STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555251	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knolls West Post Acute LLC	16890 Green Tree Blvd Victorville, CA 92395

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47098 Based on observation, interview, and record review, the facility failed to maintain resident dignity for one of seven sampled residents (Resident 311) reviewed for dignity practices by not providing a dignity bag (a cover placed over a urine collection bag so others cannot see the urine) for the foley catheter bag (a thin tube place in the bladder to drain urine into a bag) which exposed the urine contents to public view. This failure has the potential to cause Resident 311 embarrassment, and emotional distress (Feeling upset, anxious or humiliated), and loss of dignity (feeling disrespected or devaluated as a person). Findings: During a review of Resident 311's Admission Record (contains demographic and medical information) indicated Resident 311 was admitted to the facility on [DATE], with the admitted diagnosis of hemiplegia and hemiparesis following cerebral infarction (weakness on one side of the body (left side) after a stroke making it hard to move), Acute and Chronic Respiratory failure (the lungs don't work properly, causing breathing problems that make them weak, and unable to get enough oxygen), and congestive heart failure (the heart isn't pumping blood well, which can cause swelling and tiredness). During an observation on May 19, 2025, at 11:55 AM inside Resident 311's room, Resident 311 was observed lying down in bed with head of the bed elevated, awake, alert and oriented to name, time and place. On the left side of the bed, a urine collection bag was visibly hanging, filled with yellow urine and attached to a catheter tubing. The bag was uncovered, with no dignity cover or privacy bag in place. During an interview on May 19, 2025, at 11:56 AM with Resident 311, the Resident 311 stated that he uses the urine bag because he cannot urinate on his own and that the nurses take care of it. During an interview on May 19, 2025, at 11:59 AM with Certified Nurse Assistant 3 (CNA 3), CNA 3 confirmed that the urine bag should have been place inside a dignity bag to protect the resident's privacy. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on May 19, 2025, at 12:01 PM inside Resident 311's room with the Assistant Director of Nursing (ADON), the ADON acknowledge and stated that the urine collection bag should be place inside a dignity cover (privacy bag) to ensure resident privacy and for infection control. During a review of Resident 311's Physician Orders dated May 7, 2025 indicated, Foley catheter (a thin, flexible tube inserted into the bladder to drain urine into a bag when someone cannot pee on their own), FR # 16 x 10 cc (the catheter size is French size 16, which is the tube width and 10 cc balloon refers to a mall balloon at the tip that is filled with 10 milliliters of water to hold the catheter in place) to gravity drainage (the urine drains down naturally from the bladder into a collection using gravity) Dx (diagnosis) Neurogenic bladder (the bladder doesn't work properly, the person cannot fully control when or how they urinate) . During a review of Resident 311's Care Plan dated May 8, 2025, indicated, suprapubic catheter (a thin, flexible tube placed through the lower belly directly into the bladder to drain urine when someone cannot urinate thought on their own) .risk: infection / irritation at Suprapubic Site, Goals, suprapubic site will be free from infection QD (daily), Intervention .,provide privacy, promote dignity . During a concurrent interview and record review on May 22, 2025, at 10:48 AM with ADON, the facility's P&P titled, Dignity Dignity, dated August 22, 2017, was review. The P&P indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .12. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents: for example: a. helping the resident to keep urinary catheter bags covered . The ADON confirmed that the staff did not follow the facility's P&P.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51361 Based on interview, and record review, the facility failed to ensure a copy of the notice of transfer or discharge were sent to the Ombudsman for one of two sampled residents (Resident 106) reviewed for hospitalization when Resident 106 was sent to the hospital on February 9, 2025, and there was no copy of notice of transfer or discharge sent to the Ombudsman. This failure had the potential for Resident 106 to be inappropriately transferred or discharged . Findings: During a review of Resident 106's clinical record, the Admission Record (a document that gives a summary of resident's information) indicated Resident 106 was admitted to the facility on [DATE] for cellulitis (infection of the skin) and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review Resident 106's physician order (a set of instructions written by a doctor for the care of the resident) dated February 9, 2025, the physician's order indicated, Send patient to Desert Valley Hospital related to: left 4th toe infection. During a subsequent review of Resident 106's hospitalization paperwork, dated February 9, 2025, there was no record of the notice of transfer or discharge sent to the Ombudsman. During a concurrent interview and record review on May 21, 2025, at 9:30 AM with the Director of Nursing (DON) the regulation F-623 was reviewed. It stated, Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. The DON stated that the notification of the ombudsman is done by the social worker. During a concurrent interview and record review on May 21, 2025, at 9:57 AM with the Social Services, Resident 106's hospitalization paperwork, dated February 9,2025, was reviewed. The Social Services stated the notification to the Ombudsman is only done for planned discharges that are sent home, board and care or other skilled nursing facilities. The Social Worker further stated that there is no notification sent when the resident is sent to the hospital. During a subsequent interview and record review on May 21, 2025, at 10:00 AM with the Medical Records, Residents 106's chart was reviewed. The Medical Record stated when residents are sent out to he hospital, duplicate transfer sheets are used for resident information, however there is no record sent from medical records to the ombudsman, that task is handled by the social worker. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review with the DON and the Administrator on May 21, 2025, at 1:56 PM, the Administrator stated that there is no process, policy or procedure for notification for transfers. The Administrator stated there was no process in place to notify the ombudsman for residents sent to the hospital. The DON further stated this process was not a nursing issue but was an issue for the social services, and there is no notification sent for residents being discharged or transferred to a hospital setting.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40171 Based on interview, and record review, the facility failed to accurately code the Resident Assessment Instrument-Minimum Data Set (RAI-MDS - a computerized resident assessment tool) for two sampled residents (Resident 84 and Resident 99) when: 1. For Resident 84's RAI-MDS assessment was not coded to indicate she had a diagnosis of schizophrenia (a chronic mental disorder that affects how a person thinks, feels, and behaves). 2. For Resident 99's RAI-MDS assessment was not coded to indicate she had a stage 1 pressure ulcer (bed sore). These failures resulted in the MDS assessments for Resident's 84 and 99 to inaccurately reflect their current medical status which had the potential to result in unmet care needs for the residents. Findings: 1. During a review of Resident 84's Admission Record, (contains medical and demographic information), the Admission Record, indicated Resident 84 was initially admitted on [DATE], with admitting diagnoses which included schizophrenia, hemiplegia and hemiparesis (weakness and paralysis on one side of the body), altered mental status, and dementia (term for loss of memory, language, problem-solving and other thinking abilities. During a review of Resident 84's RAI-MDS assessment dated [DATE], the assessment indicated, Section I - Active Diagnoses - Psychiatric/Mood Disorder was not coded to indicate Resident 84 had the diagnosis of schizophrenia as the checkbox I6000 Schizophrenia, was left unchecked. During a concurrent interview and record review on May 22, 2025, at 10:37 AM, with the Assistant Director of Nursing 1 (ADON 1), Resident 84's RAI-MDS assessment dated [DATE], was reviewed. The ADON 1 stated Resident 84 had a diagnosis of schizophrenia and the MDS assessment should have indicated that but it did not. The ADON 1 further stated the facility used the current version of the RAI manual as their policy and procedure. During an interview on May 22, 2025, at 10:55 AM, with the Minimum Data Set Nurse (MDS Nurse), the MDS nurse stated the facility incorrectly coded Resident 84's MDS assessment dated [DATE], because it did not include Resident 84's diagnosis of schizophrenia. The MDS Nurse further stated it was an oversight. During a review of current version of the RAI Manual titled, Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Dated October 2024, the manual indicated, .Section I: Active Diagnoses .Intent: the items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status .One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status . (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 99's Admission Record, (contains medical and demographic information), the Admission Record, indicated Resident 99 was admitted on [DATE], with diagnoses which included obesity (excess weight), muscle wasting and atrophy (loss or shrinking of muscle tissue), and cellulitis (skin infection) of left toe. During a review of Resident 99's Comprehensive Resident Admission Assessment (an assessment done upon the resident's admission into the facility), dated April 27, 2025, the assessment indicated Resident 99 had a scratch/redness to the sacrococcyx area (tailbone area) upon admit. During a review of Resident 99's physician's orders, an order dated April 28, 2025, indicated, sacrococcyx stage 1 [pressure sore in the tailbone region] cleanse with soap and h20 [water] pat dry