STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555249	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sea Cliff Healthcare Center	18811 Florida St Huntington Beach, CA 92648

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure four of five final sampled residents (Residents 1, 2, 3, and 4) reviewed for unnecessary medications were free from unnecessary psychotropic medications. * The facility failed to ensure Resident 1's nonpharmacological interventions for quetiapine (antipsychotic medication) and risperidone medications were separately monitored. * Resident 2 was receiving Risperdal (risperidone, antipsychotic medication) 1.5 mg, when the order was for Risperdal 1 mg. In addition, the facility failed to ensure Resident 2's nonpharmacological interventions for Risperdal, citalopram (antidepressant medication), and Remeron (antidepressant medication) medications were separately monitored. * The facility failed to implement Resident 3's nonpharmacological interventions for divalproex sodium (mood stabilizer) medication. * The facility failed to ensure Resident 4's non-pharmacological interventions for mirtazapine (antidepressant medication), alprazolam (antianxiety medication) and quetiapine (antipsychotic medication) were separately monitored. These failures had the potential for poor health outcomes due to adverse effects of the medications.Findings: Review of the facility's P&P titled Chemical Restraints and Psychotropic Medication Management revised 4/2025 showed the psychotropic medications shall not be administered for the purpose of discipline or convenience. They are to be administered only when required to treat the resident's medical symptoms and will be considered only after nonpharmacological interventions have been attempted and failed. The attending physician will review the resident's treatment plan to re-evaluate the use of psychotropic medication. 1. Medical record review for Resident 2 was initiated on 1/7/26. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 2's H&P examination dated 7/3/24, showed Resident 2 could make his own decisions. a. Review of the facility's P&P titled Physician Orders – CA revised 1/2019 showed verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include the name and strength of the drug, quantity or specific duration of therapy, dosage and frequency of administration, route of administration, and reason for which it is given. Review of Resident 2's NP/PA Progress note dated 10/23/25, showed PA 1's plan to increase Resident 2's Risperdal medication from 0.5 mg twice a day to 1 mg twice a day. Review of Resident 2's Orders Progress Note dated 10/30/25, showed LVN 3 obtained a telephone (continued on next page)

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	order from PA 1 for Risperdal 1 mg, one tablet by mouth two times a day for angry outbursts related to unspecified psychosis. Review of Resident 2's prescription document dated 10/30/25, showed a medication order for Risperdal 1 mg, one tablet by mouth two times a day for angry outbursts related to unspecified psychosis. The medication order was confirmed by LVN 3 and the document showed NP 1 ordered the Risperdal medication. On 1/7 at 1509 hours, 1/8 at 0913 hours, and 1/9/26 at 1323 hours, Resident 2 was observed laying on his bed, asleep in his room. On 1/8/26 at 0915 hours, an interview was conducted with CNA 6. CNA 6 stated Resident 2 would scream to get help to use the bathroom in the last year, but lately he was mostly sleeping in bed. On 1/8/26 at 0928 hours, an interview was conducted with LVN 4. LVN 4 stated Resident 2 used to have frequent angry outbursts. LVN 4 further stated now Resident 2 was sleeping and resting more often in bed and had occasional angry outbursts. Review of Resident 2's Order Summary Report showed the following physician's orders: - dated 11/25/25, to administer Risperdal 0.5 mg, give one tablet by mouth two times a day for psychosis manifested by anger outburst; and - dated 11/25/25, to administer Risperdal 1 mg, give one tablet by mouth two times a day for angry outbursts related to unspecified psychosis. Review of Resident 2's MAR for 10/2025 showed Resident 2 was administered the following medications: - Risperdal 0.5 mg one tablet on 10/31 at 0900 and 1700 hours; and - Risperdal 1 mg, one tablet on 10/31 at 0900 and 1700 hours. Review of Resident 2's MAR for 11/2025 showed Resident 2 was administered the following medications: - Risperdal 0.5 mg, one tablet from 11/1 to 11/7, 11/9 to 11/20, and from 11/26 to 11/30 at 0900 and 1700 hours, and 11/8 at 1700 hours; and - Risperdal 1 mg, one tablet from 11/1 to 11/7, 11/9 to 11/20, and from 11/26 to 11/30 at 0900 and 1700 hours, and 11/8 at 1700 hours. Review of Resident 2's Medication Regimen Review dated 11/23/25, showed a note from the Pharmacist Consultant addressing Resident 2's order for Risperdal 0.5 mg twice a day since 7/5/24, and another order for Risperdal 1 mg twice a day since 10/30/25. The Pharmacist Consultant asked for clarification if Resident 2 should be on both Risperdal orders or if the 0.5 mg Risperdal twice a day order should be discontinued. The physician documented the orders were from Resident 2's readmission and to continue to administer the Risperdal 1.5 mg medication. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 2's MAR for 12/2025 showed Resident 2 was administered the following medications: - Risperdal 0.5 mg, one tablet from 12/1 to 12/11 and 12/13 to 12/31 at 0900 and 1700 hours, and 12/12 at 1700 hours; and - Risperdal 1 mg, one tablet from 12/1 to 12/11 and 12/13 to 12/31 at 0900 and 1700 hours, and 12/12 at 1700 hours. Review of Resident 2's MAR for 1/2026 showed Resident 2 was administered the following medications: - Risperdal 0.5 mg, one tablet from 1/1 to 1/7 at 0900 and 1700 hours; and - Risperdal 1 mg, one tablet from 1/1 to 1/7 at 0900 and 1700 hours. On 1/8/26 at 1155 hours, a telephone interview and concurrent medical record review for Resident 2 was conducted with NP 1. NP 1 stated he did not order the Risperdal medication. On 1/9/26 at 0921 hours, a telephone interview and concurrent medical record review for Resident 2 was conducted with PA 1. PA 1 reviewed Resident 2's progress note dated 10/23/25 and stated the plan for Resident 2 was to increase his Risperdal medication from 0.5 mg twice a day to 1 mg twice a day due to Resident 2's agitation and aggression. PA 1 stated they were not aware Resident 2 was receiving Risperdal 1.5 mg twice a day since 10/31/25. PA 1 stated his intention was to increase Resident 2's Risperdal medication to 1 mg twice a day, not 1.5 mg twice a day. b. Review of Resident 2's Order Summary Report showed the following physician's orders: - dated 11/25/25, to administer Risperdal 0.5 mg, give one tablet by mouth two times a day for psychosis manifested by anger outburst; - dated 11/25/25, to administer Risperdal 1 mg, give one tablet by mouth two times a day for angry outbursts related to unspecified psychosis. - dated 11/25/25, to administer Citalopram hydrobromide 20 mg, give one tablet by mouth one time a day for depression manifested by verbalization of feeling depressed; - dated 11/25/25, to administer Remeron 15 mg, give one tablet by mouth at bedtime for depression manifested by poor oral intake for less than 50% every meal; and - dated 11/25/25, to provide nonpharmacological interventions for anti-depressant and antipsychotic medications use every shift and to code the interventions provided to the resident: 0. Back rub, 1. Redirection, 2. Speak to / approach in a calm manner, 3. Reposition, 4. Offer snacks / fluid / milk, 5. Assess for pain, 6. Provide a quiet environment, 7. Encourage to express feelings, 8. Take to activities, and 9. Provide reassurance. Review of Resident 2's MAR for 1/2026 showed nonpharmacological interventions were provided from 1/1 to 1/7/26, for Resident 2's antipsychotic and antidepressant medication use. However, the interventions documented were grouped together and failed to specify which interventions were (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	attempted for each medication. On 1/9/26 at 1339 hours, an interview and concurrent medical record review for Resident 2 was conducted with LVN 6. LVN 6 stated the licensed staff members should document which nonpharmacological interventions were provided for Resident 2's specific behavior. LVN 6 verified there was no separate documentation specifying which nonpharmacological interventions were attempted for each medication. 2. Medical record review for Resident 1 was initiated on 1/9/26. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's H&P examination dated 9/1/25, showed Resident 1 could make their needs known but could not make medical decisions. Review of Resident 1's Order Summary Report dated 1/9/26, showed the following physician's orders: - dated 12/13/25, to administer quetiapine fumarate 100 mg, give one tablet by mouth at bedtime for psychosis manifested by sudden outburst; - dated 12/13/25, to administer risperidone 0.5 mg, give three tablets by mouth two times a day for psychosis manifested by yelling without reason; - dated 12/15/25, to provide nonpharmacological interventions for anti-psychotics every shift and to code the intervention provided to the resident: 0. Back rub, 1. Redirection, 2. Speak to / approach in a calm manner, 3. Reposition, 4. Offer snacks / fluid / milk, 5. Assess for pain, 6. Provide a quiet environment, 7. Encourage to express feelings, 8. Take to activities, 9. Provide reassurance, 10. Not applicable. Review of Resident 1's MAR for 1/2026 showed nonpharmacological interventions were provided from 1/1 to 1/9/26, for Resident 1's antipsychotic use. However, the interventions documented were grouped together and failed to specify which interventions were attempted for each medication. On 1/9/26 at 1316 hours, an interview and concurrent medical record review for Resident 1 was conducted with LVN 5. LVN 5 stated Resident 1 was taking quetiapine medication for sudden outbursts and risperidone medication for episodes of yelling without reason. LVN 5 stated Resident 1 had an order for nonpharmacological interventions for his use of antipsychotic medications. LVN 5 further stated there should be separate documentation of the nonpharmacological interventions implemented because the antipsychotic medications were prescribed to address different behaviors. LVN 5 verified the above findings. 3. Medical record review for Resident 3 was initiated on 1/12/26. Resident 3 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 3's H&P examination dated 9/11/25, showed Resident 3 had no capacity to understand and make decisions. Review of Resident 3's Order Summary Report dated 1/12/26, showed a physician's order to administer divalproex sodium delayed release 250 mg, give one tablet by mouth two times a day for (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mood swings related to bipolar disorder. Review of Resident 3's care plan for the divalproex medication dated 1/11/23, showed interventions including providing nonpharmacological interventions such as redirection and provide reassurance to Resident 3. Further review of Resident 3's medical record failed to show documented evidence nonpharmacological interventions were attempted prior to the administration of Resident 3's divalproex medication. On 1/14/26 at 1111 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Residents 1, 2, and 3. 4. Review of the facility's P&P titled Chemical Restraints and Psychotropic Medication Management dated 4/2025 showed based on a comprehensive assessment the facility will ensure the residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Medical record review for Resident 4 was initiated on 1/6/25. Resident 4 was readmitted to the facility on [DATE]. Review of Resident 4's Order Summary Report showed the following physician's orders: - dated 6/12/24, to administer alprazolam 0.25 mg, give 0.25 mg by mouth three times a day; - dated 10/6/24, to administer quetiapine 100 mg, give one tablet by mouth two times a day, and - dated 10/16/24, to administer mirtazapine 15 mg, give one by mouth at bedtime.; and - dated 2/11/25, for nonpharmacological interventions done such as back rub, redirection, speak to/ approach in a calm manner, reposition, offer snacks/fluid/milk, assess for pain, provide a quiet environment, encourage to express feelings, take to activities and provide reassurance for alprazolam, mirtazapine, and Seroquel (quetiapine, antidepressant) medications every shift. Review of Resident 4's MAR for December 2025 and January 2026 showed the following: - Resident 4 was administered the alprazolam medication from 12/1 to 12/31/25, and from 1/1 to 1/9/26 at 0900, 1300 and 1700 hours; - Resident 4 was administered the quetiapine medication from 12/1 to 12/31/25, and from 1/1 to 1/8/26 at 0900, and 1700 hours; - Resident 4 was administered the mirtazapine medication from 12/1 to 12/31/25, and from 1/1 to 1/8/26 at 2100 hours; and - Resident 4 was provided nonpharmacological interventions for the use of the alprazolam, mirtazapine, and Seroquel medications from 12/1 to 12/31/25, and from 1/1 to 1/8/26, on the day and night shifts. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/9/26 at 1542 hours, an interview and concurrent medical record review for Resident 4 was conducted with RN 2. RN 2 stated the nonpharmacological interventions for the use of alprazolam, mirtazapine, and Seroquel medications were documented in Resident 4's MAR. RN 2 verified the nonpharmacological interventions provided for Resident 4 were not separated for each of the alprazolam, mirtazapine, and Seroquel medications, or behaviors manifested for the resident. RN 2 stated they would not know the effectiveness of the nonpharmacological interventions for each psychotropic medication because the nonpharmacological interventions were documented together, and not separately. On 1/14/26 at 1424 hours, an interview and concurrent medical record review for Resident 4 was conducted with the DON. The DON was informed and verified the above findings.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided for five of five final sampled residents (Residents 24, 95, 99, 132, and 161) and one nonsampled resident (Resident 113) reviewed for respiratory care * The facility failed to ensure Resident 24 was provided with continuous oxygen at 2 LPM via nasal cannula as per the physician's order. In addition, the facility failed to ensure only the licensed nurse administered oxygen to Resident 24. Moreover, the facility failed to ensure Resident 24's nebulizer mask was not stored in a set bag when not in use. * The facility failed to ensure Resident 95's nebulizer mask was dated and stored in a set-up bag when not in use. * The facility failed to ensure Resident 99's nasal cannula was labeled with the date. * The facility failed to ensure Resident 161's nasal cannula tubing was labeled and stored in a set-up bag when not in use. * The facility failed to ensure Resident 113's Yankauer suction tip was stored in a set-up bag when not in use. * The facility failed to ensure Resident 132's nasal cannula was changed according to the facility's P&P. These failures placed the residents at risk of receiving improper respiratory care, inadequate oxygenation levels, and potential exposure to unsanitary equipment and potentially cause health complications to the residents. Findings: 1. Review of the facility's P&P titled Oxygen, Use of revised 5/2021 showed the following: - the oxygen cannula or mask will be changed at least every seven days, as well as the disposable humidifier. Tubing, masks, humidifiers and other disposables used for oxygen administration will be dated in an identifiable fashion; and - the tubing should be kept off the floor. Labeled and dated bags should be provided for cannulas and masks to be placed in when not in use. Review of the facility's P&P titled Medical Equipment – Storage, Labeling, Cleaning, and Disinfecting revised 5/2020 showed the following: - handheld nebulizer – store after each sue in plastic provided. Change mask, and mouthpiece tubing once a week and as needed; and - suction canister and suction tubing – clean and disinfect weekly and as needed. On 1/6/26 at 0910 hours, during the initial tour of the facility, Resident 24 was observed in bed, with a nasal cannula tubing connected to the oxygen concentrator. The oxygen concentrator was turned off. A nebulizer mask was also observed on the nightstand and not stored in a set-up bag. Medical record review for Resident 24 was initiated on 1/6/26. Resident 24 was admitted to the facility on [DATE]. Review of Resident 24's Order Summary Report showed the following physician's orders: - dated 12/26/25, to administer oxygen at 2 LPM via nasal cannula continuously every shift; and - dated 1/5/26, to administer ipratropium-albuterol inhalation solution (bronchodilator) 0.5-2.5 mg/3 ml via mask every six hours for shortness of breath/wheezing/ congestion. