STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555260	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bakersfield Post Acute	6212 Tudor Way Bakersfield, CA 93306

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure call lights were answered in a timely manner for four of 53 sampled residents (Resident 107, Resident 76, Resident 14, and Resident 85). This failure had the potential for residents not being assisted with their activities of daily living and have a delay in care. Findings:During an interview on [DATE] at 8:49 a.m. with Resident 107, Resident 107 stated call light was not answered timely. Resident 107 stated, That's [waiting for a long time for call light to be answered] punishment I don't deserve.During a review of Resident 107's Nursing - Admission/readmission Evaluation/Assessment (NAREA), dated [DATE], the NAREA indicated, Resident 107 was alert and oriented.During a review of Resident 107's Care Plan Report (CPR), dated [DATE], the CPR indicated under Interventions/Tasks, Transfer: Assist of (substantial) (Resident 107 requires substantial assistance with activities of daily living).During an interview on [DATE] at 8:50 a.m. with Resident 76, Resident 76 stated, Takes [staff] long to answer call light.During a review of Resident 76's Brief Interview For Mental Status (BIMS-cognitive screening), dated [DATE], BIMS indicated Resident 76 had a score of 15 (score of 13-15 means cognitively intact). Resident 76 Functional Abilities (FA), dated [DATE], the FA indicated Resident 76 was dependent with activities of daily living.During an interview on [DATE] at 10:01 a.m. with Resident 85, Resident 85 stated, I waited over an hour for a pain pill, because they took tool long to answer the call light.During a review of Resident 85's BIMS dated [DATE], BIMS indicated Resident 85 had a score of 15. Resident 85 FA, dated [DATE], the FA indicated Resident 85 was required substantial/maximal assistance (Helper does more than the effort) with activities of daily living.During an interview on [DATE] at 10:03 a.m. with Resident 14, Resident 14 stated the call light was not answered timely.During a review of Resident 14's Minimum Data Set (MDS comprehensive assessment tool), dated [DATE], the MDS indicated Section C - Cognitive Patterns BIMS summary score of 15. Resident 14's Section GG - Functional Abilities dated [DATE], the Section GG indicated Resident 14 was dependent with activities of daily living.During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light, dated [DATE], the P&P indicated, 7. Answer the resident's call as soon as possible.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, interview, and record review, the facility failed to notify physician and responsible party of abuse allegation and change of condition for three of five sampled residents (Resident 81, Resident 83, Resident 4). This failure had the potential for Resident's not to receive care and services and for physician and responsible party not to be made aware of the alleged abuse and change of condition. Findings: During a review of Resident 81's Minimum Data Set (MDS - an assessment tool), dated 2/1/26, the MDS indicated, Resident 81's BIMS (Brief Interview for Mental Status- standardized assessment tool used to evaluate the mental processes that allow individuals to think, learn, and remember) score was 15 (13 to 15 points indicates the resident has cognitive intactness). During a concurrent observation and interview on 4/9/26 at 2:17 p.m. with Resident 81, outside of Resident 81's room. Resident 81 stated that his roommate hit him last week (4/3/26). Resident 81 stated he blocked the hit from Resident 109 with his right forearm and he sustained a bruise to his right forearm; several bruises observed on right forearm of various stages of healing. During an interview on 4/9/26 at 4:38 p.m. with CNA 1, CNA 1 stated Resident 81 told him that Resident 109 had struck Resident 81 on his right forearm (4/3/26). CNA 1 stated there was what looked like a fresh mark on Resident 81's right forearm on that (4/3/26) day he stated Resident 81 always has red or purple marks on his arm but these marks looked fresh. During an interview on 4/15/26 at 4:21 p.m. with Director of Nursing (DON), DON stated the alleged abuse occurred on 4/3/26. DON stated the abuse allegations were not reported to the facility until 4/9/26, when this State Surveyor notified her of the allegations. DON stated there was no assessment completed until 4/9/26 (six days after the alleged abuse was reported to facility's staff). DON confirmed no physician or responsible party notification was made until 4/9/26 (six days after the alleged abuse was reported to facility's staff). During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, revised February 2021, the P&P indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. 