apply zinc oxide oint/cream [ointment/cream] QD [every day] & PRN [and as needed] x 21 days [for 21 days] . During a concurrent interview and record review on May 21, 2025, at 7:58 AM, with the Assistant Director of Nursing 1 (ADON 1), the ADON 1 stated Resident 99 was admitted to the facility with a Stage 1 pressure ulcer. Resident 99's RAI-MDS assessment dated [DATE], was reviewed and the ADON 1 stated the assessment was coded incorrectly and should have indicated Resident 99 had a pressure ulcer upon admit but it did not. The ADON 1 stated the facility used the current version of the RAI manual as their policy and procedure. During a review of current version of the RAI Manual titled, Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Dated October 2024, the manual indicated, Section M: Skin Conditions .Intent: The items in this section document the risk, presence, appearance, and change of pressure ulcers/injuries .A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47098 Based on interview, and record review, the facility failed to ensure the accuracy of the Minimum Data Set, (MDS- a federally required resident assessment tool used to plan care and track clinical status) for one of seven sampled residents (Resident 64) reviewed for MDS coding accuracy when the facility inaccurately, documented Resident 64 received antibiotics in February 2025, despite no physician's orders showing antibiotic use. This failure has the potential to cause poor care planning and inaccurate understanding of Resident 64's health, increasing the risk Resident 64's needs will not be met. Findings: During a review Resident 64's Admission Record (contains demographic and medical information) indicated Resident 64 was admitted to the facility on [DATE], with the admitted diagnosis of peripheral vascular disease (poor blood circulation), stiffness of right ankle (limited movement), stiffness of left ankle (limited movement) During a review of Resident 64's MDS (Minimum Data Set) Section N0300-Medications, dated February 20, 2025, the MDS indicated, this section is used to record how many days in the last 7 days Resident 64 received injections or specific medications, such as antibiotics or insulin. This section indicated Resident 64 was coded as receiving antibiotics. During a concurrent interview and record review on May 22, 2025, at 11:22 AM with MDS Nurse, the Resident 64's Physician Orders dated February 1, 2025, was reviewed. The physician's orders, indicated, there was no documented evidence that Resident 64 was on antibiotics. The MDS nurse confirmed there was no indication or supporting documentation showing antibiotic administration and identified as an oversight and coding discrepancy on his part. During a concurrent interview and record review on May 22, 2025, at 11:36 AM with the MDS nurse, Resident 64's MDS Section N - medications, dated February 20, 2025, was reviewed. The MDS nurse acknowledged Resident 64 was inaccurately coded under F (antibiotics) and further stated that the accuracy of the MDS is very important because it directly affects resident care planning. During a concurrent interview and record review on May 22, 2025, at 11:50 AM, the Centers for Medicare & Medicaid Services, CMS (U.S. Federal agency that oversees Medicare and Medicaid, and regulatory compliance for health care facilities, including nursing homes), Resident assessment Instrument, RAI (is an assessment system used in nursing homes) Version 3.0 Manual Section N: Medications was reviewed. The manual indicated, Intent: the intent of the items in this section is to record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection, insulin, and / or select medications were received by the resident. The MDS nurse acknowledged that the documentation for Resident 64 under MDS section N was inaccurate.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40171 Based on interview, and record review, the facility failed to update Resident 84's Pre-admission Screening and Resident Review (PASRR - a federally mandated program that requires all individuals seeking admission to a Medicaid-certified nursing facility to be screened to ensure individuals who are identified to have a significant mental illness [SMI], intellectual or developmental disability [I/DD] are not inappropriately placed in nursing homes for long term care) when Resident 84 did not have her diagnosis of schizophrenia (a chronic mental disorder that affects how a person thinks, feels, and behaves) included in the PASRR assessment used to admit Resident 84 into the skilled nursing facility. This failure had the potential to result in Resident 84 to not be accurately assessed regarding the need for treatment and services in alternate care settings to better suite the needs of Resident 84. Findings: During a review of Resident 84's Admission Record (contains medical and demographic information), the Admission Record indicated Resident 84 was initially admitted on [DATE]. Further review of the face sheet indicated Resident 84 had a diagnosis of schizophrenia with an onset date which indicated December 2, 2024 (date of admission). Other diagnoses Resident 84 had upon admission included altered mental status, and dementia (a general term for a decline in mental ability, including memory, thinking and social abilities, severe enough to interfere with daily life). During a review of Resident 84's Preadmission Screening and Resident Review (PASRR) Level I screening (a level 1 screening includes assessment of the resident's medical diagnoses to determine if the resident has or is suspected of having a PASRR condition [i.e. SMI, or I/DD]), dated December 2, 2024, the PASRR Level 1 screening indicated in section III for Serious Mental Illness .9. diagnosed Serious Mental Illness. Does the individual have a serious diagnoses mental disorder such as .Schizophrenia .? This question was marked NO. Further review of the PASRR indicated the resolution status was LII - not required (Level 2 assessment is not required [level 2 assessment is done when the resident is positive for possible SMI and/or I/DD]). During an interview on May 21, 2025, at 10 AM, with the Minimum Data Set Nurse (MDS Nurse), the MDS Nurse stated Resident 84's PASRR dated December 2, 2024, was inaccurate and did not include Resident 84's diagnosis of schizophrenia. The MDS Nurse further stated the PASRR assessment dated [DATE], was completed by the hospital for admission to the skilled nursing facility and the skilled nursing should have reviewed the PASRR when Resident 84 was admitted and identified the discrepancy (omission of schizophrenia diagnosis) but the discrepancy was not identified. The MDS Nurse further stated the skilled nursing facility updated the PASRR. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 84's revised PASRR level 1 screening, dated May 20, 2025, the revised PASRR indicated, .Status Change .9. diagnosed Serious Mental Illness. Does the individual have a serious diagnosis mental disorder such as .Schizophrenia .? This question was marked YES. Further review of the revised PASRR indicated the resolution status was [NAME] Categorical Review (this means the resident was positive for a categorical condition, the resident is pending a review for possible level 2 screening and should not be admitted to a skilled nursing facility until acceptable resolution is obtained. During an interview on May 21, 2025, at 10:20 AM, with the Assistant Director of Nursing 1 (ADON 1), the ADON 1 stated the facility did not have a policy and procedure (P&P) specific to the PASRR process and stated they followed the guidance provided on the document titled, Preadmission Screening and Resident Review (PASRR) Level I Screening Assessment Guide, updated October 2024. During an interview on May 22, 2025, at 8:52 AM, with the Quality Assurance Director (QA), the QA stated her expectation was that staff review PASRR assessments received from the hospital and ensure it was accurately completed and to complete a new one if needed. During a concurrent interview and record review on May 22, 2025, at 11:42 AM, with the Assistant Director of Nursing 2 (ADON 2), the ADON 2 stated Resident 84 had the diagnosis of schizophrenia upon admission into the skilled nursing facility. The ADON 2 further stated the hospital usually performed the PASRR level I assessment and skilled nursing facility staff were supposed to review it (PASRR Level 1) upon Resident 84's admission to ensure it was accurately completed. The ADON 2 stated if the PASRR was not accurate upon resident admit, the Minimum Data Set Nurse (MDS Nurse) was supposed to create an amendment to the PASRR. The ADON 2 stated the purpose of the PASRR is to ensure it is appropriate for the resident to be placed in a skilled nursing facility. The ADON 2 then reviewed Resident 84's PASRR dated May 20, 2025 (the amended PASRR which now reflected Resident 84 had schizophrenia), and acknowledged the PASRR indicated [NAME] Categorical review. During a concurrent interview and record review on May 22, 2025, at 11:43 AM, with the ADON 2, the facility document titled, Preadmission Screening and Resident Review (PASRR) Level I Screening Assessment Guide, dated October 2024, was reviewed. The document indicated, Level I Screening Corrections. The Level I screening must always reflect the individual's current condition .Submitted Screenings: Cannot be edited .For major demographic and/or clinical errors, such as entering the wrong last name or selecting the wrong option for the clinical questions, the hospital must submit a new Pre-Admission Screening (PAS) and the SNF must submit a new Resident Review (RR) to update the previous screening .Unacceptable PASRR Resolutions and Letters .The following PASRR resolutions are not valid PASRR resolutions and are unacceptable for admission to a Medicaid-Certified SNF: -[NAME] - Categorical Review .Here are explanations for each unacceptable resolution: [NAME] - Categorical Review: The Level 1 Screening was positive for a Categorical condition and is pending review by the Level II Evaluation contractor to confirm the Categorical condition. SNF admission must be deferred until an acceptable resolution is obtained .Reviewing the PASRR: .the admitting facility must accept the case and review the PASRR for the following: 1. Ensure the responses to the PASRR clinical questions were submitted accurately .