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/6/26 at 0913 hours, an interview and concurrent medical record review for Resident 24 was conducted with LVN 1. LVN 1 verified Resident 24 had a physician's order for continuous oxygen at 2 LPM via nasal cannula. On 1/6/26 at 0914 hours, an observation for Resident 24 and concurrent interview was conducted with LVN 1. LVN 1 verified Resident 24 had a nasal cannula tubing connected to the oxygen concentrator, but the oxygen concentrator was turned off. Then, CNA 1 was observed going into Resident 24's room and turned the oxygen concentrator on. When LVN 1 was asked to verify how much oxygen Resident 24 was receiving, LVN 1 checked the oxygen concentrator and stated Resident 24 was receiving oxygen at 2.5 LPM. LVN 1 also verified the nebulizer mask was on the nightstand and not placed in a set-up bag when not in use. On 1/6/26 at 1454 hours, an interview was conducted with CNA 1. CNA 1 verified she turned the oxygen concentrator on for Resident 24. CNA 1 stated she knew she was not supposed to but Resident 24 asked her to turn the oxygen concentrator on. 2. On 1/6/26 at 1418 hours, during the initial tour of the facility, Resident 161 was observed in bed, receiving oxygen at 2 LPM via nasal cannula. An unlabeled oxygen nasal cannula tubing connected to a portable oxygen tank was observed hanging on the wheelchair. Medical record review for Resident 161 was initiated on 1/6/26. Resident 161 was readmitted to the facility on [DATE]. Review of Resident 161's Order Summary Report showed a physician's order dated 12/30/25, to administer oxygen at 2 LPM via nasal cannula continuously. On 1/6/26 at 1537 hours, an observation for Resident 161 and concurrent interview was conducted with RN 1. RN 1 verified Resident 161 had an unlabeled oxygen nasal cannula tubing connected to a portable oxygen tank hanging on the wheelchair. RN 1 stated the nasal cannula tubing connected to a portable oxygen tank was used by Resident 161 when she goes to therapy. RN 1 stated the therapist might have taken the set-up bag for the nasal cannula and forgot to get a new set-up bag to store the nasal cannula tubing when not in use. 3. On 1/6/26 at 1223 hours, during the initial tour of the facility, Resident 113 was observed in bed. A Yankauer suction was observed on the nightstand and not stored in a set-up bag. The suction tubing was observed with brownish fluid. Medical record review for Resident 113 was initiated on 1/6/26. Resident 113 was admitted to the facility on [DATE]. Review of Resident 113's Order Summary Report showed a physician's order dated 12/10/25, to have oral suction at bedside as needed. On 1/6/26 at 1544 hours, an observation for Resident 113 and concurrent interview was conducted with RN 1. RN 1 verified Resident 113's suction tubing had a brownish fluid and the Yankauer suction was placed on the nightstand and not stored in a set-up bag when not in use. On 1/14/26 at 1444 hours, an interview and concurrent medical record review for Residents 24, 113, and 161 was conducted with the DON. The DON was informed and verified the above findings. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 1/6/25 at 0951 hours, during the initial tour of the facility, a nebulizer mask on top of Resident 95's cabinet was observed undated and not stored in a set-up bag. Medical record review for Resident 95 was initiated on 1/6/26. Resident 95 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 95's MDS assessment dated [DATE], showed the resident was cognitively intact. Further review of Resident 95's Order Summary Report for January 2026 failed to show a physician's order for a nebulizer. On 1/6/26 at 1032 hours, an observation and concurrent interview was conducted with LVN 3. LVN 3 verified the nebulizer mask on top of the cabinet was undated and not stored in a set-up bag. LVN 3 stated the licensed nurse should have labeled Resident 95's nebulizer mask and placed it inside a set up bag. 5. On 1/6/25 at 0910 hours, during the initial tour of the facility, Resident 99 was observed lying in bed with oxygen at 2 LPM via nasal cannula. Resident 99's nasal cannula was not labeled with a date. Medical record review for Resident 99 was initiated on 1/6/26. Resident 99 was admitted to the facility on [DATE]. Review of Resident 99's MDS assessment dated [DATE], showed the resident had severe cognitive impairment. Review of Resident 99's Order Summary Report dated 1/13/26, showed a physician's order dated 10/17/25, to administer oxygen at 2 LPM via nasal cannula continuous to maintain oxygen saturation above 90% every shift. On 1/6/26 at 1104 hours, an observation and concurrent interview was conducted with LVN 3. LVN 3 verified Resident 99's nasal cannula was not dated. LVN 3 stated Resident 99's nasal cannula must be labeled and dated. LVN 3 stated the nasal cannula should have been dated so the licensed nurse knew when to change the nasal cannula and it had to be changed every week. On 1/14/26 at 1043 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 6. During the initial tour of the facility on 1/6/25 at 0930 hours, Resident 132 was observed with oxygen at 2 LPM via nasal cannula in the nostrils. A bag for the nasal cannula hung at the oxygen concentrator was dated 12/28/25. Medical record review for Resident 132 was initiated on 1/7/26. Resident 132 was admitted to the facility on [DATE]. Review of Resident 132's Order Summary showed a physician's order dated 11/10/25, to administer oxygen at 2 LPM via nasal cannula to keep oxygen saturation above 92% every shift. Review of Resident 132's H&P examination dated 12/30/25, showed Resident 132 had no capacity to understand and make decisions. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/6/25 at 0930, an observation and concurrent interview for Resident 132 was conducted with LVN 8 inside Resident 132's room. Resident 132 was lying in bed with the nasal cannula in the nostrils. LVN 8 verified there was no date on Resident 132's nasal cannula and the bag hung in the oxygen concentrator was dated 12/28/25. LVN 8 stated the nasal canula should have been labeled with the date for the facility staff to know when the nasal canula was changed to prevent potential respiratory infection. LVN 8 further stated oxygen cannula and storage bags were routinely changed every Sundays during the night shift. On 1/14/26 at 1450, an interview was conducted with the DON. The DON stated the oxygen and storage bags were changed every week on Sundays. The DON further stated the expectation was for the licensed nurses to follow the facility policy. The DON was informed and acknowledged the above findings.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure four of five final sampled residents (Residents 1, 2, 3, and 6) reviewed for unnecessary medications were free from the unnecessary medications. * The facility failed to monitor Resident 1's SBP prior to administering the midodrine (medication to treat low blood pressure) medication as ordered by the physician. In addition, the facility failed to follow the physician's order to hold the midodrine medication when Resident 1's SBP was greater than 120 mmHg. * The facility failed to follow the physician's order to hold the midodrine medication when Resident 2's SBP was greater than 130 mmHg. * The facility failed to follow the physician's order to hold the clonidine (medication to treat high blood pressure) medication when Resident 3's systolic blood pressure (SBP) was less than 160 mmHg. * The facility failed to monitor Resident 6's Hemoglobin A1c for the appropriate use of diabetic management medications. These failures had the potential for the residents to receive unnecessary medication and affect the residents' well-being.Findings: Review of facility's P&P titled Guidelines for Medication Administration reviewed 5/27/25, showed to observe the five rights of administering medications which included the right resident, right drug, right dose, right time, and right route. In addition, to record relevant and required information on the appropriate documentation record. 1. Medical record review for Resident 3 was initiated on 1/12/26. Resident 3 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 3's H&P examination dated 9/11/25, showed Resident 3 had no capacity to understand and make decisions. Review of Resident 3's Order Summary Report showed a physician's order dated 9/14/25, to administer clonidine HCl (hydrochloride) 0.1 mg one tablet by mouth every eight hours for elevated blood pressure. The physician's order showed to give the clonidine if the SBP was greater than 160 mmHg. Review of Resident 3's MAR for December 2025 and January 2026 showed Resident 3 was administered the clonidine medication when Resident 3's blood pressure was below the parameters prescribed by the physician on the following dates and times:- on 12/1/25 at 0600 hours, a SBP of 134 mmHg, and at 2200 hours, a SBP of 128 mmHg;- on 12/2/25 at 0600 hours, a SBP of 115 mmHg, and at 2200 hours, a SBP of 137 mmHg;- on 12/3/25 at 0600 hours, a SBP of 106 mmHg, and at 2200 hours, a SBP of 132 mmHg;- on 12/4/25 at 0600 hours, a SBP of 131 mmHg, and at 1400 hours, a SBP of 138 mmHg;- on 12/12/25 at 2200 hours, a SBP of 142 mmHg;- on 12/13/25 at 0600 hours, a SBP of 139 mmHg, and at 2200 hours, a SBP of 140 mmHg;- on 12/14/25 at 0600 hours, a SBP of 137 mmHg, and at 2200 hours, a SBP of 133 mmHg;- on 12/15/25 at 0600 hours, a SBP of 133 mmHg, and at 2200 hours, a SBP of 122 mmHg;- on 12/16/25 at 0600 hours, a SBP of 122 mmHg, and at 2200 hours, a SBP of 120 mmHg;- on 12/17/25 at 0600 hours, a SBP of 118 mmHg, and at 2200 hours, a SBP of 127 mmHg;- on 12/18/25 at 0600 hours, a SBP of 108 mmHg, at 1400 hours, an SBP of 132 mmHg, and at 2200 hours, a SBP of 127 mmHg;- on 12/19/25 at 0600 hours, a SBP of 116 mmHg;- on 12/20/25 at 0600 hours, a SBP of 128 mmHg, and at 2200 hours, a SBP of 138 mmHg;- on 12/21/25 at 0600 hours, a SBP of 140 mmHg, at 1400 hours, a SBP of 132 mmHg, and at 2200 hours, a SBP of 134 mmHg;- on 12/22/25 at 0600 hours, a SBP of 129 mmHg, and at 2200 hours, a SBP of 121 mmHg;- on 12/23/25 at 0600 hours, a SBP of 124 mmHg, and at 2200 hours, a SBP of 122 mmHg;- on 12/24/25 at 0600 hours, a SBP of 112 mmHg, and at 2200 hours, a SBP of 131 mmHg;- on 12/25/25 at 0600 hours, a SBP of 132 mmHg, at 1400 hours, a SBP of 130 mmHg, and at 2200 hours, a SBP of 132 mmHg;- on 12/26/25 at 0600 hours, a SBP of 124 mmHg, at 1400 hours, a SBP of 124 mmHg, and at 2200 hours, a SBP of 135 mmHg;- on 12/27/25 at 0600 hours, a SBP of 122 mmHg;- on 12/29/25 at 2200 hours, a SBP of 133 mmHg;- on 12/30/25 at 0600 hours, a SBP of 116 mmHg, and at 2200 hours, a SBP of 120 mmHg;- on 12/31/25 at 0600 hours, a SBP of 116 mmHg, and at 2200 hours, a SBP of 148 mmHg;- on 1/1/26 at 0600 hours, a SBP of 139 mmHg, at 1400 hours, a SBP of 130 mmHg, and at 2200 hours, a SBP of 133 mmHg;- on 1/2/26 at 0600 hours, a SBP of 125 mmHg;- on 1/3/26 at 1400 hours, a SBP of 138 mmHg;- on 1/4/26 at 0600 hours, a SBP of 148 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mmHg;- on 1/5/26 at 2200 hours, a SBP of 122 mmHg;- on 1/6/26 at 0600 hours, a SBP of 117 mmHg, and at 2200 hours, a SBP of 128 mmHg;- on 1/7/26 at 0600 hours, a SBP of 120 mmHg, and at 2200 hours, a SBP of 119 mmHg;- on 1/8/26 at 0600 hours, a SBP of 125 mmHg; and- on 1/9/26 at 2200 hours, a SBP of 133 mmHg. On 1/12/26 at 1453 hours, an interview and concurrent medical record review for Resident 3 was conducted with LVN 4. LVN 4 verified the above findings. On 1/14/26 at 1111 hours, an interview was conducted with the DON. The DON stated the licensed staff members were expected to read and follow the physician's orders prior to medication administration. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 1 was initiated on 1/9/26. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's H&P examination dated 9/1/25, showed Resident 1 could make their needs known but could not make medical decisions. Review of Resident 1's Order Summary Report showed a physician's order dated 12/13/25, to administer midodrine HCl 5 mg, give one tablet by mouth two times a day for hypotension (low blood pressure). The physician's order showed to hold the midodrine if the SBP was greater than 120 mmHg. Review of Resident 1's MAR for December 2025 and January 2026 showed Resident 1 was administered the midodrine medication on the following dates and times:- dated 12/14/25 at 1700 hours; - dated 12/15 to 12/16/25 at 0900 and 1700 hours;- dated 12/17/25 at 1700 hours;- dated 12/18 to 12/22/25 at 0900 and 1700 hours;- dated 12/23/25 at 1700 hours;- dated 12/24 to 12/31/25 at 0900 and 1700 hours; and- dated 1/1 to 1/8/26 at 0900 and 1700 hours. Review of Resident 1's Blood Pressure Summary for December 2025 and January 2026 did not show blood pressure monitoring for the following dates and times of the midodrine administration:- dated 12/17 and 12/19 to 12/22 at 0900 and 1700 hours;- dated 12/23/25 at 1700 hours;- dated 12/24 to 12/25/25 at 0900 and 1700 hours; - dated 12/26/25 at 0900 hours;- dated 12/27 to 12/31/25 at 0900 and 1700 hours;- dated 1/1 and 1/2/26 at 0900 and 1700 hours;- dated 1/3/26 at 1700 hours;- dated 1/4 to 1/7/26 at 0900 and 1700 hours; and- dated 1/8/26 at 1700 hours. Further review of Resident 1's Blood Pressure Summary for December 2025 and January 2026 showed Resident 1 was administered midodrine medication when Resident 1's blood pressure was above the parameters prescribed by the physician on the following dates:- dated 12/18/25 at 1547 hours, Resident 1's SBP was 122 mmHg; and- dated 1/3/26 at 0756 hours, Resident 1's SBP was 124 mmHg. On 1/9/26 at 1427 hours, an interview and concurrent medical record review for Resident 1 was conducted with LVN 5. LVN 5 verified the above findings. On 1/14/26 at 1111 hours, an interview was conducted with the DON. The DON stated licensed staff members were expected to read and follow the physician's orders prior to the medication administration. The DON was informed and acknowledged the above findings. 3. Medical record review for Resident 2 was initiated on 1/7/26. Resident 2 was admitted to the facility on [DATE]. and readmitted on [DATE]. Review of Resident 2's H&P examination dated 7/3/24, showed Resident 2 could make his own decisions. Review of Resident 2's Order Summary Report showed a physician's order dated 11/25/25, to administer one 5 mg midodrine HCl tablet by mouth every six hours for hypotension. The physician's order showed to hold the midodrine if the SBP was greater than 130 mmHg. Review of Resident 2's MAR for December 2025 and January 2026 showed Resident 2 was administered the midodrine medication when Resident 2's blood pressure was above the parameters prescribed by the physician on the following dates and times:- dated 12/13/25 at 0600 hours, Resident 2's SBP was 132 mmHg;- dated 12/14/25 at 0000 hours, Resident 2's SBP was 132 mmHg;- dated 12/15/25 at 1200 hours, Resident 2's SBP was 135 mmHg; and- dated and 1/3/26 at 0600 hours, Resident 2's SBP was 132 mmHg. On 1/9/26 at 1339 hours, an interview and concurrent medical record review was conducted with LVN 6. LVN 6 verified the above findings. On 1/14/26 at 1111 hours, an interview was conducted with the DON. The DON stated the licensed staff members were expected to read and follow the physician's orders prior to medication administration. The DON was informed and acknowledged the above findings. 4. Review of the National Library of Medicine's publication titled Hemoglobin A1c revised 5/2025 showed a Hemoglobin A1c is a blood test that showed the average blood glucose level over the past two or three years. The Centers for (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Disease Control and Prevention (CDC) recommends a Hemoglobin A1c test for diabetes at least twice a year to monitor the condition and treatment. Medical record review for Resident 6 was initiated on 1/12/26. Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 6's laboratory result dated 1/2/25, showed the resident had a Hemoglobin A1c result of 5.7%, outside the laboratory reference range of 4.6-5.6 %. Review of Resident 6's Order Summary Report showed the following physician's orders:- dated 3/11/25, to administer 5 units of insulin glargine subcutaneous solution pen-injector subcutaneously one time a day related to Type 2 Diabetes Mellitus; and- dated 7/22/25, to administer insulin lispro injection (medication to lower blood sugar) per sliding scale subcutaneously two times a day with the following medication parameters: to inject 0 units of insulin for the blood glucose level of 70 to 150 mg/dL, to inject 1 unit of insulin for the blood glucose level of 151 to 200 mg/dL, to inject 2 units of insulin for the blood glucose level of 201 to 250 mg/dL, to inject 3 units of insulin for the blood glucose level of 251 to 300 mg/dL, to inject 4 units of insulin for the blood glucose level of 301 to 350 mg/dL, to inject 5 units of insulin for the blood glucose level of 351 to 400 mg/dL, to inject 6 units of insulin for the blood glucose level above 400 mg/dL, and to call the physician. Review of Resident 6's Medication Regimen Review from January to December 2025 did not show a recommendation from the Pharmacist Consultant to monitor Resident 6's Hemoglobin A1c . Further review of Resident 6's medical record documentation failed to show a follow up was completed for a Hemoglobin A1C test. On 1/14/26 at 1345 hours, an interview and concurrent medical record review for Resident 6 was conducted with the Pharmacist Consultant. The Pharmacist Consultant stated residents who are prescribed insulin medication should be monitored for their Hemoglobin A1c every three to six months. The Pharmacist Consultant was made aware Resident 6's Hemoglobin A1c last collected on 1/2025 and stated that it was a long period without monitoring. On 1/14/26 at 1111 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings Cross reference to F756.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure proper medication storage for two of three medication rooms inspected (Medication Room A and Central Supply Room) and two of five medication carts inspected (Medication Carts A and B). * The facility failed to ensure the expired medication was removed from Medication Cart A. * The facility failed to ensure the medications were stored in a proper room temperature in Medication Room A. * The facility failed to ensure the expired supplies were removed from Medication Cart B. * The facility failed to ensure the externally used medications were stored separately from the orally used medications in the central supply room. * The facility failed to ensure the safe storage of a hydrophilic wound dressing ointment (medication which helps maintain a moist wound healing environment to facilitate healing process) found at the bedside for Resident 150. * The facility failed to ensure the three packets of Protect zinc oxide paste (skin protectant) were not left on top of Resident 95's bedside cabinet. These failures had the potential for medication errors and negatively impact the residents' well-being.Findings: Review of the facility's P&P titled Medication Storage and Labeling (undated) showed all drugs will be labeled and stored in a manner consistent with manufacturers' published specifications, federal and state regulations, and to enhance accurate and safe medication administration by the facility staff. External use drugs shall be stored separately from drugs for internal use. Drugs shall be stored in appropriate temperatures. In addition, drugs shall not be kept in stock after the expiration date on the label. 1. On [DATE] at 1045 hours, an inspection of Medication Cart A and concurrent interview was conducted with RN 1. During the inspection of Medication Cart A, the following was observed: -one open box of diphenhydramine (medication used to treat allergy symptoms, common cold, insomnia, and motion sickness) with an expiration date of 2/2025. RN 1 verified the above findings and removed the box of diphenhydramine from Medication Cart A. On [DATE] at 1111 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Review of the Healthcare Corporation A's manufacturer's guideline for sodium chloride injection (a sterile IV solution used to replenish fluids, sodium, and chloride in the body, crucial for hydration) revised 3/2018 showed the recommendation for the products to be stored at room temperature of 77 degrees Fahrenheit. On [DATE] at 0828 hours, an inspection of Medication Room A, facility record review, and concurrent interview was conducted with RN 1. When asked how the licensed staff members monitored the temperature of Medication Room A, RN 1 provided the following temperature logs: Review of the medication room temperature log for Medication Room A dated 12/2025 showed the temperature range should be between 59 degrees and 86 degrees Fahrenheit. The log also showed the following entries of temperatures above 77 degrees Fahrenheit: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-dated 12/2, 12/6, 12/20, 12/21, and [DATE] PM, temperatures of 78 degrees Fahrenheit; -dated [DATE] AM, temperature of 84 degrees Fahrenheit; -dated 12/18, 12/19, 12/20, 12/23, 12/24, 12/26, and [DATE] AM, temperatures of 78 degrees Fahrenheit; and -dated [DATE] AM, temperature of 80 degrees Fahrenheit. RN 1 also provided Medication Room A's temperature log dated 1/2026. Review of the Medication Room A's temperature log showed the following dates with entries of temperatures above 77 degrees Fahrenheit: - dated [DATE] PM, temperature of 78 degrees Fahrenheit; and -dated [DATE] AM, temperature of 78 degrees Fahrenheit. RN 1 reviewed the manufacturer's instructions for the storage of normal saline intravenous bags. RN 1 verified the above findings. On [DATE] at 1111 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. On [DATE] at 0934 hours, an inspection of Medication Cart B and concurrent interview was conducted with RN 1. During the inspection of Medication Cart B, the following was observed: -one pair of sterile gloves, sealed, with an expiration date of [DATE]; and -one box of multi-function sterile red caps, opened, with an expiration date of 9/2025. RN 1 verified the above findings and removed the items from Medication Cart B. On [DATE] at 1111 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 4. On [DATE] at 0853 hours, an inspection of the Central Supply Room and concurrent interview was conducted with RN 1. The following medications were observed side by side in the Central Supply Room medication cabinet: -six boxes of saline enema (medication to relieve constipation), -six bottles of fish oil (supplement), -three boxes of ear wax removal drops, and - seven bottles of saline nasal spray. RN 1 verified the above findings and separated the external use medications from the internal use medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1111 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 5. On [DATE] at 1207 hours, during the initial tour of the facility, Resident 150 was observed in bed, and a tube of hydrophilic wound dressing ointment was observed at bedside. Resident 150 stated she did not remember using the ointment. Medical record review for Resident 150 was initiated on [DATE]. Resident 150 was admitted to the facility on [DATE]. Review of Resident 150's Order Summary Report for [DATE] did not show a physician's order to administer hydrophilic wound dressing ointment. On [DATE] at 1211 hours, an observation for Resident 150 and a concurrent interview and medical record review was conducted with RN 1. RN 1 verified a tube of hydrophilic wound dressing ointment was at Resident 150's bedside. RN 1 further verified there was no physician's order to administer hydrophilic wound dressing ointment to Resident 150. RN 1 stated the hydrophilic wound dressing ointment should not be at bedside and should be stored in the treatment cart. On [DATE] at 1444 hours, an interview and concurrent medical record review for Resident 150 was conducted with the DON. The DON was informed and verified the above findings. 6. On [DATE] at 0951 hours, during the initial tour of the facility, three packets of Protect zinc oxide paste (skin protectant) was observed on top of Resident 95's right bedside cabinet. Resident 95 stated the staff applied the Protect zinc oxide paste on her buttocks. Medical record review for Resident 95 was initiated on [DATE]. Resident 95 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 95's MDS assessment dated [DATE], showed the resident was cognitively intact. Review of Resident 95's Order Summary Report dated [DATE], showed the following physician's order: - dated [DATE], bilateral ischium (also known as the sit bone), cleanse with normal saline, pat dry, apply barrier cream, leave open to air every day for skin maintenance and as needed for skin maintenance. - dated [DATE], right thigh posterior scar tissue, cleanse with soap and warm water, pat dry, apply barrier cream every day for skin management. - dated [DATE], left thigh posterior scar tissue, cleanse with soap and warm water, pat dry, apply barrier cream every day for skin management. On [DATE] at 1032 hours, an observation and concurrent interview was conducted with LVN 3. LVN 3 verified the three packets of Protect zinc oxide paste (skin protectant) on top of Resident 95's right bedside cabinet. LVN 3 stated the nurse should have checked Resident 95's room. LVN 3 stated the Protect zinc oxide paste should not be on the bedside and it should have a physician's order. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1135 hours, an interview and concurrent medical record review for Resident 95 was conducted with LVN 2. LVN 2 stated the licensed nurse should be the one applying the barrier cream and should not be left at Resident 95's bedside because it was a medication. LVN 2 stated the licensed nurses and CNAs should be educated, and the medication should not be at the resident's bedside. LVN 2 acknowledged Resident 95's physician's order for the barrier cream and verified the physician's order did not specify to use the Protect zinc oxide paste. LVN 2 stated the Protect zinc oxide paste was the standard barrier cream used before the wound opens. LVN 2 further stated she applied the Protect zinc oxide paste on Resident 95's right thigh, left thigh, and bilateral ischium. LVN 2 stated she applied the barrier cream every shift. On [DATE] at 1043 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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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, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitary requirements were met in the kitchen. * The facility failed to ensure food preparation utensils and equipment were in good, sanitary, and cleanable working conditions. * The facility failed to ensure food items were discarded by the best by or use by date. * The facility failed to ensure fruits with tough rinds or peels like cantaloupes were washed with a brush. These failures had the potential to cause foodborne illnesses to the medically vulnerable resident population who consumed food prepared in the kitchen. Findings: Review of the facility's Diet Type Report dated 1/7/26, showed 159 residents (including 17 residents on puree diet) received food prepared from the kitchen. 1. According to the USDA Food Code 2022, Section 4-601.11, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils: (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (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. According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces. Review of the facility's P&P titled Sanitation dated 2023 showed all equipment shall be maintained as necessary and kept in working order. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas. Moreover, the P&P showed plastic ware, china, and glassware that becomes unsightly, unsanitary, or hazardous because of chips, cracks, or loss of glaze shall be discarded. On 1/6/26 at 0848 hours, an observation of the kitchen and concurrent interview was conducted with the DSS. The following were observed:- one can opener with brown discoloration;- two green, one brown, one red, and one blue cutting boards heavily marred and melted;- one scooper with white handle with dried white and brown food particles; and - one scooper with green handle with dried white and brown food particles. The DSS verified the above findings and stated the items should be replaced to ensure particles will not go into the food. 2. Review of the facility's P&P titled Labeling and Dating of Foods dated 2023 showed all food items in the storeroom, refrigerator, and freezer need to be labeled and dated on established procedures for either food safety or product rotation. The use by date will be the absolute date in which the food must be consumed or discarded by the facility. On 1/6/26 at 0826 hours, an observation of the walk-in refrigerator and concurrent interview was conducted with the DSS. One bag of used tofu dated 12/20/25, was observed in the walk-in refrigerator. The DSS verified the findings and stated it was good for three days and should be discarded. On 1/6/26 at 0841 hours, an observation of the preparation refrigerator and concurrent interview was conducted with the DSS. One pitcher of nectar water with a use by date of 1/5/26, was observed in the preparation refrigerator. The DSS verified the findings and stated it should be discarded. On 1/6/25 at 0919 hours, an observation of the dry storage room and concurrent interview was conducted with the RD. One bag of hamburger buns with a best by date of 12/23 was observed in the dry storage room. The RD verified the findings and stated she will discard the item. 3. According to the USDA Food Code 2022, Section 3-302.15 Washing Fruits and Vegetables showed pathogenic microorganisms, such as Salmonella spp. (bacteria spread through contaminated food or water affecting the intestinal tract), and chemicals such as pesticides, may be present on the exterior surfaces of raw fruits and vegetables. The USDA Food Code further showed scrubbing with a clean brush is only recommended for produce with a tough rind or peel, such as carrots, cucumbers or citrus fruits that will not be bruised easily or penetrated by brush bristles. Scrubbing firm produce with a (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	clean produce brush and drying with a clean cloth towel or fresh disposable towel can further reduce bacteria that may be present. Review of the facility's P&P (untitled) with a subcategory titled Preparation of Fruits dated 2023 showed fresh fruit are washed thoroughly under running water and scrub with a brush, if needed, to remove soil or other contaminants before being cut, peeled, combined with other ingredients, cooked, or served. Failure to wash fruit before cutting it may result in contamination of the fruit's interior. On 1/6/25 at 0841 hours, an observation of the preparation refrigerator and concurrent interview was conducted with the DSS. Six cups of cantaloupe was observed inside the preparation refrigerator. On 1/6/25 at 0927 hours, an interview was conducted with the Dietary Aide. The Dietary Aide was asked how she washed the fruits with tough rinds like cantaloupes. Dietary Aide 1 stated she wore gloves and washed the cantaloupes under cold water. The Dietary Aide denied using a brush to scrub the tough rinds. On 1/14/26 at 1440 hours, an interview was conducted with the Administrator, DON, RD, and DSS. The Administrator, DON, RD, and DSS acknowledged the above findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain the infection control practices to help prevent the development and transmission of diseases and infection. * The facility failed to ensure the infection control practices were implemented in the facility's laundry room when the laundry staff folded the clean linen towards her body touching her uniform. In addition, the facility failed to maintain the laundry area free from grayish dust particles. * LVN 4 failed to disinfect the insulin pen injector prior to the administration of medication for Resident 6. * RN 3 failed to disinfect the vial medication prior to the medication administration for Resident 9. * The facility failed to ensure Resident 42's five small bottles of water were not on the floor. * The facility failed to ensure the EBP were followed for Resident 132 when LVN 8 failed to perform hand hygiene after touching the resident's nasal cannula and oxygen concentrator. * The facility failed to ensure Resident 161 who had a midline catheter was placed on EBP. * The facility failed to ensure Resident 196 with midline IV catheter was placed on EBP and failed to ensure the RN 3 wore the proper PPE when disconnecting the IV. * The facility failed to ensure one gray basin on top of the toilet tank, and a hairbrush on the countertop of the bathroom sink in Room A were labeled. * The facility failed to ensure the five basins on top of the shower chair in Room B were labeled. These failures posed the risk of not preventing the spread of infection in the facility and posed the risk of unsanitary