so the CNA who cared for Resident 54 would not have been aware that there should be two and not just one fall mats in place. 3. During an observation on 1/27/26 at 12:06 PM, room [ROOM NUMBER] was noted to have a 6-inch metal strip and 1/4-inch in width protruding at knee height out of the wall in a loop type fashion (coming out of the wall at top and back into the wall at the bottom) next to the bathroom door near Resident 7's bed. During a concurrent observation and interview on 1/29/26 at 10:21 AM with CNA 7, a metal strip was observed coming out of the wall next to the bathroom and door and near Resident 7's bed. CNA confirmed the observation and stated the metal strip had been there for a while and she wasn't sure what it was from. CNA 7 stated that she had gotten her clothing caught up on while providing care for Resident 7. CNA 7 stated that the issue should have been written in the maintenance logbook that was kept at the nurses' station, but she had not personally written it there. CNA 7 stated the metal strip had the potential to injure someone if they weren't paying attention. During a concurrent observation and interview on 1/30/26 at 11:10 AM of room [ROOM NUMBER] with the MS, the MS confirmed that the metal strip that came out of the wall next to Resident 7's bed presented a potential for injury if staff or Resident 7 happened to get caught on it. The MS was not sure where it was coming from and stated he had not been told that it was there by the staff. During a concurrent observation, interview, and record review on 1/30/26, at 11:20 AM, with the MS, a facility document titled, Maintenance Log, dated 1/26, was reviewed. The MS stated that staff were supposed to write down on the log form when equipment needed to be repaired or replaced, or when there was an issue with how a resident's room looked. The MS stated that a Maintenance Log binder (continued on next page)

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	555245	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Park Post-Acute	2586 Buthmann Ave Tracy, CA 95376

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was kept at each nurses' station and the MS, or the Assistant Maintenance (AM) checked the logs at the start of their shift for items that needed their attention. Reviewed Maintenance Log dated January 2026, located in a binder at the North Nurses Station, where room [ROOM NUMBER] was located, with the MS. The MS confirmed that there were no entries for any repairs needed for room [ROOM NUMBER]. During an interview on 1/30/26, at 11:27 AM, with the Director of Staff Development (DSD), the DSD stated that she provided training to the staff on when to write a repair or concern about resident equipment or rooms that need maintenance's attention. The DSD further stated that she needed to provide more training for the nursing staff on the importance of keeping the facility in good repair and how to complete the maintenance log. During a review of the facility's policy and procedures titled, Hazardous Areas, Devices and Equipment, dated 7/17, the policy indicated, .All hazardous areas, devices and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards.A hazard is defined as anything in the environment that has the potential to cause injury. Examples of environment hazards include, but not limited to.sharp objects that are accessible to vulnerable residents.irregular floor surfaces. During a review of a facility provided job description titled, Director of Maintenance, dated 2003, the job description indicated, .Duties and Responsibilities.Assist in establishing a preventive maintenance program.Ensure that supplies, equipment, etc., are maintained to provide a safe and comfortable environment.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview, and record review, the facility failed to accurately assess and obtain a physician's order for the safe use of bed rails (side rails, metal or plastic rails that can attached to the side of a bed) for 1 of 46 sampled residents (Resident 1) when, Resident 1's side rail screening tool (an assessment used to decide if bed rails are safe and needed for a resident) was completed incorrectly and Resident 1 did not have a physician's order to ensure side rails were clinically appropriate and safe.This failure placed Resident 1 at risk for entrapment (an event in which an individual is caught, trapped or entangled in the space) and could have led to serious injury.Findings:A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses including hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left non-dominant side (weakness or paralysis on the left side of the body caused by bleeding in the brain not related to injury), unsteadiness on feet, cognitive communication deficit (difficulty understanding, processing, or expressing thoughts and communication), other reduced mobility, and developmental disorder of scholastic skills (difficulty learning skills such as reading, writing, or understanding information).A review of Resident 1's Minimum Data Set Assessment [MDS: an assessment tool] section titled Section C-Cognitive Patterns, dated 12/1/25, the record indicated Resident 1 had short-term and long-term memory problems, impaired recall ability, and severely impaired cognitive skills for daily decision making. During a concurrent observation and interview on 1/29/26 at 8:56 AM with the Restorative Nursing Assistant (RNA) in Resident 1's room, Resident 1 had the left and right half side rails in the raised position. The RNA stated Resident 1 was totally dependent on staff for bed mobility and repositioning and could not follow instructions to hold or use the side rails. The RNA further stated Resident 1 did not have the ability to use the side rails. During a concurrent interview and record review on 1/29/26 at 2:13 PM with Licensed Nurse (LN) 2, Resident 1's Side Rails Screening Tool V.2, dated 11/27/25, was reviewed. The side rails screening tool indicated Resident 1 required three staff members to assist with repositioning in bed and during transfers, had poor safety awareness, could not follow instructions, Resident 1 had no means of communication, and demonstrated poor concentration and confusion. The side rails screening tool also indicated the reasons for using side rails for Resident 1 was to support himself during care, such as holding the side rails while caregivers provided care and scooting up in bed to maintain proper positioning. LN 2 stated Resident 1 did not have the ability to hold the side rails, which indicated the documented reasons for using side rails were not possible for Resident 1 to perform. LN 2 further stated the side rails screening tool was inaccurate and made side rails unsafe for Resident 1. During a concurrent