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40171 Based on observation, interview, and record review, the facility failed to ensure physical therapy services were provided to one of three residents (Resident 59) sampled for rehabilitative and restorative services when Resident 59 did not receive physical therapy five times a week as ordered by the physician. This failure had the potential to cause a decrease in Resident 59 overall functioning or the inability for Resident 59 to reach his/her highest level of functioning. Findings: During a review of Resident 59's face sheet (contains medical and demographic information), the face sheet indicated Resident 59 was admitted on [DATE], with diagnoses which included polyneuropathy (condition in which multiple nerves are damaged or dysfunctional on both sides of the body, often leading to symptoms like weakness, numbness, and burning pain), generalized osteoarthritis (breakdown of cartilage in multiple joints, leading to pain, stiffness, and decreased joint function), heart failure (the heart not being able to fill with and pump blood), obesity (excess weight), and low back pain. During a concurrent observation and interview on May 19, 2025, at 10:56 AM, Resident 59 was lying in her bed and when asked how she was doing, Resident 59 stated she wanted to leave the facility but couldn't leave until she was able to walk again. Resident 59 further stated she was supposed to receive physical therapy daily but stated she did not receive it (physical therapy) as often as she thinks she was supposed to. During a review of Resident 59's physician's orders, an order dated April 30, 2025, indicated, Physical therapy .PT [physical therapy] eval [evaluation], and treatment. See patient QD [every day] 5 x/wk [five times a week] x 4 wks [for four weeks]. TX [treatment] approved may include .gait training [walking training] . manual PT [physical therapy] .wheelchair mobility and training . During a review of Resident 59's medical record a document titled, PT Evaluation & Plan of Treatment (an initial evaluation by the physical therapy department and an individualized rehabilitative treatment plan) dated April 30, 2025, indicated, frequency 5 times(s)/week 4 weeks, daily . During a review of Resident 59's care plan (individualized plan for the medical care of a resident), a care plan dated April 30, 2025, indicated, encourage mobility/activity as tolerated. Assist with ADL functioning & monitor for decline. During a review of Resident 59's Physical Therapy Treatment Encounter Note(s) (documentation of physical therapy sessions) dated all of May 2025, Resident 59 only received 3 physical therapy sessions for the week of May 14, 2025 to May 21, 2025. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on May 21, 2025, at 9:24 AM, with the Rehab director (RHD), the RHD reviewed Resident 59's clinical record and stated the rehab week starts on the day of the evaluation and treatment plan which for Resident 59 was on Wednesday April 30, 2025. The RHD stated Resident 59 was supposed to receive physical therapy services 5 days a week. The RHD acknowledged Resident 59 did not receive physical therapy 5 days a week for the week of May 14, 2025 to May 21, 2025. The RHD stated Resident 59 was supposed to receive physical therapy on May 16, 2025, but did not because he thought there may have been a scheduling error because Resident 59 was not assigned to a rehab staff for services. The RHD further stated Resident 59 did not receive services on May 20, 2025, because the physical therapy assistant who was assigned to work with Resident 59 called off and there was no documentation that Resident 59 received services on that day either. During an interview on May 22, 2025, at 12:52 PM, with the Assistant Director of Nursing 2 (ADON 2), the ADON 2 stated it was important for Resident 59 to receive therapy services to ensure the resident maintains functional ability and is able to reach their highest functioning level possible. During a review of the facility's policy and procedure (P&P) titled, Physician Orders, dated October 2014, the policy indicated, Policy - It shall be this facility's policy to provide care and services to the resident in accordance with physician orders . During a review of the facility's P&P titled, Care Plan, dated August 22, 2017, the policy indicated, Consistent with the facility's policy of providing appropriate care & services to residents admitted to the facility, the facility shall ensure development of a comprehensive care plan for each resident to meet his/her medical, nursing, and mental and psychosocial needs .5. Services that are to be furnished for resident to attain or maintain the resident's highest practicable physical, mental and psychosocial well being are to be included in the plan of care .