environment.Findings: Review of CDC's publication titled Single Dose or Multi Dose dated 8/2019 showed to disinfect the medication vial by rubbing the diaphragm with alcohol prior to administration. Review of the facility's P&P IPCP Standard and Transmission-Based Precautions revised 3/2024 showed Enhanced Barrier Protection (EBP): used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident-to-resident. (e.g., residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs). Review of the facility's P&P titled IPCP Standard and Transmission-Based Precautions revised 3/2024 showed examples of high-contact resident care activities requiring gown and glove use for EBP include device care or use of central vascular line including hemodialysis catheters, indwelling urinary catheters, feeding tube. The P&P further showed PPE included the use of gown and gloves for high-contact resident care activities for residents with indwelling medical devices including, but are not limited to central lines, peripherally inserted central catheter (PICC) lines, urinary catheters, feeding tubes, and tracheostomies. Review of the facility's P&P titled IPCP Standard and Transmission-Based Precautions revised date 3/2024, showed the following: - EBP is used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident to resident (e.g. residents with wounds and medical devices are at especially high risk of both acquisition of and colonization with MDROs; and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Examples of high-contact resident care activities requiring gown and glove use for EBP include device care or use. According to CDC's Implementation of PPE Use in Nursing Homes to Prevent Spread of MDROs dated 4/2/24, EBP may be indicated, when Contact Precautions do not otherwise apply, for any resident with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status, and infection or colonization with MDRO. Review of the CDC's Frequently Asked Questions About Enhanced Barrier Precautions in Nursing Homes dated 6/2024 showed an indwelling medical device provides a direct pathway for pathogens in the environment to enter the body and cause infections. The CDC does not currently consider peripheral IVs (except for midline catheters), continuous glucose monitors, and insulin pumps as indications for EBP. According to CDC's Frequently Asked Questions about EBP in Nursing Homes dated 6/28/24, an indwelling medical device provides a direct pathway for pathogens in the environment to enter the body and cause infection. Examples of indwelling medical devices include, but are not limited to, central vascular catheters (including hemodialysis catheters, PICC lines, indwelling urinary catheters, feeding tubes, and tracheostomy tubes. Although the data are limited, CDC does not currently consider peripheral I.V.s (except for midline catheters), continuous glucose monitors, and insulin pumps as indications for EBP. Review of the facility's P&P titled Insulin Injection Administration (undated) showed to prepare the insulin injection, the licensed staff member should determine the correct amount of insulin to be drawn, prepare syringe and needle, swab the rubber cap with an alcohol wipe, assist the resident into prone position, if possible, select site of injection and to cleanse the injection site. 1.a. On 1/7/26 at 1421 hours, an observation was conducted with Laundry Staff 1. Laundry Staff 1 was observed folding the clean linen towards her body touching her clothing twice. On 1/7/26 at 1425 hours, an observation of Laundry Staff 1 and concurrent interview was conducted with the Maintenance Supervisor. Laundry Staff 1 was observed folding the clean linen towards her body and touching her clothing. The Maintenance Supervisor acknowledged Laundry Staff 1 folding the clean linen touching her clothing and advised Laundry Staff 1 to properly fold the clothing. The Maintenance Supervisor informed Laundry Staff 1 to put the contaminated folded linens to wash again. b. On 1/7/26 at 1448 hours, an observation of the laundry area and concurrent interview was conducted with the Maintenance Supervisor. The pipes by the side wall of the laundry room close to the dryers was observed with grayish dust particles. The Maintenance Supervisor touched the pipes and part of the grayish dust particles flew in the air. The Maintenance Supervisor acknowledged the pipes were not clean and may possibly contaminate the clean linen and the residents' clothing when removed from the dryer. On 1/14/26 at 1509 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the above findings. 2. Review of the Enhanced Barrier Precautions (EBP) posted by Resident 132's door of Room C showed everyone must clean their hands, including before entering and after leaving the room . The (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Providers and staff must also wear gloves and gowns for residents who are on EBP. The six groups of care activities are morning and evening care; toileting and changing incontinence briefs; caring for devices and giving medical treatments; wound care; mobility assistance, and preparing to leave room; and cleaning and disinfecting the environment. Medical record review for Resident 132 was initiated on 1/7/26. Resident 132 was admitted to the facility on [DATE]. Review of Resident 132's H&P examination dated 12/30/25, showed Resident 132 had no capacity to understand and make decisions. Review of Resident 132's Order Summary dated 1/14/26, showed a physician's order dated 11/11/25, for Enhanced Barrier Precautions: PPE required for high resident contact care activities. For use of the indwelling urinary catheter and gastrostomy tube. On 1/6/25 at 0930, an observation for Resident 132 was conducted with LVN 8 inside Resident 132's room. Resident 132 was observed lying in bed with the nasal cannula in Resident 132's nostrils. LVN 8 touched the resident's nasal cannula and the bag hung in the oxygen concentrator. On 1/6/25 at 0936 hours, an observation was conducted with LVN 8. LVN 8 was observed to have walked out from Room C then went to the hallway. LVN 8 went straight to the med cart, touched the surface of the medication cart and laptop without performing hand hygiene. On 1/6/25 at 0939 hours, an interview was conducted with LVN 8. LVN 8 verified Resident 132 was on EBP. LVN 8 verified she failed to perform hand hygiene when she left Room C after touching the resident's nasal cannula and oxygen concentrator. On 1/14/26 at 1509 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the above findings. 3. On 1/6/26 at 0849 hours, a medication administration observation for Resident 6 was conducted with LVN 4. LVN 4 prepared and administered five units of the Lantus SoloStar insulin glargine (medication to lower blood sugar level) pen injector to Resident 6. LVN 4 was not observed cleaning the rubber cap of the insulin pen prior to the medication administration for Resident 6. LVN 4 verified the above findings. On 1/14/26 at 1111 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 4. On 1/6/26 at 1434 hours, a medication administration observation for Resident 9 was conducted with RN 3. RN 3 prepared and administered cefazolin (an antibiotic used to treat and prevent various bacterial infections) to Resident 9. RN 3 was not observed cleaning the rubber stopper of the two-gram cefazolin vial prior to the medication preparation for Resident 9. RN 3 verified the above findings. On 1/14/26 at 1111 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 5. Medical record review for Resident 196 was initiated on 1/6/26. Resident 196 was admitted to the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility on [DATE]. Review of Resident 196's H&P examination dated 1/2/26, showed Resident 196 was alert and oriented with normal cognition. Review of Resident 196's Order Summary Report for January 2026 showed the following physician's orders: - dated 12/31/25, for ertapenem sodium (broad-spectrum antibiotic to treat moderate to severe bacterial infection in various parts of the body) 1 gm use intravenously every 24 hours for UTI (urinary tract infection) for 10 days. - a discontinued order dated 12/31/25, for Enhanced Barrier Precautions: PPE required for high resident contact care activities with indication: peripheral IV line every shift. Further review of Resident 196's Order Summary Report for January 2026 failed to show an active physician's order for the EBP. Review of Resident 196's medical records titled Medical Center A After Visit Summary dated 12/31/25, showed resident had a midline IV catheter placed by the PICC Nurse at the acute care hospital. On 1/6/26 at 1121 hours, an observation and concurrent interview for Resident 196 was conducted with RN 3 in Resident 196's room. Resident 196 was observed sitting in the wheelchair and connected to an IV. RN 3 arrived to Resident 196's room and was observed disconnecting Resident 196's IV without donning a gown. RN 3 verified Resident 196 was on IV antibiotics for UTI and had a double lumen midline IV catheter to her left upper arm. RN 3 further verified there was no signage of EBP posted outside Resident 196's room. RN 3 stated residents with IV, wounds, GT, drains, and Foley catheters should be placed on EBP for infection control purposes. RN 3 stated gown and gloves were required when providing care to the residents on EBP. RN 3 verified she did not wear a gown while disconnecting Resident 196's IV and stated she should have. On 1/9/26 at 1105 hours, an interview and concurrent medical record review for Resident 196 was conducted with the DON. The DON verified Resident 196 had a midline IV catheter and should have been placed on EBP as per CDC guidelines to maintain infection control. On 1/14/26 at 1440 hours, an interview was conducted with the DON. The DON stated the residents on EBP should have the EBP signage outside their rooms and the staff were expected to wear the proper PPE including the gloves and gown. The DON acknowledged the above findings. 6. On 1/6/26 at 1418 hours, during the initial tour of the facility, Resident 161 was observed in bed and an IV access was observed on her left upper arm. There was no EBP signage observed by the door. Medical record review for Resident 161 was initiated on 1/6/26. Resident 161 was readmitted to the facility on [DATE]. Review of Resident 161's Progress Notes dated 12/30/25, showed a nursing note Resident 161 had a midline IV access on the left upper arm. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident 161's medical record failed to show documentation Resident 161 was placed on EBP related to the midline catheter. On 1/6/26 at 1537 hours, an observation for Resident 161 and concurrent interview was conducted with RN 1. When asked about Resident 161's IV access, RN 1 donned clean gloves; however, did not don a gown and proceeded to check Resident 161's left upper arm. RN 1 stated Resident 161 had a double-lumen midline catheter on her left upper arm. RN 1 also verified Resident 161 was not placed on EBP, and she did not wear a gown when checking Resident 161's midline catheter. RN 1 stated, The facility's protocol was to place residents only with central lines on EBP, but if the resident has a peripheral line such as a midline catheter, then the resident was not placed on EBP. On 1/14/26 at 1054 hours, an interview was conducted with the IP. The IP verified Resident 161 was not placed on EBP related to the midline catheter. The IP stated she was not sure why Resident 161 was not placed on EBP, and maybe there was a confusion with the IV access, whether it was a midline or a PICC line. On 1/14/26 at 1444 hours, an interview and concurrent medical record review for Resident 161 was conducted with the DON. The DON was informed and verified the above findings. 7. On 1/6/26 at 0923 hours, during the initial tour of the facility, five small bottles of water was observed on the floor near Resident 42's left side cabinet. Medical record review for Resident 42 was initiated on 1/6/26. Resident 42 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 42's MDS assessment dated [DATE], showed the resident's cognition was moderately impaired. On 1/6/26 at 1213 hours, an observation and concurrent interview for Resident 42 was conducted with CNA 5. CNA 5 verified the five small bottles of water on the floor. CNA 5 stated Resident 42's bottles of water should not be on the floor for infection control purposes. On 1/13/26/26 at 1310 hours, an interview was conducted with the IP. The IP stated the facility provided plastic storage for the residents. The IP stated the CNA or the licensed nurse should have removed Resident 42's water bottles from the floor for infection control purposes. 8. On 1/6/26 at 0937 hours, during the initial tour of the facility, the restroom in Room A was observed with one gray basin on top of the toilet tank and a hairbrush on the countertop of the bathroom sink unlabeled. Room A was occupied by Residents 42 and 92. Medical record review for Resident 42 was initiated on 1/6/26. Resident 42 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 42's MDS assessment dated [DATE], showed the resident's cognition was moderately impaired. Medical record review for Resident 92 was initiated on 1/6/26. Resident 92 was admitted to the facility on [DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 92's MDS assessment dated [DATE], showed the resident had severe cognitive impairment. On 1/6/26 at 1023 hours, an observation and concurrent interview was conducted with CNA 3. CNA 3 verified the gray basin on top of the toilet tank and a hairbrush on the countertop of the bathroom sink were not labeled. CNA 3 stated the room had two residents and it should be labeled with the resident's name and room number. CNA 3 stated the facility provided the hairbrush and basin to the residents. On 1/13/26 at 1314 hours, an interview was conducted with the IP. The IP stated the basin should be in the closet or drawer and the hairbrush should be in a plastic bag inside the resident's drawer. The IP stated the CNA should have labeled the hairbrush and put it in a plastic bag, and the basin should have been thrown away if it was in the bathroom and already used, for infection prevention. 9. On 1/6/26 at 0940 hours, during the initial tour of the facility, the restroom in Room B was observed with five unlabeled basins on top of the shower chair. Room B was occupied by Residents 11 and 86. Medical record review for Resident 11 was initiated on 1/6/26. Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's MDS assessment dated [DATE], showed the resident's cognition was moderately impaired. Medical record review for Resident 86 was initiated on 1/6/26. Resident 86 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 86's H&P examination note dated 9/17/25, showed the resident was alert and oriented to person, place, and forgetful. On 1/6/26 at 1029 hours, an observation and concurrent interview was conducted with CNA 3. CNA 3 verified the five basins on top of the shower chair in the restroom were not labeled. CNA 3 stated it should have been labeled for infection control purposes and the residents should have their own personal items. On 1/13/26/26 at 1320 hours, an interview was conducted with the IP. The IP acknowledged the above findings. The IP stated the gray basin should have been labeled prior to use. The IP stated the gray basin should have been thrown away by the CNA because it was used and not labeled. On 1/14/26 at 1043 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to fully inform the resident or responsible party and obtain a completed informed consent prior to the use of the psychotropic medications for three of five final sampled residents (Residents 2, 4, and 14) reviewed for unnecessary psychotropic medications. * The facility failed to ensure Resident 2's consent form for the use of risperidone (antipsychotic medication) included information about the medication's exact daily dosage. * The facility failed to ensure the informed consent was obtained from Resident 4's representative prior to Resident 4's use of mirtazapine (antidepressant medication), alprazolam (antianxiety medication) and quetiapine (antipsychotic medication). * The facility failed to ensure Resident 14's Public Patient Representative was informed or involved when obtaining informed consent for the use of fluoxetine (antidepressant medication) and olanzapine (antipsychotic medication) use. These failures had the potential for the residents and their responsible party to be unaware of the risks associated with the psychotropic medications and the potential side effects.Findings: Review of the facility's P&P titled Informed Consent – CA revised 5/2019 showed among the rights under this section included the right to receive in advance all information that is material to a decision to accept or refuse treatment, and physician's orders related to the use of psychotherapeutic drug should not be initiated until an informed consent is obtained. 