interview and record review on 1/29/26 at 2:18 PM with LN 2, Resident 1's physician's orders were reviewed. LN 2 stated Resident 1 did not have a physician's order for side rails, which could indicate the physician was not aware of the use of side rails. LN 2 further stated the lack of a physician's order for side rails placed Resident 1 at increased risk for harm, including possible entrapment.During an interview on 1/29/26 at 4:18 PM with the Director of Nursing (DON), the DON stated that before residents could use side rails, there must be a physician's order and accurate assessment. The DON further stated that without a physician's order, side rails could be considered a restraint (the act of limiting, controlling, or holding back movement, emotions, or actions) and could have placed residents at risk for safety hazards and entrapment. Review of facility's policy and procedure (P&P) titled, BED SAFETY, revised 1/23, the P&P indicated, .If side rails are used, there shall be interdisciplinary assessment of the resident, consultation with the Attending Physician,.Side rails may be used if assessment and consultation with the Attending Physician has determined that they are needed to help manage a medical symptom or condition, or to help the resident reposition or move in bed and transfer.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview, and record review, the facility failed to ensure one of 46 sampled residents (Resident 3) prescribed psychotropic drugs (drugs that affect a person's mind, emotions, and behavior) was free from unnecessary medications when Resident 3's as needed (PRN) order for alprazolam (used for short term relief of anxiety, by calming the nervous system) did not have a stop date.This failure had the potential to negatively affect Resident 3's health and well-being.Findings:A review of Resident 1's admission RECORD, indicated Resident 3 was admitted to the facility with diagnoses which included an anxiety disorder (persistent, excessive, and irrational fear or worry that interferes with daily life) and post-traumatic stress disorder (a mental health condition that's caused by an extremely stressful or terrifying event).During a concurrent interview and record review on 1/29/26 at 11:33 AM with the Director of Nursing (DON), Resident 3's Order Summary, dated 11/29/26, was reviewed. The DON confirmed Resident 3's order for alprazolam (a medication to reduce anxiety) was given on an as needed (PRN) basis and the start date of the medication was 12/2/25.The DON stated the medication order was not appropriate because a PRN medication needed a stop date, in order to reassess if the medication was still appropriate for Resident 3. The DON further stated Resident 3 was at risk of experiencing unnecessary side effects of the medication such as constipation and drowsiness.During an interview on 1/29/26 at 1:49 PM with the Pharmacist Consultant (PC), The PC stated Resident 3's medication orders that were ordered on a PRN basis should have had a 14 day stop date unless the provider provided an explanation for the extended PRN use of the alprazolam.During a review of the facility's policy and procedure (P&P) titled, Medication Orders, dated 11/24, the P&P indicated, .PRN orders for psychotropic drugs are limited to 14 days.if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications were stored and labeled to meet professional standards of practice for one of four medication carts when:1. One of four medication carts, Cart 4, contained three insulin pens (a medication dispensing device that help deliver medicine to lower blood sugar) and one insulin vial (a small container of medication) without open dates; and2. One of four medication carts, Cart 4, contained loose pills in the medication drawers.These failures had the potential to reduce the efficacy (effective of the medication) of the insulins and for bubble packs (single dose medication packets) to be short of resident needed medications, negatively impacting residents' health related to ineffective insulin from reduced potency and delayed medication administration related to undiscovered loss of medication from bubble packs.Findings:1.During a concurrent interview and observation of medication cart 4 on 1/27/26 at 2:20 PM, with licensed nurse licensed nurse (LN 10), the top left drawer of the medication cart contained insulin pens and insulins vials for residents in the facility. LN 10 retrieved multiple insulin pens and insulin vials from a section of the top left drawer of the in-use insulin pens and vials, of which three insulin pens and one insulin vial did not have an open date indicated on them. LN 10 confirmed the three insulin pens, and one insulin vial did not have open dates and should have. LN 10 explained the importance of the open dates was that if the insulin medications were safe to use. During an interview with the Director of Nurses on 1/30/26 at 9:37 AM, the DON stated her expectation for insulin pens and insulin vials was to ensure they had an open date listed on the medication container. The DON stated it was important to know when to discard the medication.2. During a concurrent observation and interview of medication cart 4 on 1/27/26 at 2:20 PM, with LN 10, LN 10 confirmed there were two unidentifiable pills on the bottom of drawer 2 on the right-hand side of medication cart 4 and four unidentifiable pills on the bottom of drawer 3 on the right-hand side of medication cart 4. LN 10 explained keeping the pills secure was for accountability and to ensure the correct number of medications were given to the residents.A review of the facility policy titled, Storage of Medications, revised 4/07, the P&P indicated, . The facility shall store all drugs and biologicals in a safe, secure, and orderly manner . Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received . Only the issuing pharmacy is authorized to transfer medications between containers . The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner . Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy . The facility shall not use .outdated . deteriorated drugs or biologicals . Drugs shall be stored in an orderly manner in . drawers, carts . Each resident's medications shall be assigned to an individual cubicle, drawer . to prevent the possibility of missing medication of several residents .A review of the facility policy titled, Labeling of Medication Containers, revised 4/07, indicated, . All medications maintained in the facility shall be properly labeled in accordance with current state and federal regulations . Medication labels must be legible at all times . Labels for individual drug containers shall include all necessary information, such as . The date the medication was dispensed . The expiration date .