1. The nurse will notify the resident's attending physician on call when there has been a (an) : a. accident or incident involving the resident. 3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR [Situation, Background, Assessment, and Recommendation] Communication Form. 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: a. the resident is involved in any accident or incident that results in an injury. 5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. During a review of Resident 83's BIMS, dated 3/27/26, the BIMS indicated, Resident 83's score was 10 (8-12 means moderate cognitive impairment). During a concurrent interview and record review on 5/13/26 at 10:15 a.m. with Quality Assurance (QA) Nurse, Change in Condition Evaluation (COC), dated 5/9/26 was reviewed. The COC indicated (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 83 had an open wound to left foot and redness with swelling to the right lower leg. COC indicated under Resident Representative (RP) Notification stated self. QA Nurse stated there was no RP notified. QA Nurse stated only the resident was notified and not RP. During a concurrent interview and record review on 5/13/26 at 10:17 a.m. with QA Nurse, Change in Condition Evaluation (COC), dated 5/11/26 was reviewed. The COC indicated, Resident 83 had a skin tear on left forearm. The COC indicated under Resident Representative Notification indicated self. QA nurse stated there was no RP notified. QA Nurse stated only the resident was notified and not RP. During a review of Resident 4's BIMS dated 2/17/26, the BIMS indicated, Resident 4's score is 3 (Severe cognitive impairment). During a concurrent interview and record review on 5/13/26 at 10:40 a.m. with QA nurse, COC, dated 5/8/26 was reviewed. The COC indicated Resident 4 had weight loss. The COC indicated under Resident Representative Notification indicated self. QA Nurse stated there was no RP notified. QA Nurse stated only the resident was notified and not RP. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, revised February 2021, the P&P indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. 1. The nurse will notify the resident's attending physician on call when there has been a (an) : a. accident or incident involving the resident. 3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR [Situation, Background, Assessment, and Recommendation] Communication Form. 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: a. the resident is involved in any accident or incident that results in an injury. 5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure:1) Floor mats were implemented bilaterally for one of six sampled residents (Resident 51).2) Falling star was implemented for one of six sampled residents (Resident 70).3) Certified Nursing Assistants (CNAs) were knowledgeable on falling star program.4) One of three sampled residents (Resident 51) was safely transferred when utilizing a Hoyer lift (a mechanical assistive device designed to safely transfer residents with limited mobility between a bed, wheelchair, or bathroom).These failures had the potential to result in injury for Resident 51, Resident 70 and other fall risk residents.5) To prevent accidents for one of six residents (Resident 51) when the facility failed to evaluate Resident 51's personal shower chair for safety before allowing its use, failed to train staff on the use and operation of Resident 51's personal shower chair, and allowed Resident 51 to use his personal shower chair when the facility knew it was unsafe. These failures resulted in Resident 51's falling from his personal shower chair during a shower causing Resident 51 to hit his head on the wall and his face on the floor of the shower stall. As a result of the impact on the wall and floor from the fall, Resident 51 suffered a nosebleed, experienced severe pain, and was sent to the hospital for evaluation and treatment of his injuries. Findings: 1) During a review of Resident 51's care plan (a comprehensive, personalized document that outlines the specific needs of an individual requiring care, detailing the type of support, how it will be provided, and the goals of the care) with the focus on Falls: [Resident 51] is at risk for falls, initiated [DATE]. The care plan indicated a few of the interventions were Floor mat to left and right side, initiated [DATE]. During a concurrent observation and interview on [DATE] at 9:43 a.m. with Certified Nursing Assistant (CNA) 3, inside Resident 51's room, Resident 51 was sleeping in bed. During a concurrent observation and interview on [DATE] at 10:27 a.m. with CNA 3 outside of Resident 51's room, CNA 3 stated Resident 51 did not have fall mats at bedside. 