1. Medical record review for Resident 2 was initiated on 1/7/26. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 2's Order Summary Report, showed the following physician's orders: - dated 11/25/25, to administer Risperdal 0.5 mg, give one tablet by mouth two times a day for psychosis manifested by anger outburst; and - dated 11/25/25, to administer Risperdal 1 mg, give one tablet by mouth two times a day for angry outbursts related to unspecified psychosis. Review of Resident 2's Consent for Treatment: Using Anti-Psychotic Medication for risperidone medication dated 10/30/25, showed an informed consent was obtained for a daily dosage of 1 mg twice a day for risperidone from Resident 2's family member. Review of Resident 2's MAR from October 2025 to November 2025 showed the following: - Resident 2 was administered risperidone 0.5 mg on 10/31, from 11/1 to 11/7, from 11/9 to 11/20, and from 11/26 to 11/30 at 0900 and 1700 hours, and 11/8 at 1700 hours. - Resident 2 was administered risperidone 1 mg on 10/31, from 11/1 to 11/7, from 11/9 to 11/20, and from 11/26 to 11/30 at 0900 and 1700 hours, and 11/8 at 1700 hours. 2. Review of the facility's P&P titled Consent: Residents Unable to Provide Informed Consent and Without a Health Care Decision-Maker – CA revised 1/2023 showed the facility's responsibility to facility a diligent search for an available patient personal representative unaffiliated with the facility. If the facility cannot find a resident representative within 72 hours from the time of the (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician's order the medical intervention that requires informed consent, the facility must contact the Office of the Long Term Care Patient Representative to provide a Public Patient Representative to serve on the IDT. Medical record review for Resident 14 was initiated on 1/13/26. Resident 14 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 14's H&P examination dated 4/29/25, showed Resident 14 was unable to make her own decisions. Review of Resident 14's Order Summary Report, showed the following physician's orders: - dated 4/26/25, to administer fluoxetine HCl 20 mg, give one capsule by mouth one time a day for verbalization of low self-image related to depression; and - dated 9/2/25, to administer olanzapine 10 mg, give one tablet by mouth at bedtime for schizoaffective disorder manifested by uncontrollable picking of skin. Review of Resident 14's Consent for Treatment: Using Anti-Psychotic Medication for olanzapine medication dated 12/18/25, showed an informed consent was obtained by the facility's IDT. Review of Resident 14's Consent for Treatment: Using Anti-Depressant Medication for fluoxetine medication dated 12/18/25, showed an informed consent was obtained by the facility's IDT. Review of Resident 14's MAR for December 2025 and January 2026 showed the following: - Resident 14 was administered the olanzapine medication from 12/2 to 12/31/25, and from 1/1 to 1/13/26 at 2100 hours; and - Resident 14 was administered the fluoxetine medication from 12/6 to 12/31/25, from 1/1 to 1/4/26, and from 1/10 to 1/14/26 at 0900 hours. On 1/14/26 at 1010 hours, an interview and concurrent medical record review for Resident 14 was conducted with the SSD. The SSD stated when a resident who was unable to make their own medical decisions and did not have an available personal representative, the facility would request a public representative from the Office of the Long Term Care Patient Representative. The SSD stated the Public Patient Representative was not involved or informed regarding the consent for psychotropic medications on 12/18/25 for Resident 14. The SSD further stated the IDT should not have signed Resident 14's consent forms without a representative present. The SSD stated Resident 14 had no Public Patient Representative since 2024. The SSD further stated the facility requested a new Public Patient Representative from the Office of the Long Term Care Patient Representative on 1/13/26, and verified the facility did not contact them prior to 1/13/26. On 1/14/26 at 1111 hours, during an interview with the DON, the DON was informed and acknowledged the above findings for Residents 2 and 14. 3. Medical record review for Resident 4 was initiated on 1/6/25. Resident 4 was readmitted to the facility on [DATE]. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 4's Order Summary Report showed the following physician's orders: - dated 6/12/24, to administer alprazolam 0.25 mg, give 0.25 mg by mouth three times a day; - dated 10/6/24, to administer quetiapine 100 mg, give one tablet by mouth two times a day, and - dated 10/16/24, to administer mirtazapine 15 mg, give one by mouth at bedtime. Review of Resident 4's Consent for Treatment: Using Anti-Anxiety Medication for alprazolam medication dated 12/18/25, showed the boxes to show whether Resident 4's representative consented or declined were not checked. Review of Resident 4's Consent for Treatment: Using Anti-Psychotic Medication for quetiapine medication dated 12/18/25, showed the boxes to show whether Resident 4's representative consented or declined were not checked. Review of Resident 4's Consent for Treatment: Using Anti-Depressant Medication for mirtazapine medication dated 12/18/25, showed the boxes to show whether Resident 4's representative consented or declined were not checked. Review of Resident 4's MAR for December 2025 and January 2026 showed the following: - Resident 4 was administered the alprazolam medication from 12/1 to 12/31/25, and from 1/1 to 1/9/26 at 0900, 1300, and 1700 hours; - Resident 4 was administered the quetiapine medication from 12/1 to 12/31/25, and from 1/1 to 1/8/26 at 0900, and 1700 hours; and - Resident 4 was administered the mirtazapine medication from 12/1 to 12/31/25, and from 1/1 to 1/8/26 at 2100 hours. On 1/9/26 at 1542 hours, an interview and concurrent medical record review for Resident 4 was conducted with RN 2. RN 2 stated two licensed nurses obtained the informed consents for the alprazolam, quetiapine, and mirtazapine medications from Resident 4's representative via telephone. RN 2 was not able to show documentation whether Resident 4's representative consented to the use of the alprazolam, quetiapine, and mirtazapine medications for Resident 4. RN 2 verified the informed consents were not completed to show whether Resident 4's representative consented or declined. On 1/14/26 at 1424 hours, an interview and concurrent medical record review for Resident 4 was conducted with the DON. The DON was informed and verified the above findings.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure two of 33 final sampled residents (Residents 23 and 162) were assessed to self-administer medications. * Resident 23's nightstand drawer had a stomach relief bismuth subsalicylate (medication to treat diarrhea, heartburn, nausea, and upset stomach) inside the drawer. There was no physician's order for bismuth subsalicylate and no self-administration assessment for Resident 23. *Resident 162's bedside table had two calcium carbonate (a medication used as antacids for relief from heartburn or acid indigestion) tablets. These failures had the potential to impact Resident 23 and 162's safety and well-being. Findings: 1. On 1/6/25 at 0944 hours, during the initial tour of the facility, Resident 23's left nightstand drawer was open. Inside the drawer was a Stomach Relief bismuth subsalicylate (medication to treat diarrhea, heartburn, nausea, and upset stomach) inside the drawer. Medical record review for Resident 23 was initiated on 1/6/26. Resident 23 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 23's MDS assessment dated [DATE], showed the resident had severe cognitive impairment. Review of Resident 23's Order Summary Report for January 2026 did not show for a physician order for bismuth subsalicylate (medication to treat diarrhea, heartburn, nausea, and upset stomach) and self-administration. On 1/6/26 at 1053 hours, an observation and concurrent interview was conducted with LVN 3. LVN 3 verified the Stomach Relief bismuth subsalicylate was stored inside Resident 23's nightstand. LVN 3 stated Resident 23's family member should have let the nurse know when they brought the medication. LVN 3 further stated the medication would need an order even if it was over the counter. LVN 3 stated the licensed nurse should have observed during the medication pass if there was any medication in Resident 23's room and the medication should have been checked during room rounds which the licensed nurse did on the change of shift. On 1/8/26 at 1458 hours, an interview and concurrent medical record review was conducted with LVN 4. LVN 4 verified there was no physician's order for the Stomach Relief bismuth subsalicylate medication, no care plan, and no documented evidence an assessment of self-administration of the medication was conducted for Resident 23. LVN 4 stated Resident 23 would not qualify for self-administration of medication because she was confused at times. On 1/14/26 at 1043 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. During the initial tour of the facility on 1/6/26 at 1100 hours, an observation was conducted with Resident 162. Resident 162's bedside table was observed with two calcium carbonate tablets in a medication cup. Medical record review for Resident 162 was initiated on 1/6/26. Resident 162 was admitted to the facility on [DATE]. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 162's Order Summary Report showed a physician's order dated 9/13/25, to administer calcium carbonate chewable 500 mg tablet, give two tablet by mouth two times a day. Review of Resident 162's MDS Quarterly assessment dated [DATE], showed resident's BIMS score was 13, indicating the resident was cognitively intact. On 1/6/26 at 1101 hours, an interview was conducted with Resident 162. Resident 162 stated the nurse left the medication at the bedside. Resident 162 further stated she usually takes the calcium carbonate after she eats lunch. On 1/6/26 at 1105 hours, an interview and concurrent observation was conducted with LVN 4. LVN 4 verified the medication left at the beside was calcium carbonate 500 mg chewable tablets. LVN 4 stated he gave the medication to the resident at approximately 0945 hours. LVN 4 further stated the resident usually takes the medication when she needs it. LVN 4 stated he should not have left the medication at the bedside for safety reasons. On 1/14/26 at 1453 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure two of 33 final sampled residents (Residents 2 and 30) were treated with dignity. * CNA 6 failed to close Resident 2's privacy curtains, exposing the resident's thighs to other residents, visitors, and staff. * CNA 6 was standing when she fed Resident 2, who was eating in bed. * Resident 30 was observed from the hallway wearing a diaper and their thigh exposed. Additionally, Resident 30's privacy curtain was open. These failures had the potential to impact Resident 2 and 30's psychosocial well-being.Findings: 1. Medical record review for Resident 2 was initiated on 1/7/26. Resident was admitted in the facility on 7/25/24. Review of Resident 2's H&P examination dated 7/3/25, showed the resident was able to make decisions. Review of Resident 2's MDS assessment dated [DATE], showed the resident's BIMS score was 5, indicating severe cognitive impairment. On 1/8/26 at 0907 hours, an observation of Resident 2 was conducted with CNA 6 in Resident 2's room. Resident 2's door was open. CNA 6 pulled up Resident 2's top sheet to check the heel protectors. Resident 2's thighs were exposed. On 1/8/26 at 0909 hours, during an interview with CNA 6, CNA 6 acknowledged they did not provide privacy when providing care to Resident 2. CNA 6 acknowledged the resident's room was open and could be seen by other residents, visitors, and staff outside of the room. b. On 1/8/25 at 0925 hours, an observation was conducted of Resident 2 in Resident 2's room. CNA 6 was feeding Resident 2. Resident 2 was eating in bed. CNA 6 was standing while feeding the resident. On 1/8/25 at 0927 hours, an interview was conducted with CNA 6. CNA 6 acknowledged she was standing while feeding the resident. CNA 6 stated there was no chair available. CNA 6 further stated she should have been sitting down when feeding the resident to maintain eye contact and maintain dignity of the resident. On 1/14/26 at 1456 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 30 was initiated on 1/7/26. Resident 30 was admitted in the facility on 5/31/25. Review of Resident 30's MDS assessment dated [DATE], showed the resident's BIMS score was 14, indicating the resident was cognitively intact. On 1/7/26 at 1109 hours, during an observation, Resident 30 was observed from the hallway with the thighs exposed. Resident 30 was wearing a diaper and the resident's privacy curtain was open. Resident 30 was calling for help and asking to be covered. Resident 30 did not have a top sheet or blanket on the bed. On 1/7/26 at 1113 hours, an interview was conducted with CNA 5. CNA 5 acknowledged Resident 30 was exposed and did not have any sheets or blanket to cover the resident. On 1/14/25 at 1431 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to develop a care plan and implement care plan interventions for four of 33 final sampled residents (Residents 42, 95, and 161) and one of three closed record sampled residents (Resident 83). * The facility failed to implement Resident 42 and 95's care plan intervention to monitor the residents' safety for entrapment every shift. * The facility failed to develop a care plan to address Resident 83's intergluteal cleft extending to perianal (describes the natural groove between the buttocks that reaches the anus) MASD (Moisture-Associated Skin Damage, skin inflammation or erosion from prolonged exposure to moisture like urine, feces, sweat, or wound drainage, weakening the skin's barrier and making it vulnerable to irritation, infection, friction, and breakdown). * The facility failed to develop a care plan to address Resident 161's left upper arm midline catheter. These failures had the potential risk of not providing appropriate, consistent, and individualized care to these residents.Findings: Review of the facility's P&P titled Comprehensive Person-Centered Care Planning revised April 2025 showed it is the policy of this facility that the IDT shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The IDT team will also develop and implement a baseline care plan for each resident, within 48 hours of admission, that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care. 1.a. Medical record review for Resident 42 was initiated on 1/6/26. Resident 42 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 42's care plan for risk for entrapment/bodily injury secondary to but not limited by bilateral 1/2 (half) siderails initiated 8/24/23, showed the interventions included to monitor the resident's safety for entrapment for the use of the bedrails to aid bed mobility every shift. Review of Resident 42's MDS assessment dated [DATE], showed the resident's cognition was moderately impaired. Review of Resident 42's medical record failed to show documented evidence the resident was monitored for safety for entrapment for the bedrail use. On 1/13/26 at 1357 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 verified Resident 42's care plan intervention to monitor resident's safety for entrapment for the use of the bedrails to aid bed mobility every shift was not implemented. LVN 3 stated the licensed nurse should have documented the monitoring of Resident 42 in the MAR or progress note. b. Medical record review for Resident 95 was initiated on 1/6/26. Resident 95 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 95's care plan for risk for entrapment/bodily injury secondary to but not limited by the use of the bariatric bed with built in bilateral 1/2 siderails initiated 5/13/22, showed the interventions included to monitor the resident's safety for entrapment for the use of the bedrails to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aid bed mobility every shift. Review of Resident 95's MDS assessment dated [DATE], showed the resident was cognitively intact. Review of Resident 95's medical record failed to show documented evidence the resident was monitored for safety for entrapment for the bedrail use. On 1/13/26 at 1416 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 verified Resident 95's care plan intervention to monitor resident's safety for entrapment for the use of the bedrails to aid in bed mobility every shift was not implemented. LVN 3 stated Resident 95 should have been monitored every shift as indicated in the care plan. On 1/14/26 at 1043 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Closed medical record review for Resident 83 was initiated on 1/9/25. Resident 83 was admitted to the facility on [DATE]. Review of Resident 83's Order Summary Report showed an order dated 12/12/25, to cleanse intergluteal cleft extending to perianal MASD with soap and water, pat dry and apply barrier cream every day shift. Review of Resident 83's medical record failed to show a care plan was developed to address Resident 83's intergluteal cleft extending to perianal MASD. On 1/14/26 at 1040 hours, an interview and concurrent medical record review for Resident 83 was conducted with RN 4. RN 4 verified there was no care plan developed for Resident 83's intergluteal cleft extending to perianal MASD. On 1/14/26 at 1435 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. On 1/6/26 at 1418 hours, during the initial tour of the facility, Resident 161 was observed in bed with an IV access on her left upper arm. Medical record review for Resident 161 was initiated on 1/6/26. Resident 161 was readmitted to the facility on [DATE]. Review of Resident 161's Nursing Progress Note dated 12/30/25, showed Resident 161 had a midline IV access on the left upper arm. Review of Resident 161's plan of care showed a care plan initiated 12/30/25, for Resident 161's IV medication and midline catheter on the right upper arm, instead of the left upper arm. On 1/8/26 at 1500 hours, an interview and concurrent medical record review for Resident 161 was conducted with RN 1. RN 1 verified Resident 161 had midline IV access on the left upper arm. RN 1 also verified the care plan for midline catheter was for the right upper arm, instead of the left upper arm. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/26 at 1444 hours, an interview and concurrent medical record review for Resident 161 was conducted with the DON. The DON was informed and verified the above findings.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the plan of care was revised for one of 33 final sampled residents (Resident 30). * Resident 30's care plan was not revised to address the specific care needs for the resident's weight loss and pressure injury prevention. This failure posed the risk for Resident 30 to not receive the person-centered care and services required to attain or maintain her highest level of physical and mental well-being.Findings: Medical record review for Resident 30 was initiated on 1/7/26. Resident 30 was admitted in the facility on 5/31/25. Review of Resident 30's MDS assessment dated [DATE], showed the resident's BIMS score was 14, indicating the resident was cognitively intact. a. Review of the facility's P&P titled Nutrition Care Management revised 1/29/25, showed the facility is to provide care and services including monitoring and evaluating the resident's response to the interventions, especially when there is no progress toward the nutritional goal. Revising or discontinuing approaches as appropriate or justifying the continuation of the current approaches. The care plan shall be updated and revised as appropriate. Review of Resident 30's Monthly Weight Report dated 1/9/26, showed the following weights:- dated 11/9/25, a weight of 130.4 lbs. and - dated 12/4/25, a weight of 116.4 lbs. a weight loss total of 10.74% in one month. Review of Resident 30's care plan for nutrition problem or potential nutritional problem dated 11/19/25, showed the interventions included monthly weight monitoring. Further review of the medical record failed to show the care plan was revised to address the resident's weight loss of 10.74 %. Review of Resident 30's Monthly Weight Report failed to show documentation of the resident's weight or whether the resident refused to be weighed for January 2026. On 1/9/26 at 0924 hours, an interview and concurrent medical record review was conducted with LVN 6. LVN 6 verified Resident 30's weight was documented as 116.4 lbs. on 12/4/25. LVN 6 verified the resident experienced weight loss from the previous weight of 130.4 lbs. on 11/9/25. LVN 6 further verified the resident's medical record failed to show documentation of Resident 30's weight for January 2026 or whether the resident had refused the weight measurement. LVN 6 verified the resident's care plan was not revised to include Resident 30's actual weight loss for 12/4/25. On 1/9/25 at 0950 hours, an interview and concurrent medical record review for Resident 30 was conducted with the RD. The RD verified Resident 30's care plan was not updated timely to reflect resident's actual weight loss on 12/4/25, and resident's refusal to be weighed. On 1/14/26 at 1433 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. Cross reference to F692. b. Review of the facility's P&P titled Skin Management System revised on May 2020 showed a plan of care will be initiated to address areas of actual skin breakdown. The plan of care will be reviewed and revised as needed. Review of Resident 30's Order Summary Report showed a physician's order dated 11/9/25, to elevate the heels on a pillow when in bed to offload pressure. Review of Resident 30's care plans showed the following:- dated 5/31/25, a care plan for risk for development or skin breakdown; and- dated 11/9/25, a care plan for a resolved pressure injury to the right heel. Further review of Resident 30's care plans failed to show the care plans were revised to include the intervention of elevating the heels on the pillow when in bed to offload pressure, as ordered by the physician. On 1/9/26 at 1053 hours, an interview and concurrent medical record review for Resident 30 was conducted with LVN 6. LVN 6 stated Resident 30 had history of pressure injury to the heels. LVN 6 verified the resident had a physician's order to elevate the heels on a pillow when in bed to offload pressure dated 11/9/25. LVN 6 further verified Resident 30's care plan was not updated to include the intervention to elevate the heels on a pillow when in bed to offload pressure. On 1/14/26 at 1426 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. Cross reference to F686, example #2.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the development of a new pressure injury (areas of damaged skin caused by staying in one position for a long time which reduces blood flow to the area and causes the skin to die and develop a sore) and promote healing of the existing pressure ulcer for two of four final sampled residents (Residents 2 and 30) reviewed for pressure injury. * RN 4 failed to follow Resident 2's physician's order to cleanse the pressure injury with normal saline during the wound care observation. * The facility failed to ensure Resident 30's heels were elevated on pillow to offload pressure as ordered by the physician. These failures posed the risks of complications and delayed wound healing for Resident 2 and potential development of pressure injury for Resident 30. Findings: 1. Review of the facility's P&P titled Physician Orders revised 1/2019 showed no drugs or biologicals shall be administered except upon the order of a person lawfully authorized to prescribe for and treat human illnesses. Medical record review for Resident 2 was initiated on 1/7/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 7/3/25, showed the resident was able to make decisions. Review of Resident 2's MDS assessment dated [DATE], showed the resident's BIMS score was 5, indicating severe cognitive impairment. Under section GG, the resident was dependent for bed mobility. Under section H, the resident was always incontinent of both urinary and bowel function. Review of Resident 2's Order Summary Report showed a physician's order dated 1/7/26, to cleanse sacrococcyx (area lowest part of the spine, above the buttocks) extending to right and left buttocks with normal saline apply Santyl (collagenase) External Ointment 250 unit/gm topically and cover with dry dressing every day shift. On 1/8/26 at 1430 hours, a wound care observation for Resident 2 was conducted with RN 4. RN 4 used the Skintegrity wound cleanser to clean Resident 2's sacrococcyx pressure injury. On 1/8/26 at 1453 hours, an observation and concurrent interview was conducted with RN 4. RN 4 verified she used the Skintegrity wound cleanser to clean Resident 2's pressure injury. The Skintegrity wound cleanser's label showed it contained water Polysorbate 80, cocoamphodiacetate, and Lauryl Polyglucose, along with other gentle ingredients like Sorbitol, Lactic Acid, Triethanolamine, Disodium EDTA, Methylparaben, and Diazolidinyl Urea (or Imidazolidinyl Urea) (non-ionic surfactants). RN 4 stated she read the physician's order incorrectly and should have used normal saline to clean Resident 2's wound. On 1/14/26 at 1458 hours, an interview was conducted with the DON. The DON stated the expectation was for the licensed nurses to follow the physician's order when providing wound care for the resident. The DON was informed and acknowledged the above findings. 2. Review of the facility's P&P titled Skin Management revised on May 2020 showed to prevent the development of skin breakdown or prevent existing pressure injuries from worsening, nursing staff shall implement preventative approaches as appropriate and consistent with resident's condition and preferences: Reposition the individual in such a way that pressure is relieved or redistributed. Use pressure relieving/ reducing and redistributing devices (including but not limited to low air loss mattresses, wedges and pillows). Medical record review for Resident 30 was initiated on 1/7/26. Resident 30 was admitted in the facility on 5/31/25. Review of Resident 30's Order Summary Report showed a physician's order dated 11/9/25, to elevate heels on pillow when in bed to offload pressure. Review of Resident 30's MDS assessment dated [DATE], showed the resident's BIMS score was 14, indicating the resident was cognitively intact. Under section GG, the resident was dependent for bed mobility. Review of Resident 30's care plans showed the following:- dated 5/31/25, a care plan for risk for development or skin breakdown; and- dated 11/9/25, a care plan for a resolved pressure injury to the right heel. Further review of Resident 30's care plans failed to show the care plans were revised to include the intervention of elevating the heels on the pillow when in bed to offload pressure, as ordered by the physician. On 1/8/26 at 0928 hours, an observation of Resident 30 was (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted with RN 4. Resident 30 was lying in bed and slightly turned to the left side. Resident 30's left leg was elevated on pillow, however the left heel was not offloaded and was touching the mattress. Resident's right heel was on top of resident's left lower leg. On 1/8/26 at 0930 hours, an interview was conducted with RN 4. RN 4 acknowledged Resident 30's left heel was not offloaded and was touching the mattress, and the right heel was on top of the left lower leg. On 1/8/26 at 1015 hours, an interview and concurrent medical record review was conducted with RN 4. RN 4 verified Resident 30's Order Summary Report showed a physician's order dated 11/9/25, to elevate heels on pillow when in bed to offload pressure. On 1/8/26 at 1541 hours, an observation of Resident 30 and concurrent interview was conducted with RN 4. Resident 30's heels were elevated on a pillow, both heels were touching the pillow and were not offloaded. RN 4 stated she would inform the CNA to position resident's heels offloaded from pressure to prevent recurrence of pressure injury to the heels. Cross reference to F657.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of three final sampled residents (Resident 30) reviewed for nutrition maintained acceptable parameters of nutritional status. * The facility failed to ensure Resident 30's weight was monitored monthly as indicated in the care plan. This failure had the potential to negatively impact the resident. Findings: Review of the facility's P&P titled Nutrition Care Management revised 1/9/25, showed the monthly weights are to be completed unless there is an order from the physician to discontinue. Resident declination of weight will be documented and incorporated into the plan of care. Alternative care plan goals such as monitoring anthropometrics, po intake parameters, labs or other criteria will be addressed by the Registered Dietitian/ nutritionist as appropriate. Monthly weights will be taken by within the first week of each month. Medical record review for Resident 30 was initiated on 1/7/26. Resident 30 was admitted in the facility on 5/31/25. Review of Resident 2's MDS assessment dated [DATE], showed the resident's BIMS score was 14, indicating the resident was cognitively intact. Review of Resident 30's Monthly Weight Report dated 1/9/26, showed the following weights:- dated 11/9/25, a weight of 130.4 lbs.; and - dated 12/4/25, a weight of 116.4 lbs., a weight loss total of 10.74% in one month. Review of Resident 30's care plan for nutrition problem or potential nutritional problem dated 11/19/25, showed the interventions included monthly weight monitoring. Further review of the resident's medical record failed to show the care plan was revised to address the resident's weight loss of 10.74 % or whether the resident refuses to be weighed. Further review of Resident 30's Monthly Weight Report failed to show documentation of the resident's weight or whether the resident refused to be weighed for January 2026. Review of Resident 30's RD note dated 12/12/25, showed the IDT agreed to continue with the plan of care. On 1/9/26 at 0924 hours, an interview and concurrent medical record review was conducted with LVN 6. LVN 6 verified Resident 30's weight was documented as 116.4 lbs. on 12/4/25. LVN 6 verified the resident experienced weight loss from the previous weight of 130.4 lbs. on 11/9/25. LVN 6 further verified the resident's medical record failed to show documentation of Resident 30's weight for January 2026 or whether the resident had refused the weight measurement. LVN 6 verified the resident's care plan was not revised to include Resident 30's actual weight loss for 12/4/25. On 1/9/26 at 0950 hours, an interview and concurrent medical record review for Resident 30 was conducted with the RD. The RD verified Resident 30's medical record failed to show documentation of resident's weight and whether the resident refused to be weighed in January. The RD stated Resident 30 refused to be weighed. The RD verified Resident 30's care plan was not updated timely to reflect resident's actual weight loss on 12/4/25 and resident's refusal to be weighed. On 1/14/26 at 1024 hours, an interview and concurrent medical record review for Resident 30 was conducted with RNA 2. RNA 2 stated he was not sure if the resident refused to be weighed. RNA 2 verified Resident 30's medical record failed to show January 2026's weight was completed. RNA 2 further stated when a resident refused to be weighed, he would try to re-offer to the resident and document the refusal. RNA 2 verified Resident 30's medical record failed to show documentation on whether the resident refused to be weighed. On 1/14/26 at 1433 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified Resident 30's medical record failed to show documentation whether the resident refused to be weighed in January. The DON was informed and acknowledged the above findings. Cross reference to F657