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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** 47098 Based on observation, interview, and record review, the facility failed to follow the physician's orders for heel protector boots for one of seven sampled residents (Resident 64) reviewed for skin integrity when Resident 64 was observed without the ordered heel protectors and was documented to have develop a deep tissue injury (DTI). This failure has the potential to contribute to Resident 64 delayed wound healing (slower recovery of injured skin and tissue), pain (physical discomfort), and further skin breakdown (worsening skin condition leading to open wounds). Findings: During a review Resident 64's Admission Record (contains demographic and medical information) indicated Resident 64 was admitted to the facility on [DATE], with the admitted diagnosis of peripheral vascular disease (poor blood circulation), stiffness of right ankle (limited movement), stiffness of left ankle (limited movement). During an observation on May 19, 2025, at 10:50 AM inside Resident 64's room, Resident 64 was lying down on her back in bed with the head of the bed elevated. A pair of heel protectors was observed place on top of her nightstand. During an interview on May 19, 2025, at 11:25 AM with the Assistant Director, ADON 1, the ADON 1 confirmed that the heel protectors were found on top of the nightstand. The ADON 1 further stated after checking with the wound treatment nurse, Resident 64 should have been wearing the heel protector boots as ordered by the physician. During a review of Resident 64's Physician Orders dated May 12, 2025, indicated, heel protectors when in bed (for skin maintenance). During review of Resident 64's Braden Scale (a standardized clinical tool used to assess a resident's risk for developing pressure injuries or bedsores), dated February 20, 2025. The Braden assessment indicated a total score of 12. (Braden Scoring a total score of 12 or less = high, 13-14=Moderate risk; 15-16 = low risk. The Braden Scale indicates six areas: sensory perception (how well the resident feels discomfort or pain), moisture (How often the skin is wet) activity (how much the resident moves), mobility (How well the resident can change positions), nutrition (how well the resident eats), and friction / Shear (how much the skin rubs or slides when moving.) A high score (the resident requires specific interventions to protect skin integrity and prevent development of wounds). During a review of Resident 64's care plan titled, Pressure Ulcer / Skin Integrity dated November 22, 2024, the care plan indicated, .related to manifested by pressure ulcers/ skin breakdown, delayed/poor wound healing related to: impaired mobility, impaired condition urinary incontinence, chairfast/bedfast most of the time, impaired cognition .goals Maintain intact skin integrity ., interventions, Assist in turning and repositioning, Use pressure reducing devise such as gel cushion . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a second observation on May 21, 2025, at 5:35 AM, Resident 64 was lying on bed on her back with the head of the bed elevated. On top of her bedside table, a pair of purple heel protectors were resting alongside a stack of folded blue disposable under pads and linens. The heel protectors were visibly place aside on the table and not applied to Resident 64's heels as ordered by the physician. During an interview on May 21, 2025, at 5:45 AM with Certified Nursing Assistant 4 (CNA 4), the CNA 4 stated that when she started her shift at 10:00 PM in May 2025, the heel protectors were already place on the bedside table. The CNA 4 confirmed that the heel protectors remained there through her shift and that she did not notify the nurse. The CNA 4 further stated that she chose not to apply the protectors because Resident 64 did not have a dressing on her left ankle. During an interview on May 21, 2025, at 5:50 AM with License Vocational Nurse 4, (LVN 4), LVN 4 stated that it was her first time working with Resident 64 and that she had not assessed Resident 64's skin during her shift. LVN 4 admitted she missed that step due to being unfamiliar with Resident 64. The LVN 4 further stated that her last rounding was at 5:00 AM, and she did not notice that the heel protectors were not being worn. During a review of Resident 64's nursing documents titled, License Progress Notes, dated May 21, 2025, at 7:15 AM, the license progress notes indicated, Noted resident left lateral ankle-deep tissue injury (DTI) with open area measuring 3.1 cm x 2 cm, with redness, purplish red discoloration, irregular surrounding skin and dark skin center . During a concurrent interview and record review on May 22, 2025, at 3:08 PM, the facility's policy and procedure (P&P) titled, Physician Orders, dated October 2014, was reviewed. The P&P indicated, It shall be this facility's policy to provide care and services to the resident in accordance with physician orders. Procedure. 1. All aspect of resident's care, including but not limited to the following shall only be provided if ordered by the physician .treatments . The ADON 1 acknowledged and confirmed that the staff should have followed the policy, but they did not.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50631 Based on interview, and record review, the facility did not ensure physician's visits were conducted or physician's orders were signed in a timely manner when: 1. Two of eight sampled residents (Residents 19 and 22) were missing required physician's visits for their Medicare Part A&B (Government hospital insurance and medical insurance) stay. This failure had the potential to result in transcription errors for Resident 19 and 22. 2. Four of eight sampled residents (Resident 14, 44, 56, and 43) had unsigned physician's orders in their chart. This failure had the potential to result in medical errors, and increased risk to resident's safety for Resident 14, 44, 56, and 43. Findings: 1. A review of Resident 19's face sheet (demographic information) indicates Resident 19 is an [AGE] year-old female, admitted from the hospital on March 12, 2025, with diagnoses which include arthritis (redness, painful, swollen joint), atrial fibrillation (irregular rhythm that disrupts the normal flow of blood through the heart), hyperlipidemia (having too much fat in the blood), dementia (group of conditions that cause a progressive decline in cognitive abilities, such as memory, thinking, reasoning, and judgment), nutritional deficiency (occurs when someone doesn't get enough of the essential nutrients their body needs to function properly, like vitamins, minerals, or protein), fracture of left femur (a break in the femur, the largest and strongest bone in the human body). Resident 19 was admitted to the facility under a short term stay with Medicare coverage part A&B. During a review on May 20, 2025, of Resident 19's medical chart, it was noted that all physician's orders since Resident 19 admission on March 12, 2025, are red flagged for physician's signature. A record review of Resident 19's physician's orders (written instructions from a doctor outlining what should be done for a Resident 19 care and treatment) indicates the physician's orders were received via phone and there are no physician's signatures for the months of March 2025, April 2025, and May 2025 physician orders. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 22's face sheet (demographic information) indicates the resident is a [AGE] year-old female, admitted from the hospital on April 8th, 2025, with diagnoses which include end stage renal disease (the final, permanent stage of chronic kidney disease, where kidney function has declined to the point that the kidneys can no longer function on their own), diabetes mellitus (high blood sugars), morbid obesity (a complex chronic disease in which you have a body mass index (BMI) of 40 or higher), dependence on renal dialysis (Dialysis acts as a substitute for the kidneys, filtering the blood and removing waste products), hypertension (high blood pressure), muscle weakness, major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy), history of falling. Resident 22 was admitted to the facility under a short term stay with Medicare coverage part A&B. During a review on May 20, 2025, of Resident 22's medical chart, it was noted that all physician's orders since Resident 22 admission on April 8th, 2025, are red flagged for physician's signature. A record review of Resident 22's physician's orders indicates the physician's orders were received via phone and there are no physician signatures for the months of April 2025 and May 2025 physician's orders. In an interview with the Assistant Director of Nursing 1 (ADON 1) on May 22, 2025, at 12:10 PM, the ADON 1 acknowledged that in a skilled nursing facility the first physician visit (this includes the initial comprehensive visit) must be conducted within the first 30 days after admission, and then at 30-day intervals up until 90 days after the admitted . The ADON 1 stated that the facility notified the physician several times via fax of the overdue visit. During a concurrent interview and record review on May 22, 2025, at 12:18 PM with the ADON 1, the facility's Policy and Procedure (P&P) titled, Physician Visits, dated August 22, 2017, was reviewed. The P&P states, 1. The attending physician will visit residents in a timely fashion, consistent with applicable State and Federal requirements . 