2) During a concurrent observation, interview, and record review, on [DATE] at 10:33 a.m. with Director of Staff Development (DSD) outside of Resident 70's room, Resident 70's care plan with the focus on Falls: Resident had an unwitnessed fall on [DATE] initiated [DATE] was reviewed. The care plan indicated, Falling Star fall prevention program (place Falling Star identifier on the outside of room door and on assistive devices as applicable). DSD stated no falling star on Resident 70's name plate. 3) During an interview on [DATE] at 9:48 a.m. with CNA 14, CNA 14 stated the happy face sticker indicated fall risk. During an interview on [DATE] at 10:53 a.m. with CNA 6, CNA 6 stated the happy face sticker indicated the resident was a fall risk. During an interview on [DATE] at 3:54 p.m. with the Director of Nursing (DON), DON stated that the happy face sticker indicated the resident was on enhanced barrier precautions and the gold star on a resident name plate indicated the resident was part of the falling star program. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) During a review of Resident 51's Minimum Data Set (MDS - an assessment tool), dated [DATE], the MDS indicated Resident 51's BIMS (Brief Interview for Mental Status- standardized assessment tool used to evaluate the mental processes that allow individuals to think, learn, and remember) score was 15 (13 to 15 points indicates the resident has cognitive intactness). During a review of Resident 51's Change in Condition Evaluation (CICE), dated [DATE], the CICE indicated, [Resident 51] stated that when he was getting transferred by two CNAs to the [NAME] chair [specialized padded medical chairs on wheels designed for resident with limited mobility] he hit his neck, and shoulder on the corner of the bed. (Resident 51) c/o (complained of) neck and back pain 8/10 [numeric pain scale - allow residents to rate their pain. Zero is considered no pain; 1 to 3 is mild pain; 4 to 6 is moderate pain and 7 to 10 is severe pain]. During a review of the facility provided Incident Report, dated [DATE], written by CNA 14, the statement indicated, When lifting [Resident 51] from bed, I tried not to have [Resident 51] all the way up as we had to adjust [Resident 51]. When turned to the side w/out [without] moving Hoyer the weight of the (Resident 51) caused bed to tilt. During an interview on [DATE] at 1:58 p.m. with Resident 51, Resident 51 stated he was dropped by a CNA 14 on Monday ([DATE]). Resident 51 stated he was supposed to be transferred with the use of a Hoyer lift and there should always be two CNAs but on Monday CNA 14 came in and transferred him alone. Resident 51 stated the Hoyer lift tipped over and he hit the back of his head and neck on the foot board of the bed. Resident 51 stated the CNA 14 left the room and returned with a female CNA 15 who assisted him back to bed. Resident 51 stated he asked to be transferred back to the Geri-chair so he could go and talk to the nurse and tell her what happened. Resident 51 stated when he spoke to the nurse, the CNAs had already told her a whole different story. During an interview on [DATE] at 9:48 a.m. with CNA 14, CNA 14 stated on [DATE] there was an incident happened when he and CNA 15 were transferring Resident 51 from bed to Geri chair. CNA 14 stated Resident 51 was ready for transfer he and CNA 15 started hooking Resident 51 up and raised Resident 51 up just a little. CNA 14 stated, when the bed shift, I saw [Resident 51] lean down because of the weight CNA 14 and CNA 15 decide to lift the Hoyer higher to prevent the bed form shifting. CNA 14 stated the bed shifted due to Resident 51's weight. CNA 14 stated Resident 51's left side was still touching the bed. During an interview on [DATE] at 11:52 a.m. with CNA 15, CNA 15 stated on Monday ([DATE]) she assisted CNA 14 with Resident 51's transfer. She stated, When I went in, [Resident 51] was dressed and in the sling when we [CNA 14 and CNA 15] went to turn [Resident 51] the foot of his bed went down and the head went up it was weird so we had already had him turned so we just lifted the Hoyer a