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to properly maintain and assess the IV accesses for three of three final sampled residents (Residents 9, 161, and 196) reviewed for IV catheters. * The facility failed to ensure Resident 9's arm circumference was measured after the initial assessment related to the resident's PICC line catheter as per the facility's P&P. * The facility failed to ensure Resident 161's midline catheter dressing was changed in seven days as per the physician's order. In addition, there was no measurement of the arm circumference after the initial assessment. Moreover, the physician's orders for the cap changes of the midline catheter were for a PICC line instead of a midline catheter. * The facility failed to ensure Resident 196 had orders for monitoring the midline IV catheter. These failures had the potential to put the residents at an increased risk of infection and to cause a delay in identifying signs of catheter-related complications for the residents.Findings: 1. Review of the facility's P&P titled Dressing and Injection Cap Change for Central Venous Access Devices (undated) showed the following: - the purpose of the P&P is to reduce the risk of infection to the insertion or exit site and surrounding area a central venous access devices such as PICC or midline catheters; - routine central, PICC, and midline catheters dressing changes shall be done every seven days and as needed; - document arm circumference in inches on treatment record prior to dressing change, compare to measurement from admission. Also, document arm circumference after the dressing change is completed; and - arm circumference shall be documented before and after the procedure and documented on the treatment record. On 1/6/26 at 1418 hours, during the initial tour of the facility, Resident 161 was observed in bed. There was an IV access observed on her left upper arm. On 1/6/26 at 1537 hours, an observation for Resident 161 and concurrent interview was conducted with RN 1. RN 1 verified Resident 161 had a double-lumen midline catheter on her left upper arm with a dressing dated 12/29/25. Medical record review for Resident 161 was initiated on 1/6/26. Resident 161 was readmitted to the facility on [DATE]. Review of Resident 161's Nursing Progress Note dated 12/30/25, showed Resident 161 had a midline IV access on the left upper arm, with an arm circumference of 11.5 inches. Review of Resident 161's Order Summary Report showed the following physician's orders: - dated 12/30/25, cap change every seven days and as needed or blood draw on the left upper arm PICC line ports; (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 12/30/25, dressing and securement device, change every device and as needed, using sterile technique; and - dated 12/30/25, measure arm circumference in inches every seven days during dressing changes. Review of Resident 161's IV MAR for January 2026 showed the caps for the left upper arm PICC line and dressing were changed on 1/6/26. Further review of Resident 161's medical record did not show documentation of Resident 161's arm circumference measurement after the initial assessment on 12/30/25. On 1/8/26 at 1500 hours, an interview and concurrent medical record review for Resident 161 was conducted with RN 1. RN 1 stated the midline catheter dressing should be changed every seven days. RN 1 verified Resident 161's left upper arm midline catheter had a dressing dated 12/29/25. RN 1 stated Resident 161's midline catheter dressing was changed on 1/6/26. RN 1 verified Resident 161's midline catheter dressing was changed eight days later, and not in seven days per the physician's order. RN 1 showed documentation of Resident 161's arm circumference when the resident was admitted on [DATE]. However, RN 1 could not provide documented evidence Resident 161's arm circumference was measured after seven days, prior and after dressing changes. RN 1 also verified the physician's order for cap changes was for PICC line, and not for midline catheter. On 1/14/26 at 1444 hours, an interview and concurrent medical record review for Resident 161 was conducted with the DON. The DON was informed and verified the above findings. 2. Medical record review for Resident 9 was initiated on 1/6/26. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's Order Summary Report showed the following physician's orders: - dated 11/17/25, to measure arm circumference in inches every seven days during dressing changes; - dated 11/17/25, to measure external catheter length in cm from end to hub to insertion site into skin; and - dated 11/18/25, to measure arm circumference in inches on admission. Review of Resident 9's IV MAR for November 2025, December 2025, and January 2026 showed the arm circumference was measured 30 cm on 11/18/25. Further review of Resident 9's medical record review did not show did not show documentation of Resident 9's arm circumference and external catheter length measurement after the initial assessment on 11/18/25. On 1/8/26 at 1514 hours, an interview and concurrent medical record review for Resident 9 was conducted with RN 1. RN 1 showed documentation of Resident 9's arm circumference when the resident was admitted on [DATE]. However, RN 1 could not provide documented evidence to Resident 9's arm circumference was measured after seven days, prior and after dressing changes. In addition, RN 1 could not provide documented evidence to show the measurement of Resident 9's external PICC line catheter length. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/26 at 1447 hours, an interview and concurrent medical record review for Resident 9 was conducted with the DON. The DON was informed and verified the above findings. 3. Medical record review for Resident 196 was initiated on 1/6/26. Resident 196 was admitted to the facility on [DATE]. Review of Resident 196's H&P examination dated 1/2/26, showed Resident 196 was alert and oriented with normal cognition. Review of Resident 196's Order Summary Report for January 2026 showed the following physician's orders: - dated 12/31/25, ertapenem sodium (broad-spectrum antibiotic) 1 gm use intravenously every 24 hours for UTI (urinary tract infection) for 10 days. - dated 12/31/25, start IV change site every 74 hours and PRN for infiltration or soiling as needed. - dated 12/31/25, may extend site beyond 72 hours due to poor venous access. Review of Resident 196's Medical Center After Visit Summary dated 12/31/25, showed the resident had a midline IV catheter placed by the PICC Nurse at the acute care hospital. Review of Resident 196's progress note dated 1/1/26, showed Resident 196 had a midline on the left upper arm. On 1/9/26 at 1022 hours, an interview and concurrent medical record review for Resident 196 was conducted with RN 2. RN 2 verified Resident 196 was on IV antibiotics and had a midline IV catheter to the left upper arm. RN 2 further verified the IV orders were inaccurate and failed to show Resident 196 had midline IV monitoring ordered. RN 2 stated Resident 196's IV monitoring orders were for a peripheral IV. On 1/9/26 at 1105 hours, an interview and concurrent medical record review for Resident 196 was conducted with the DON. The DON verified the above findings and stated the IV monitoring orders were for a peripheral IV. The DON acknowledged Resident 196 had a midline IV catheter and did not have a peripheral IV. The DON stated the orders should have been clarified to monitor for midline IV catheter. On 1/14/26 at 1440 hours, an interview was conducted with the DON. The DON acknowledged the above findings.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to attain or maintain the highest physical well-being for one of one final sampled resident (Resident 95) reviewed for dialysis care. * The facility failed to ensure Resident 95's fluid intake and output related to the dialysis were consistently monitored. This failure posed the risk of possible medical complications for Resident 95.Findings: Review of the facility's P&P titled Documentation revised May 2007 showed the resident's clinical record is a concise and accurate account of treatment, care, response to care, signs, symptoms, and progress of the resident's condition. Medical record review for Resident 95 was initiated on 1/6/26. Resident 95 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 95's H&P examination note dated 9/24/25, showed the resident had ESRD and on dialysis. Review of Resident 95's MDS assessment dated [DATE], showed the resident was cognitively intact. Review of Resident 95's Documentation Survey Report v2 for November 2025 showed the following:- for the intervention/task for 1500 ml fluid restriction, the breakdown was AM/Dietary 240 ml, lunch meal 120 ml, dinner 240 ml every shift. The total fluid intake was not monitored on 11/18/25 at 1500-2300 hours, 11/2-11/5, 11/11, 11/15, 11/23, and 11/30/25 at 2300-0700 hours; and- for the intervention/task for bladder continence, the total output was not monitored on 11/18/25 at 1500-2300 hours, 11/2 to 11/5, 11/11, 11/23, and 11/30/25 at 2300-0700 hours. Review of Resident 95's Documentation Survey Report v2 for December 2025 showed the following:- for the intervention/task for 1500 ml fluid restriction, the breakdown was AM/Dietary 240 ml, lunch meal 120 ml, dinner 240 ml every shift. The total fluid intake was not monitored on 12/22/25 at 0700-1500 hours, 12/8, 12/12, 12/19 to 12/20, and 12/31/25 at 2300-0700 hours; and- for the intervention/task for bladder continence, the total output was not monitored on 12/22/25 at 0700-1500 hours, 12/8, 12/12, 12/19 to 12/20, and 12/31/25 at 2300-0700 hours. Review of Resident 95's Documentation Survey Report v2 for January 2026 showed the intervention/task for 1500 ml fluid restriction breakdown as follows: AM/Dietary 240 ml, lunch meal dietary 120 ml, dinner dietary 240 ml every shift. The total fluid intake was not monitored on 1/12/26 at 0700-1500 hours. On 1/1/26 at 0946 hours, an interview and concurrent medical record review was conducted with CNA 4. CNA 4 verified the multiple missing entries of Resident 95's fluid intake and output. CNA 4 stated the CNAs should have charted everything they did for the residents. On 1/14/26 at 1009 hours, an interview and concurrent medical record review was conducted with LVN 4. LVN 4 acknowledged the facility failed to consistently monitor Resident 95's intake and output. LVN 4 stated the licensed nurses always encouraged the CNAs to finish their charting before they go home. LVN 4 stated Resident 95 was a dialysis resident and it was important to know the resident's intake and output. On 1/14/26 at 1043 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility document review, the facility failed to ensure the facility staff (LVNs 4 and 8) had specific competencies and standard of practice skill sets needed to provide the safe and efficient nursing care to the residents. * LVN 4 administered expired insulin to Resident 6. * LVN 8 administered medications left at Resident 102's nightstand prepared by another licensed nurse. These failures had the potential to put the residents at risk for care not provided in a safe and competent manner.Findings: 1. On [DATE] at 0839 hours, an observation and concurrent interview was conducted with Resident 102. Resident 102 was lying in bed. There were three tablets in a medication cup placed on the resident's nightstand beside resident's bed. Resident 102 stated the medications were her levothyroxine sodium (thyroid hormone replacement used to treat an underactive thyroid or hypothyroidism), Protonix (known as pantoprazole, a prescription proton pump inhibitor that reduces stomach acid and morphine sulfate (is an opioid analgesic used for moderate to severe pain). Resident 102 further stated the nurse must not have been able to wake her up in the morning. On [DATE] at 0844 hours, an observation and concurrent interview for Resident 102 was conducted with LVN 8, inside Resident 102's room. The medications were still observed on the resident's nightstand. LVN 8 verified the medications were levothyroxine sodium, Protonix, and morphine sulfate. LVN 8 further stated the medications were dispensed by the night shift licensed nurse. LVN 8 administered the three medications left at the bedside to the resident. On [DATE] at 0849 hours, an interview was conducted with LVN 8. LVN 8 verified she gave the medications left at the resident's bedside dispensed by the night nurse. LVN 8 stated she should had not given the medications dispensed by another nurse to the resident for safety. Medical record review for Resident 102 was initiated on [DATE]. Resident 102 was admitted to the facility on [DATE]. Review of Resident 102's H&P examination dated [DATE], showed Resident 102 had the capacity to understand and make decisions. Review of Resident 102's Order Summary dated [DATE], showed the following physician's orders: - dated [DATE], to administer Protonix 40 mg tablet by mouth in the morning. - dated [DATE], to administer levothyroxine sodium 100 mcg tablet by mouth every 24 hours. - dated [DATE], to administer morphine sulfate 15 mg tablet by mouth three times a day. Review of Resident 102's MAR for [DATE] showed the following medications were administered: - dated [DATE] at 0630 hours, Protonix 40 mg tablet by mouth in the morning. - dated [DATE] at 0643 hours, levothyroxine sodium 100 mcg tablet by mouth every 24 hours. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated [DATE] at 0700 hours, morphine sulfate 15 mg tablet by mouth three times a day. Review of LVN 8's LN Clinical Competency Review 2025 dated [DATE], showed LVN 8 met competency expectations for medication administration. On [DATE] at 1439 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Review of the Lantus manufacturer's guideline for Lantus SoloStar pen insulin glargine injection dated 2022 showed an opened Lantus SoloStar pen should be discarded after 28 days, even if the pen still contained insulin. On [DATE] at 0849 hours, a medication administration observation for Resident 6 was conducted with LVN 4. LVN 4 prepared and administered 5 units of the Lantus SoloStar insulin glargine pen injector to Resident 6. The pen cap of Resident 6's Lantus insulin pen injector was labeled date opened [DATE]. On [DATE] at 0934 hours, an interview was conducted with LVN 4. LVN 4 verified the above findings. Review of LVN 4's LN Clinical Competency Review 2025 dated [DATE], showed LVN 4 met competency expectations for medication administration and medication labeling and storage. Review of facility's In-Service Training for Medication Pass Documentation and Medication Pass Policy dated [DATE], showed LVN 4 was in attendance. Further review of the in-service lesson plan showed the purpose of the in-service was to ensure licensed nursing staff safely, accurately, and consistently administer medications during the medication pass. On [DATE] at 1111 hours, an interview was conducted with DON. DON was informed and acknowledged the above findings. Cross reference to F755.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the pharmaceutical services to ensure the accurate administration of the medication. The facility's medication error rate was 4.76%. * LVN 4 administered expired insulin to Resident 6. * LVN 8 administered medications left at Resident 102's nightstand prepared by another licensed nurse. These failures had the potential to put the residents at risk for care not provided in a safe and competent manner.Findings: 1. Review of the facility's P&P titled Self-Administration of Medications (undated) showed medications to be self-administered are specifically ordered and monitored by the nursing staff. On [DATE] at 0839 hours, an observation and concurrent interview was conducted with Resident 102. Resident 102 was lying in bed. There were three tablets in a medication cup placed on the resident's nightstand beside resident's bed. Resident 102 stated the medications were her levothyroxine sodium (thyroid hormone replacement used to treat an underactive thyroid or hypothyroidism), Protonix (known as pantoprazole, a prescription proton pump inhibitor that reduces stomach acid and morphine sulfate (is an opioid analgesic used for moderate to severe pain). Resident 102 further stated the nurse must not have been able to wake her up in the morning. On [DATE] at 0844 hours, an observation and concurrent interview for Resident 102 was conducted with LVN 8, inside Resident 102's room. The medications were still observed on the resident's nightstand. LVN 8 verified the medications were levothyroxine sodium, Protonix and morphine sulfate. LVN 8 further stated the medications were dispensed by the night shift licensed nurse. LVN 8 stated medications should not be left at resident's bedside for safety reasons. On [DATE] at 0849 hours, an interview was conducted with LVN 8. LVN 8 verified she gave the medications left at resident's bedside dispensed by the night nurse. LVN 8 stated she should had not given the medications dispensed by another nurse to the resident for safety. Medical record review for Resident 102 was initiated on [DATE]. Resident 102 was admitted to the facility on [DATE]. Review of Resident 102's care plan for self-administration of medications by mouth dated [DATE], showed an intervention to evaluate resident can appropriately follow directions and tell time to know when the medication needs to be taken. Review of Resident 102's H&P examination dated [DATE], showed Resident 102 had the capacity to understand and make decisions. Review of Resident 102's Self-Administration of Medication dated [DATE], showed Resident 102 was approved for self-administration of medications and resident may keep at bedside. Review of Resident 102's MDS assessment dated [DATE], showed the resident's BIMS score was 13, indicating resident was cognitively intact. Review of Resident 102's Order Summary dated [DATE], showed the following physician's order: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated [DATE], to administer Protonix 40 mg tablet by mouth in the morning; - dated [DATE], may self-administer medications by mouth, transdermal patches, inhalers, breathing treatment and eye drops; - dated [DATE],to administer levothyroxine sodium 100 mcg tablet by mouth every 24 hours; and - dated [DATE], to administer morphine sulfate 15 mg tablet by mouth three times a day. Review of Resident 102's MAR for [DATE] showed the following medications were administered: - dated [DATE] at 0630 hours, Protonix 40 mg tablet by mouth in the morning. - dated [DATE] at 0643 hours, levothyroxine sodium 100 mcg tablet by mouth every 24 hours. - dated [DATE] at 0700 hours, morphine sulfate 15 mg tablet by mouth three times a day. On [DATE] at 1439 hours, an interview was conducted with the DON. The DON stated she understood the risk of leaving the medications exposed at the resident's bedside. The DON was informed and acknowledged the above findings. 