2. The attending physician must visit his/her patients within 72 hours of admission, at least once every 30 days for the first 90 days following the resident's admission, and then at least every 60 days thereafter . 6. a physician visit is considered timely if it occurs no later than 10 days after the date the visit was required . The ADON 1 stated that the physicians were reminded by fax that their visits are overdue on several occasions. The ADON 1 stated the physicians responded to facility phone calls, provided verbal orders, and visited the facility during this timeframe and does not know as of why the documentation is not completed and orders are not signed. The ADON 1 recognized that as of May 22, 2025, all physician Orders for Residents 19 and 22 are not signed and dated by the physicians. ADON 1 acknowledged that the facility's P&P was not followed. 51099 2. During a record review on May 20, 2025, at 9:15 AM, Resident 14's medical chart was reviewed. The physician order dated March 31, 2025, indicated, .D/C [discontinue] Benadryl [a medication used for allergies]. Alprazolam [a medication used for anxiety] 0.5 MG [milligram- a unit of measurement] tab [tablet] PO [by mouth] BID [twice a day] PRN [as needed] x [times] 30 days; Dx anxiety m/b [manifested by] inability to relax. Continue all monitors . The order was not signed by the physician. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review on May 20, 2025, at 9:23 AM, Resident 44's medical chart was reviewed. The physician order dated February 2, 2025, indicated, .0.1 MG Clonidine [a medication used for blood pressure] PO Q 6 H [hours] PRN for SBP [systolic blood pressure] > [greater than] 160. Monitor for BP [blood pressure] Q 6 H for PRN Clonidine use . The physician order dated February 27, 2025, indicated, .Rebels [a medication for high blood sugar] 7 MG tab PO QD [every day] AC [before] Breakfast; Dx [diagnoses]; DM . The orders were not signed by the physician. During a record review on May 20, 2025, at 9:30 AM, Resident 56's medical chart was reviewed. The physician order dated March 20, 2025, indicated, .Discontinue D 5 NS [dextrose in normal saline- a type of fluid given through the veins of the resident]; discontinue norepinephrine [a medication that helps regulates heart rate, blood pressure, attention, memory, and emotion]; discontinue dilaudid [a pain medication]; discontinue morphine [a pain medication] . The physician order dated April 8, 2025, indicated, .Flagyl [an antibiotics] 500 MG PO TID [three times a day] x 10 days; Dx: C-diff [an infection of the gut] . The orders were not signed by the physician. During a record review on May 20, 2025, at 9:39 AM, Resident 43's medical chart was reviewed. The physician order dated April 14, 2025, indicated, .D/C contact isolation precautions . The order was not signed by the physician. During a concurrent interview and record review on May 20, 2025, at 11:50 AM, with the Assistant Director of Nursing (ADON), the facility's policy and procedure (P&P) titled, Telephone Orders, revised 2017, was reviewed. The P&P indicated, .Telephone orders must be countersigned by the physician during his or her next visit . The ADON stated facility did not follow the P&P.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50631 Based on observation, interview, and record review, the facility failed to ensure the attending physician conducted an initial comprehensive visit within the first 30 days after admission, for two sampled residents under a Medicare Part A&B stay (Resident 19 and 22). This failure has the potential to place Residents 19 and 22 at risk for serious harm or death. Findings: 1. A review of Resident 19's face sheet (demographic information) indicates Resident 19 is an [AGE] year-old female, admitted from the hospital on March 12, 2025, with diagnoses which include arthritis (redness, painful, swollen joint), atrial fibrillation (irregular rhythm that disrupts the normal flow of blood through the heart), hyperlipidemia (having too much fat in the blood), dementia (group of conditions that cause a progressive decline in cognitive abilities, such as memory, thinking, reasoning, and judgment), nutritional deficiency (occurs when someone doesn't get enough of the essential nutrients their body needs to function properly, like vitamins, minerals, or protein), fracture of left femur (a break in the femur, the largest and strongest bone in the human body). Resident 19 was admitted to the facility under a short term stay with Medicare coverage part A&B. During a concurrent observation and record review on May 20, 2025, Resident 19 chart was noted to have a blank History and Physical (H&P) [a comprehensive assessment where a healthcare provider gathers information about a patient's health history and performs a physical examination] page. As of May 20, 2025, the H&P was not completed by the physician and was red flagged for his/her attention. 2. A review of Resident 22's face sheet (demographic information) indicates Resident 22 is a [AGE] year-old female, admitted from the hospital on April 8th, 2025, with diagnoses which include end stage renal disease (the final, permanent stage of chronic kidney disease, where kidney function has declined to the point that the kidneys can no longer function on their own), diabetes mellitus (a disease where the body has trouble regulating blood sugar levels, either because it doesn't produce enough insulin, or the body can't properly use the insulin it does produce), morbid obesity (a complex chronic disease in which you have a body mass index (BMI) of 40 or higher), dependence on renal dialysis (Dialysis acts as a substitute for the kidneys, filtering the blood and removing waste products), hypertension (high blood pressure), muscle weakness, major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy), history of falling. Resident 22 was admitted to the facility under a short term stay with Medicare coverage part A&B. During a concurrent observation and record review on May 20, 2025, Resident 22's chart was noted to have a blank History and Physical (H&P) [a comprehensive assessment where a healthcare provider gathers information about a patient's health history and performs a physical examination] page. As of May 20, 2025, the H&P was not completed by the physician and was red flagged for his/her attention. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Assistant Director of Nurses 1 (ADON 1) on May 22, 2025, at 12:10 PM, the ADON 1 acknowledged that in a skilled nursing facility the first physician visit (this includes the initial comprehensive visit) must be conducted within the first 30 days after admission, and then at 30-day intervals up until 90 days after the admitted . The ADON 1 stated that the facility notified the physician several times via fax of the overdue visit. During a concurrent interview and record review on May 22, 2025, at 12:18 PM with the ADON 1, the facility's Policy and Procedure (P&P) titled, Physician Visits dated August 22, 2017, was reviewed. The P&P states, 1). The attending physician will visit residents in a timely fashion, consistent with applicable State and Federal requirements . 2). The attending physician must visit his/her patients within 72 hours of admission, at least once every 30 days for the first 90 days following the resident's admission, and then at least every 60 days thereafter . 6) a physician visit is considered timely if it occurs no later than 10 days after the date the visit was required . The ADON 1 stated that the physicians were reminded by fax that their visits are overdue on several occasions. The ADON 1 stated the physicians responded to facility phone calls, provided verbal orders, and visited the facility during this timeframe and does not know as of why the documentation is not completed and orders are not signed. The ADON 1 recognized that as of May 22, 2025, Resident 19 and 22 History and Physical Examinations are not completed, not signed, and not dated by the Physician. The ADON 1 acknowledged that the facility's P&P was not followed.

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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. 51099 Based on observation, interview, and record review, the facility did not ensure staff signed the narcotic reconciliation log when discrepancies were found in two of four narcotic reconciliation logbooks. This failure had the potential to result in improper administration of medication and dosage, increasing risk of adverse drug reactions, and possible harm to 106 vulnerable patients. Findings: During a concurrent observation and interview with Registered Nurse Supervisor 3 (RNS 3), on May 21, 2025, at 5:07 AM, in the hallway, the narcotic reconciliation logbook in station 4 was inspected. The dates: March 7, 18, 19, 26; April 13, 17, 24; May 14, 20, 21, 2025 were missing signatures. RNS 3 confirmed the dates were missing signatures. During a concurrent observation and interview with Licensed Vocational Nurse 5 (LVN 5), on May 21, 2025, at 1:04 PM, in the hallway, the narcotic reconciliation logbook in station 1 was inspected. The dates: March 9, 10, 11, 12, 16, 22, 25, 26, 29; May 19, 20, 21, 2025 were missing signatures. LVN 5 confirmed the dates were missing signatures. During a concurrent interview and record review on May 21, 2025, at 1:10 PM, with the Assistant Director of Nursing (ADON), the facility's policy and procedure (P&P) titled, Controlled Drug Reconciliation, revised 2020, was reviewed. The P&P indicated, .At the completion of each nursing shift, the on-coming and off-going nurses will count and reconcile controlled drugs subject to regulations and/or facility policies for individual counts . The ADON stated the facility staff should have followed the P&P.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50631 Based on observation, interview, and record review, the facility failed to ensure secure storage of medications when: 1. One Medication Storage room and one Medication Refrigerator located at Nursing station 4 was found unlocked, and 2. One medication refrigerator located at Nursing station 1 was found unlocked. This failure has the potential for medications to be accessed and dispersed by an unauthorized person, in a vulnerable population of 103 residents. Findings: 1. During a concurrent observation and interview on May 19, 2025, at 8:44 AM, the Medication Storage room located at the Nursing station 4 was accessed without a key by Licensed Vocational Nurse 1 (LVN 1). Inside the Medication Storage room, the Medication Refrigerator displays lock latches in place and no padlock. The unlocked medication refrigerator contains vials of injectable Ativan (a medication used to treat anxiety) and Haldol (a medication used to treat mental disorders), several Insulin (a medication used to treat high blood sugar) pens, and one Emergency Kit. The LVN 1 stated that he started working at the facility at the end of April 2025, and that the medication room and the medication refrigerator are always unlocked. The LVN 1 added that he never noticed a padlock on the medication refrigerator, and he has no key to the Medication Storage Room and has no key to the medication refrigerator. During a secondary observation on May 19, 2025, at 12:12 PM, the Medication Storage room and the Medication refrigerator at Nursing station 4 were rechecked in the presence of the Assistant Director of Nursing 1 (ADON 1). The ADON 1 opened the Medication Storage room without using a key and found the medication refrigerator still unlocked. The ADON 1 stated that the facility's policies require all medication storage areas and the medication refrigerator to be locked at all times and accessible by licensed nurses only. The ADON 1 called the RN Supervisor 1 (RNS 1). The supervisor confirmed that the medication room should be locked and accessible by key and the medication refrigerator should be locked with a padlock. 2. During a concurrent observation and interview on May 19, 2025, at 12:21 PM, the second Medication Storage room located at the Nursing station 1 was inspected. The ADON 1 unlocked the door using a key. Inside this Medication Storage room, the Medication Refrigerator was unlocked. The medication refrigerator contains resident's medications that need to be refrigerated. The ADON 1 acknowledged this is a security problem with the medication storage areas, stating that many new nurses received online training during COVID (a lung disease caused by a virus). The RNS 1 suggested staff retraining and refresher courses regarding medication storage safety and enforcement of consequences for staff who fail to follow medication security protocols. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on May 21, 2025, at 3:18 PM with the ADON 1, the facility's Policy and Procedure (P&P) titled, Storage of Medications dated August 22, 2017, was reviewed. The P&P indicated, 1). Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications .6). Compartments (including, but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use . 7). Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secure location . The ADON 1 stated the facility's P&P was not followed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47098 Based on observation, interview, and record review, the facility failed to maintain food safety practices in the kitchen as required by facility's policy and procedure (P&P). The facility did not ensure food preparation areas, equipment, and storage were kept clean, labeled, and safe and failed to prevent cross-contamination, improper thawing and unsanitary conditions when: 1. One kitchen staff was not wearing a hairnet in the food prep area. 2. The juice machine nuzzle, and black rubber ring had dark grime, old stains, and residue. 3. Six red colored drink pitchers were left on a counter without date labels. 4. A large blue plastic container labeled ICE ONLY was found uncovered and filled with ice on a metal prep table. 5. Two dented cans (6 lbs.) of pears in light syrup were found in the kitchen ready to use. 6. About 20 packages of raw meat were thawing in stacked plastic container under running water in the sanitizing compartment of the three-compartment sink; the meat was not labeled with thawing dates and temperature measured 62.4 F. 7. Four trays of uncovered deserts bowls were found in the refrigerator. 8. Two ovens had heavy grease, burnt food particles, and dark residue of interior walls racks and the oven floor; two loose screws were also found inside the bottom of one of the non-working ovens. The ovens contained heavy greasy, burnt food particles, dark residue on the interior walls, and debris on the oven floor. 9. The stove burners were covered in thick black greased and crumbled food debris 10. The flat top griddle had layers of grease stains and dark discoloration with a dirty spatula resting on its edged. 11. Personal beverages and food items belonging to staff were stored inside the refrigerator designated for resident food. These failures have the potential to result in foodborne illness(caused by eating food or drinking water contaminated with harmful germs such as bacteria, parasites, or viruses) for 100 of 103 residents who rely on the kitchen for their meals and beverages. Findings: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. During a concurrent observation and interview on May 19, 2025, at 8:32 AM with the Dietary Aid 1 (DA 1), the DA 1 was working inside the kitchen food preparation area without wearing a hairnet. DA 1 acknowledged the requirement and stated Yes, I will put one on. During a concurrent interview and record review on May 19, 2025, at 8:42 AM with the Dietary Supervisor (DSS)the facility's policy and procedure (P&P) titled Food Preparation and Service, dated August 22, 2017, was reviewed. The P&P indicated, Food and nutrition services staff swear hair restraints (hair net, hat beard restrain, etc.) so that hair does not contact food. The DSS stated that it was the facility's expectation for staff to wear proper hairnets while working inside the kitchen areas and that the staff did not follow the P&P. 2. During a concurrent observation and interview on May 19, 2025, at 8:35 AM with DA 1, during a juice machine inspection, the juice machine was observed with a juice nozzle and surrounding black rubber ring. It was observed to be visible dirty and stained and covered with old residue and grime buildup. The clear plastic dispenser handle had yellow and red residue trapped inside and appeared discolored. The DA 1 acknowledged the condition and stated the equipment should be clean. During a concurrent interview and record review on May 22, 2025, at 8:35 AM with the Dietary Supervisor (DSS) the facility's policy and procedure (P&P) titled, Sanitation, dated August 22, 2017, was reviewed. The P&P indicated, All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions. The DSS stated that the expectation was for staff to clean and sanitize the juice machine regularly as part of daily cleaning routines and confirmed that the policy was not followed by staff. 3. During an concurrent observation and interview on May 19, 2025, at 8:36 AM with Dietary Aid 1 (DA 1), six drink pitchers were observed on a metal preparation table filled with dark red liquid. The pitchers were unlabeled with the date indicating when they were prepared. The DA 1 confirmed the six pitchers should have been labeled with the preparation date, to track when they were prepared. During a concurrent interview and record review on May 22, 2025, at 8:44 AM with the Dietary Services supervisor (DSS), the facility's policy and procedure (P&P) titled, Food Receiving and Storage, dated Revised January 2020 was reviewed. The P&P indicated, 8. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). The DSS stated that the expectation for staff was to label the drink pitchers with the preparation date. The DSS confirmed that the P&P was not follow by the staff. 