2. Review of the Lantus manufacturer's guideline for Lantus SoloStar pen insulin glargine injection dated 2022 showed an opened Lantus SoloStar pen should be discarded after 28 days, even if the pen still contained insulin. On [DATE] at 0849 hours, a medication administration observation for Resident 6 was conducted with LVN 4. LVN 4 prepared and administered 5 units of the Lantus SoloStar insulin glargine pen injector to Resident 6. The pen cap of Resident 6's Lantus insulin pen injector was labeled date opened [DATE]. On [DATE] at 0934 hours, an interview was conducted with LVN 4. LVN 4 verified the above findings. On [DATE] at 1111 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. Cross reference to F726.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the Pharmacist Consultant identified and reported all irregularities during the monthly medication regimen for one of five final sampled residents (Resident 6) reviewed for pharmaceutical services. * Resident 6 was diagnosed with diabetes and was on long term insulin. Resident 6 did not have a Hemoglobin A1C test completed for over a year. This failure resulted in inadequate management of Resident 6's diabetes, increasing the risk of serious health issues.Findings: Review of the facility's P&P titled medication Regimen Review last revised 5/2025 stated the Pharmacist Consultant reviews the medication regimen of each resident at least monthly. Findings and recommendations are reported to the Administrator, Director of Nursing, the responsible physician and the Medical Director where appropriate.The monthly review visit includes review of all drugs ordered, information concerning the resident related to the drug therapy, physician progress notes, nurses' notes, and laboratory results. The Pharmacist Consultant documents potential or actual medication therapy problems and communicates them to the responsible physician and the director of nursing. Medical record review for Resident 6 was completed on 1/9/26. Resident 6 was originally admitted to the facility on [DATE]. Review of Resident 6's laboratory result dated 1/2/25, showed the resident had a Hemoglobin A1C result of 5.7%, outside the laboratory reference range of 4.6-5.6 %. Review of Resident 6's Order Summary Report showed the following orders:- dated 3/11/25, for insulin Glargine Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Glargine) inject 5 units subcutaneously one time a day to treat Type 2 diabetes. - dated 7/21/25, for insulin Lispro Injection Solution 100 unit/ml (Insulin Lispro) inject as per sliding scale: if blood sugar 70 - 150 mg/dL = 0-unit insulin, blood sugar less than 70 mg/dL, may give 8oz orange juice if able to swallow or 1 mg Glucagon intramuscularly if unresponsive & call the doctor; blood sugar 151 - 200 mg/dL = 1-units insulin; 201 - 250 mg/dL = 2-units insulin; 251 - 300 mg/dL = 3-units insulin; 301 - 350 mg/dL = 4-units insulin; 351 - 400 mg/dL = 5-units insulin, blood sugar 400 mg/dL give 6-units insulin and call the responsible physician. Review of the Medication Regimen Review report completed monthly by the Pharmacist Consultant in 2025 failed to show a recommendation for Resident 6's Hemoglobin A1C test. Further review of Resident 6's medical record documentation failed to show a follow up was completed for a Hemoglobin A1C test. On 1/14/26 at 1346 hours, a telephone interview and concurrent medical record review was conducted with the Pharmacist Consultant. The Pharmacist Consultant stated the Hemoglobin A1C test should be done every three to six months. The Pharmacist Consultant stated they typically would not go past six months without checking/monitoring the Hemoglobin A1C test result and it should have been followed up. Cross reference to F757, example #4.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure two of five sampled residents (Residents 2 and 3) reviewed for unnecessary medications were free from significant medication errors. * The facility failed to ensure Resident 2 received the appropriate dose of Risperdal (antipsychotic medication) as ordered by the physician. * The facility failed to ensure Resident 3's clonidine HCL (hydrochloride) (medication to lower blood pressure) was held as ordered by the physician. These failures had the potential to negatively impact the residents' health outcomes. Findings: Review of facility's P&P titled Guidelines for Medication Administration reviewed 5/27/25, showed to observe the five rights of administering medications which included the right resident, right drug, right dose, right time, and right route. Review of the facility's P&P titled Physician Orders - CA revised 1/2019 showed verbal orders must be recorded immediately in the resident's' chart by the person receiving the order and must include name and strength of the drug, quantity or specific duration of therapy, dosage and frequency of administration, route of administration, and reason for which it is given. 1. Medical record review for Resident 2 was initiated on 1/7/26. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 2's H&P examination dated 7/3/25, showed Resident 2 had the capacity to make his own decisions. Review of Resident 2's Order Summary Report 1/8/26, showed the following physician's orders:- dated 11/25/25, to administer Risperdal 0.5 mg one tablet by mouth two times a day for psychosis manifested by anger outburst; and- dated 11/25/25, to administer Risperdal 1 mg one tablet by mouth two times a day for angry outbursts related to unspecified psychosis. Review of Resident 2's MAR for October, November, and December 2025; and January 2026 showed Resident 2 was administered the following medications:- On 10/31/25 at 0900 and 1700 hours, Resident 2 was administered with Risperdal 0.5 mg and 1mg tablets which totaled 1.5 mg for each administration time,- From 11/1 to 11/7, 11/9 to 11/20, and 11/26 to 11/30/25 at 0900 and 1700 hours, and 11/8/25 at 1700 hours, Resident 2 was administered with Risperdal 0.5mg and 1mg Risperdal tablets which totaled 1.5 mg for each administration time,- From 12/1 to 12/11 and 12/13 to 12/31/25 at 0900 and 1700 hours, and 12/12/25 at 1700 hours, Resident 2 was administered Risperdal 0.5mg and 1mg tablets which totaled 1.5 mg for each administration time, and- From 1/1 to 1/7/26 at 0900 and 1700 hours; Resident 2 was administered Risperdal 0.5mg and 1mg tablets which totaled 1.5 mg for each administration time. Review of Resident 2's NP/PA Progress Note dated 10/23/25 at 1751 hours, showed PA 1 plan to increase Resident 2's Risperdal medication from 0.5 mg BID to 1 mg BID. Review of Resident 2's prescription document dated 10/30/25 at 1732 hours, showed a medication order for Risperdal 1 mg one tablet by mouth two times a day for angry outbursts related to unspecified psychosis. The medication order was confirmed by LVN 3 and NP 1 ordered the Risperdal medication. Review of Resident 2's Order Progress Note dated 10/30/25 at 1735 hours, showed LVN 3 obtained a telephone order from PA 1 for Risperdal 1 mg one tablet by mouth two times a day for angry outbursts related to unspecified psychosis. On 1/8/26 at 1155 hours, a telephone interview and concurrent medical record review for Resident 2 was conducted with NP 1. NP 1 stated he did not order the Risperdal medication. On 1/9/26 at 0921 hours, a telephone interview and concurrent medical record review for Resident 2 was conducted with PA 1. PA 1 reviewed Resident 2's progress note dated 10/23/25, and stated the plan for Resident 2 was to increase the Risperdal medication from 0.5mg BID to 1 mg BID due to Resident 2's agitation and aggression. When asked if PA 1 was aware Resident 2 was receiving 1.5 mg Risperdal BID since 10/31/25, PA 1 stated no, he was not aware. PA 1 stated his intention was to increase Resident 2's Risperdal medication to 1 mg BID, not 1.5 mg BID. On 1/14/26 at 1111 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. Cross reference to F605 example #1. 2. Medical record review for Resident 3 was initiated on 1/12/26. Resident 3 was admitted to the facility on [DATE], and readmitted on [DATE]. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 3's H&P examination dated 9/11/25, showed Resident 3 had no capacity to understand and make decisions. Review of Resident 3's Order Summary Report dated 1/12/26, showed a physician's order dated 9/14/25, to administer clonidine HCl 0.1 mg one tablet by mouth every eight hours for elevated blood pressure. The physician's order showed to give the clonidine if the systolic blood pressure (top number in a blood pressure reading, representing the pressure in the arteries when the heart beats and pushes blood out) was greater than 160 mmHg. Review of Resident 3's MAR for December 2025 and January 2026 showed Resident 3 was administered the clonidine medication when Resident 3's blood pressure was below the parameters prescribed by the physician on the following dates and times: -on 12/1/25 at 0600 hours, a systolic blood pressure of 134 mmHg, and at 2200 hours, a systolic blood pressure of 128 mmHg, -on 12/2/25 at 0600 hours, a systolic blood pressure of 115 mmHg, and at 2200 hours, a systolic blood pressure of 137 mmHg, -on 12/3/25 at 0600 hours, a systolic blood pressure of 106 mmHg, and at 2200 hours, a systolic blood pressure of 132 mmHg, -on 12/4/25 at 0600 hours, a systolic blood pressure of 131 mmHg, and at 1400 hours, a systolic blood pressure of 138 mmHg, -on 12/12/25 at 2200 hours, a systolic blood pressure of 142 mmHg,-on 12/13/25 at 0600 hours, a systolic blood pressure of 139 mmHg, and at 2200 hours, a systolic blood pressure of 140 mmHg; -on 12/14/25 at 0600 hours, a systolic blood pressure of 137 mmHg, and at 2200 hours, a systolic blood pressure of 133 mmHg;-on 12/15/25 at 0600 hours, a systolic blood pressure of 133 mmHg, and at 2200 hours, a systolic blood pressure of 122 mmHg; -on 12/16/25 at 0600 hours, a systolic blood pressure of 122 mmHg, and at 2200 hours, a systolic blood pressure of 120 mmHg; -on 12/17/25 at 0600 hours, a systolic blood pressure of 118 mmHg, and at 2200 hours, a systolic blood pressure of 127 mmHg; -on 12/18/25 at 0600 hours, a systolic blood pressure of 108 mmHg, at 1400 hours, a systolic blood pressure of 132 mmHg, and at 2200 hours, a systolic blood pressure of 127 mmHg; -on 12/19/25 at 0600 hours, a systolic blood pressure of 116 mmHg, -on 12/20/25 at 0600 hours, a systolic blood pressure of 128 mmHg, and at 2200 hours, a systolic blood pressure of 138 mmHg; -on 12/21/25 at 0600 hours, a systolic blood pressure of 140 mmHg, at 1400 hours, a systolic blood pressure of 132 mmHg, and at 2200 hours, a systolic blood pressure of 134 mmHg; -on 12/22/25 at 0600 hours, a systolic blood pressure of 129 mmHg, and at 2200 hours, a systolic blood pressure of 121 mmHg; -on 12/23/25 at 0600 hours, a systolic blood pressure of 124 mmHg, and at 2200 hours, a systolic blood pressure of 122 mmHg; -on 12/24/25 at 0600 hours, a systolic blood pressure of 112 mmHg, and at 2200 hours, a systolic blood pressure of 131 mmHg; -on 12/25/25 at 0600 hours, a systolic blood pressure of 132 mmHg, at 1400 hours, a systolic blood pressure of 130 mmHg, and at 2200 hours, a systolic blood pressure of 132 mmHg; -on 12/26/25 at 0600 hours, a systolic blood pressure of 124 mmHg, at 1400 hours, a systolic blood pressure of 124 mmHg, and at 2200 hours, a systolic blood pressure of 135 mmHg; -on 12/27/25 at 0600 hours, a systolic blood pressure of 122 mmHg; -on 12/29/25 at 2200 hours, a systolic blood pressure of 133 mmHg; -on 12/30/25 at 0600 hours, a systolic blood pressure of 116 mmHg, and at 2200 hours, a systolic blood pressure of 120 mmHg; -on 12/31/25 at 0600 hours, a systolic blood pressure of 116 mmHg, and at 2200 hours, a systolic blood pressure of 148 mmHg; - on 1/1/26 at 0600 hours, a systolic blood pressure of 139 mmHg, at 1400 hours, a systolic blood pressure of 130 mmHg, and at 2200 hours, a systolic blood pressure of 133 mmHg; -on 1/2/26 at 0600 hours, a systolic blood pressure of 125 mmHg; -on 1/3/26 at 1400 hours, a systolic blood pressure of 138 mmHg; -on 1/4/26 at 0600 hours, a systolic blood pressure of 148 mmHg; -on 1/5/26 at 2200 hours, a systolic blood pressure of 122 mmHg; -on 1/6/26 at 0600 hours, a systolic blood pressure of 117 mmHg, and at 2200 hours, a systolic blood pressure of 128 mmHg; -on 1/7/26 at 0600 hours, a systolic blood pressure of 120 mmHg, and at 2200 hours, a systolic blood pressure of 119 mmHg; -on 1/8/26 at 0600 hours, a systolic blood pressure of 125 mmHg; and -on 1/9/26 at 2200 hours, a systolic blood pressure of 133 mmHg. On 1/12/26 at 1453 hours, an interview and concurrent medical record review for Resident 3 was conducted with LVN 4. LVN 4 verified the above findings. On 1/14/26 at 1111 hours, an interview was conducted with the DON. The DON stated the licensed staff members were expected to read and (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	follow the physician's orders prior to the administration of the medication. The DON was informed and acknowledged the above findings. Cross reference to F757 example #1.

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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 0645 Level of Harm - Potential for minimal harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the PASRR (Preadmission Screening and Resident Review) screening was accurately completed for one of five final sampled residents (Resident 12) reviewed for PASRR. * Resident 12's PASRR Level 1 screening was not updated to include the serious mental illness diagnosis. This failure had the potential of not providing the resident to be screened for mental illness or intellectual disabilities with additional resources if needed.Findings: Review of the facility's P&P titled Resident Assessment - PASRR dated 12/2021 showed it is the policy of this facility to ensure that each resident is properly screened using the PASRR specified by the State. A PASRR shall be completed on every resident upon admission. Based upon the assessment, the facility will ensure proper referral to appropriate state agencies for the provision of specialized services to residents with intellectual disability or related condition or serious mental illness. Medical record review for Resident 12 was initiated on 1/6/26. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's PASRR Level I Screening dated 11/24/25, showed under Section III - Serious Mental Illness, No was marked for whether the resident was diagnosed with serious mental illness such as psychosis and mood disturbance. Review of Resident 12's H&P examination dated 11/25/25, showed Resident 12 had the capacity to understand and make decisions. Review of Resident 12's Face sheet - Diagnosis Information dated 1/9/26, showed Resident 12 had a diagnosis of unspecified psychosis with the onset date of 11/24/25. On 1/13/26 at 1420 hours, an interview and concurrent medical record review for Resident 12 was conducted with the MDS Coordinator. The MDS Coordinator stated the acute care hospital completed the PASARR; however, if there were discrepancies in the information, then the facility would update and complete the PASRR for the resident upon admission. The MDS Coordinator verified Resident 12 had a diagnosis of psychosis upon admission and stated Section III of Resident 12's PASRR Level I Screening dated 11/24/25, should have been marked, Yes. The MDS Coordinator further stated the facility should have done a reassessment and submitted another PASRR with accurate information. On 1/14/26 at 1440 hours, an interview was conducted with the DON. The DON acknowledged the above findings.