4. During a concurrent observation and interview on May 19, 2025, at 8:37 AM with Dietary Supervisor Assistant 1(DSSA 1), a large blue plastic container labeled ICE ONLY was observed uncovered and filled with ice on top of a metal preparation table. The container was open to the air and left uncovered. DSSA 1 confirmed the ice container should have been covered and not left open to air. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on May 22, 2025, at 8:46 AM with the Dietary Services Supervisor (DSS) the facility's policy and procedure (P&P) titled, Food Preparation and services, dated August 2017, was reviewed. The P&P indicated, 5. Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of food bone illness. The DSS stated that ice is considered food and confirmed that the ice container should be covered when not in use to protect it from contamination. The DSS acknowledged that the P&P was not followed by staff. 5. During a concurrent observation and interview on May 19, 2025, at 8:39 AM with Dietary Aide 1 (DA 1), two dented 6 - lbs. (six, pounds measure of weight) were found on the bottom area of a metal car in the kitchen's ready to use section. The DA 1 confirmed that dented cans should not be used and acknowledged they were incorrectly placed in the ready to use section. During a concurrent interview wand record review on May 22, 2025, at 8:51 AM with Dietary Services Supervisor (DSS), the facility's policy and procedure (P&P) titled, Food Receiving and Storage. Dated Revised January 2020 was reviewed. The P&P indicated, Food that are prepared off site will only be accepted from institutions that are subject to federal, state or local inspection. The food and nutrition services manager shall verify the latest approved inspection and also monitor food quality of the supplier. The DSS stated that dented cans should be removed and discarded. The DSS acknowledged that the policy was not follow by staff. 6. During a concurrent observation and interview on May 19, 2025, at 8:40 AM with Dietary services Supervisor 1 (DSSA 1) approximately 20 packages of raw meat were observed thawing inside two stacked clear plastic containers under running water in the sanitize compartment off the three-compartment sink. DSSA 1 confirmed the packages were unlabeled and acknowledged that the facility did not maintain a thawing log. During a follow up observation and interview on May 19, 2025, at 9:38 AM with [NAME] 1 and DSSA 1, meat temperature was measured the temperature of the raw meat was found at 62.4 F and the [NAME] 1 stated that the meat had been thawing since 6:00 AM. [NAME] 1 further stated the meat would need to be discarded because the temperature exceeded the safe limit (above 41 F) increasing the risk of foodborne illness. DSSA 1 confirmed the meat should be kept at or below 41 F to remain safe. During an interview on May 19, 2025, at 4:46 PM with the Registered Dietitian (RD), the RD stated the facility standard procedure is to thaw meat in the refrigerator over approximately three days and that using the running water method is only acceptable if done correctly and for less than two hours. The RD confirmed the observed practice of thawing meat in the sanitize sink under running water was not the preferred method and acknowledged that no thawing log was maintained. The RD further stated that the staff education is needed to ensure proper thawing methods. During a concurrent interview and record review on May 22, 2025, at 8:55 AM with the Dietary Services Supervisor (DSS), the facility's policy and procedure (P&P) titled, Food Preparation and Service, dated August 22, 2017, was reviewed. The P&P indicted, Thawing Frozen Food, 1. Foods will not be thawed at room temperature. Thawing procedures include a. Thawing the refrigerator in a drip-proof container; b. completely submerging the item in cold running water (70 F or below) that is running fast enough to agitate and remove loose ice particles . The DSS stated the expectation was for staff to follow the proper thawing procedures, explaining that correct thawing is important to avoid foodborne hazards, and confirmed that the policy was not follow by staff. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. During a concurrent observation and interview on May 19, 2025, at 8:54 AM with Dietary Services Supervisor Assistant 1 (DSSA 1) the walking refrigerator was inspected and there were four trays with bowls of uncovered resident desserts were observed stored inside the refrigerator. The trays were not covered, leaving the food exposed to the air. DSSA 1 acknowledged that the desserts should have been covered to prevent contamination. During a concurrent interview and record review on May 22, 2025, at 8:56 AM with the Dietary Services supervisor (DSS), the facility's policy and procedure (P&P) titled, Food Receiving and Storage, dated Revised January 2020, was reviewed. The P&P indicated, 8. All foods stored in the refrigerator or freezer will be covered . The DSS stated all foods should be covered while inside the refrigerator. The DSS confirmed the P&P was not follow by the staff. 8. During a concurrent observation and interview on May 19, 2025, at 9:05 AM with Dietary Supervisor Assistant 1 (DSSA 1), two out of five ovens were inspected inside the kitchen. Oven 2 was observed with heavy grease and burned food suck on the inside walls and racks and floor pan. Rust was noted on the oven racks, and no signs of recent cleaning or sanitization were evident. The DSSA 1 confirmed that the oven should have been cleaned regularly even if not in use. During a concurrent observation and interview on May 19, 2025, at 9:06 AM with Dietary Supervisor Assistant 1(DSSA 1). Oven 3 was inspected inside the kitchen. The oven was visibly dirty with thick layers of burnt food particles, dark grease stains, and heavy discoloration across the interior surfaces, including the walls, racks, and bottom pan. Two loose screws were noted inside the oven bottom. DSSA 1 stated although the oven was reported as out of order, it should still have been cleaned by staff. During a concurrent interview and record review on May 22, 2025, at 9:08 AM with the Dietary Services Supervisor (DSS), the facility's policy and procedure (P&P) titled, Sanitation, dated August 17, 2017, was reviewed. The P&P indicated, 2. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair shall be free from breaks, corrosion, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fastener will be kept in good repair .17. The food services manage will be responsible for scheduling staff for regular cleaning of kitchen and dining areas. Food service staff will be trained to maintain cleanliness thought their work areas during all tasks, and to clean after task before proceeding to the next assignment. The DSS stated that staff are expected to follow the sanitation policy, ensuring all equipment including nonfunctional ovens, is kept clean. The DSS acknowledged that the P&P was not followed by the staff. 9. During a concurrent observation and interview on May 19, 2025, at 9:07 AM with Dietary Supervisor Assistant 1(DSSA 1), the kitchen stove burners were inspected and found with a thick layer of blackened grease, burned food residue, and crumbled food debris across the top surface and burners. DSSA 1 stated the stove should have been regularly cleaned and confirmed that the equipment was not found in a clean condition. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on May 22, 2025 , at 9:09 AM with the Dietary Services Supervisor (DSS), the facility policy and procedure (P&P) titled, Sanitization dated August 17, 2017, was reviewed. The P&P indicated, 2. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair shall be free from breaks, corrosion, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fastener will be kept in good repair .17. The food services manage will be responsible for scheduling staff for regular cleaning of kitchen and dining areas. Food service staff will be trained to maintain cleanliness thought their work areas during all tasks, and to clean after task before proceeding to the next assignment. The DSS acknowledged the P&P was not followed by staff. 10. During a concurrent observation and interview on May 19, 2025, at 9:12 AM with Dietary Supervisor Assistant 1 (DSSA 1) the flat top griddle inside the kitchen was inspected and found with thick layers of dark grease stains, burnt food residues, and heavy discoloration across the surface. A dirty spatula was resting on the edge of the griddle. DSSA 1 stated that the griddle should have been cleaned regularly after each use and confirmed that it was found unclean. During a concurrent interview and record review on May 22, 2025, at 9:12 AM with the Dietary Services Supervisor (DSS), the facility's policy and procedure (P&P) titled, Sanitization, dated August 17, 2017, was reviewed. The P&P indicated, 2. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair shall be free from breaks, corrosion, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fastener will be kept in good repair The DSS stated that staff are expected to clean the griddle regularly, have cleaning logs and deep cleaning rotations, and acknowledged the staff did not follow the P&P. 11. During a concurrent observation and interview won May 19, 2025, at 9:14 AM with the with Dietary supervisor assistant (DSSA 1), personal food and beverage items were found stored inside the refrigerator designated for residents' food. These included three opened bottles of water, two canned drinks, multiple condiments cups containing left over food, and a grocery store plastic bag (labeled with name of an employee). DSSA 1 confirmed that staff are not allowed to store their personal items in the resident designated refrigerator and acknowledged the refrigerator should be kept free of non-resident items to avoid cross contamination. During an concurrent interview and record review on May 22, 2025, at 9:18 AM with the Dietary Services Supervisor (DSS), the facility's policy and procedure (P&P) titled, Food Receiving and Storage, revised January 2020, was reviewed. The P&P indicated, 14 d. Beverages must be dated, when opened and discarded after twenty-four (24) hours .f. Partially eaten food may not be kept in the refrigerator. The DSS stated the staff should not place personal items in the resident designated refrigerator to avoid cross - contamination and confirmed that the P&P was not follow by staff.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 51361 Based on interview, and record review, the facility failed to ensure quarterly (every 3 months) Payroll Based Journal (PBJ) Staffing Data (data combining census and staffing information) report required by Centers of Medicare and Medicaid Services (CMS), was transmitted (submitted) to CMS in accordance with federal submissions timeframes, for quarter 2 (January 1 through March 31 of 2024. This failure resulted in inadequate monitoring of staffing information to be transmitted to CMS. Findings: During a record review of the PBJ Staffing data report for quarter 2 of 2024 for January 1 through March 31, 2024, no PBJ data was submitted (due May 15, 2024). On May 22 at 2:00 PM a policy and procedure (P&P) was requested from the facility, the Director of Nursing (DON) stated I don't have one. During a phone interview on May 22, 2025 at 2:21 PM with the Administration resource, the Administration Resource stated one of her roles was ensuring the PBJ Staffing Data report is submitted on a timely basis. The Administration Resource verified and stated quarter 2 of 2024 was not submitted. The Administration Resource stated timely submission of the PBJ Data is important to ensure staffing is adequate and as needed for patient care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40171 Based on observation, interview, and record review, the facility failed to ensure it followed its infection control program when: 1. A Registered nurse Supervisor 3 (RNS 3) did not perform hand hygiene (hand washing or the use of alcohol based hand sanitizer) after performing a blood glucose check (procedure done to check the level of sugar in the blood and requires a pinprick blood sample). This failure had the potential for the spread of infectious blood borne pathogens (bacteria and viruses which can cause disease and illness) and the spread of infectious microorganisms from one patient to another in a vulnerable population of 106 patients. 2. There was a bag of intravenous antibiotics (antibiotics administered into the veins) and IV tubing set (disposable IV set used to administer medication intravenously) dated [DATE] and [DATE], left at Patient 33 bedside on [DATE] (23 days after it was used). This failure had the potential for inadvertent use of an expired IV tubing set or antibiotic bag which was past its expiration date placing the resident at increased risk of infection. Findings: 1. During an observation on [DATE], at 5:37 AM, with Registered Nurse Supervisor 3 (RNS 3), RNS 3 used a lancet (a device used to pinprick a finger and create a drop of blood) to test Resident 69's blood sugar (amount of sugar in the blood). After RNS 3 obtained a blood sample from Resident 69 and tested the resident's blood sugar, RNS 3 took off his gloves and began documenting in the Medication Administration Record (a document used to record the administration of medications). During continued observation on [DATE], at 5:51 AM, with RNS 3, RNS 3 completed medication administration for Resident 69 and began preparing the medications for administration to his next resident. RNS 3 still had not performed hand hygiene after performing a blood glucose test on Resident 69. During an interview on [DATE], at 5:56 AM, with RNS 3, RNS 3 stated he didn't perform hand hygiene after removing the gloves he used to check Resident 69's blood sugar because he forgot. RNS 3 further stated he was supposed to use hand sanitizer immediately after removing his gloves and prior to preparing another patients medications but he didn't. RNS 3 stated the Licensed Vocational Nurse who was supposed to work the current shift had called off and that was why he had to administer medications. The RNS 3 stated it had been a while since he had to administer medications. During an interview on [DATE], at 8:37 AM, with the Infection Preventionist (IP), the IP stated staff were supposed to perform hand hygiene immediately after removing their gloves. The IP further stated staff should also be doing hand hygiene before and after performing a blood glucose check on a resident. The IP stated it was important to perform hand hygiene to help prevent the spread of infectious microorganisms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE], at 11:51 AM, with the Assistant Director of Nursing 2 (ADON 2), the ADON 2 stated staff should be performing hand hygiene after removing gloves and after using a glucometer (device used to check blood sugar) because it was important to prevent cross contamination (the spread of micro-organisms from one person or object to another) between patients for infection control. During a review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, dated [DATE], the P&P indicated, This facility considers hand hygiene the primary means to prevent the spread of infections .2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors .Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicobial) and water for the following situations: b. Before and after direct contact with residents; c. Before preparing or handling medications; d. Before and after handling an invasive device .l. After removing gloves .8. Hand hygiene is the final step after removing and disposing of personal protective equipment [i.e. gloves] . 51361 2. During a review of Resident 33's clinical record, the Admission Record (a document that gives a summary of residents information) indicated Resident 33 was admitted to the facility on [DATE] with the diagnoses of Cellulitis (a kin infection that causes swelling and redness), Acute Respiratory Failure with Hypoxia, Essential Hypertension (high blood pressure) and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During an observation on [DATE] at 10:23 AM, Resident 33 was found to have two intravenous (IV) pole was found next to Resident 33 bed with two empty IV medication bags with tubing, labeled Ceftriaxone (medication used to treat infection) 2 gm into 100 ML of Normal Saline with attached tubing dated [DATE], (32 days later) and the second labeled Ceftriaxone (medication used to treat infection) 2 gm into 100 ML of Normal Saline with tubing labeled with an expiration date of [DATE] (31 days). During a concurrent observation and interview on [DATE] at 4:06 PM, with the Director of Nursing (DON), the DON confirmed that the medication bags were dated [DATE] and [DATE] and further stated that the medication bag should have been removed following the administration completion. During a concurrent interview and record review on [DATE] at 1:08 PM with the DON, the facility's policy and procedure (P&P) titled, Infection Control Universal Precautions was reviewed. The P&P indicated .All personnel involved with administering IV therapy will comply with universal precaution guidelines on all patients during any and all IV therapy procedures. The DON confirmed the P&P was not followed.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47098 Based on observation, interview, and record review, the facility failed to maintain essential kitchen equipment in safety operating condition when: 1. Two ovens located in the kitchen were observed to be non-functional not in use, yet they remained accessible and unmarked as out of order. This failure has the potential to result in limited cooking capacity, delays, and disruption in the kitchen's ability to deliver timely meals and maintain appropriate sanitation. Findings: During a concurrent observation and interview on May 19, 2025, at 9:06 AM with the Dietary Services Supervisor Assistant 1 (DSSA 1) inside the kitchen, during and inspection two of five ovens were to be visible nonfunctional. The second oven (Oven 2) had heavy blackened residue, grease build up, burned on grease and buildup from old food spills, along with rust on the interior walls, racks and bottom tray. The oven was grimy and clearly nonoperational, with no signage or markings indicating it was out of order. DSSA 1 stated the oven should be cleaned and kept in working condition and further confirmed that oven had been out of order for some time and, although maintenance had been notified, no repairs had been completed. During a concurrent observation and interview on May 19, 2025, at 9:10 AM with the DSSA 1, a third oven (Oven 3) was inspected and found to be nonfunctional and contained two loose screws on their interior bottom surface. DSSA 1 confirmed that Oven 3 was also out of order and had been reported to maintenance but was not labeled or marked as out of service. DSSA 1 acknowledged that even nonworking equipment should have been kept clean. During a concurrent interview and record review on May 21, 2025, at 9:21 AM with the Dietary Services Supervisor (DSS), the facility's policy and procedure (P&P) titled, Sanitation, dated August 22, 2017, was reviewed. The P&P indicated, 2. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners will be kept in good repair .16, Kitchen and .surfaces not in contact with food shall be cleaned on a regular scheduled and frequently enough to prevent accumulation of grime. The DSS stated that the two nonfunctional ovens (Oven 2 and Oven 3) had been out of order since February 2025 (approximately 1.5 to 2 months) and that maintenance had been notified. The DSS acknowledged that the equipment should have been labeled as out of order and kept clean even when not in use. The DSS further confirmed that although maintenance had been contacted and follow up was expected, no repairs had yet been made. The DSS also stated that staff are expected to clean equipment daily, including items like grills and top burners, even if the equipment is not currently operational The DSS explained that the pilot lights on the ovens would not stay lit, and [NAME] ovens were not currently in use, the staff had not followed the facility's sanitation P&P.