little more and placed [Resident 51] in the chair. During a concurrent interview and record review on [DATE] at 4:06 p.m. with DON, DON stated Resident 51 hit his head during a Hoyer lift transfer. DON stated with Resident 51's condition it may have been a nerve sensation but both CNAs said he did not touch the bed or anything. DON stated CNA 14 and CNA 15 had consistent stories and there were no other witnesses, DON stated CNA 14 and CNA 15 stated Resident 51 did not touch the bed. CNA 14's Incident report, dated [DATE] was reviewed. DON stated CNA 14's statement indicated Resident 51 was in contact with the mattress when the transfer took place. During a review of the Facility's Competency Evaluation (CE) titled, Transferring with a Mechanical (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Lift (2 Person Assist), undated, the CE indicated, Transferring from Bed to Chair . 22. On the count of three raise the lift using the lift control until the resident and the sling are elevated and clear of the bed. Transferring from Chair to Bed . 47. On the count of three raise the lift using the lift control until the resident and the sling are elevated and clear of the wheelchair/geri-chair (sic). During a review of the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents, dated 1/2025, the P&P indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility -wide priorities. 4. Employees Shall be trained and inserviced (sic) on potential accident hazards and how to identify and report accident hazards, (sic) and try to prevent avoidable accidents. 4. Employees Shall be trained and inserviced (sic). 4 Implementing interventions to reduce accident risk and hazards shall include the following: . c. providing training, as necessary; . d. ensuring that interventions are implemented; and . 5. Monitoring the effectiveness of interventions shall include the following: a. ensuring that interventions are implemented correctly and consistently. 5) During a review of Resident 51's admission Record (AR), undated, the AR indicated Resident 51 was admitted to the facility on [DATE] with a primary diagnoses of complete quadriplegia (total paralysis of both arms and legs). During a review of Resident 51's MDS, dated [DATE], the MDS indicated Resident 51 had a BIMS score of 15 and was completely dependent (helper does all the effort/resident does none of the effort to complete the activity) for bathing and showers. During a review of Resident 51's Care Plan Report (CPR), [DATE], the CPR indicated Resident 51 had a shower chair brought from home for his use in the facility. The CPR indicated, [Resident 51] prefers to use his own shower chair from home. The CPR indicated [Resident 51's] preference will be honored. The CPR indicated the following interventions initiated on [DATE]: (1) maintenance to eval[uate] chair for safety, okay'ed for use, (2) explain risk v benefits of using his own chair, (3)honor resident's preferences, (4) therapy to educate resident on safety. During a review of Resident 51's clinical record, the clinical record indicated document titled [Facility] Resident Personal Equipment Acknowledgement & Liability Waiver (Liability Waiver), dated and signed by Resident 51 on [DATE]. The Liability Waiver indicated Resident 51 agreed to bring and use his own personal shower chair at the facility; agreed that the facility was not responsible for maintenance, storage, condition, or safety of the shower chair; and agreed that the facility assumed no liability for injury related to the use of the shower chair. During an observation on [DATE] at 11:45 a.m. in front of the shower room in the 400 hall, Resident 51 was taken out of the shower room on a stretcher by Emergency Medical Personnel (EMS) and CNA 5. Resident 51 had gauze on his right nostril. During a concurrent observation and interview on [DATE] at 11:47 a.m. with CNA 5 in the 400 hall shower room, CNA 5 stated Resident 51 was being taken to hospital because he had fallen in the shower, hit his head on the floor, and was bleeding from his nose. An observation of the shower room indicated a pool of blood on the upper left corner of the shower stall. CNA 5 stated Resident 51 was on his personal shower chair in the shower stall when his personal shower chair rolled towards the center of the stall, flipped over, and threw Resident 51 on the floor. CNA 5 stated he did not witness the fall but the above was reported to him by CNA 6, who was with Resident 51 in the shower room when Resident 51 fell. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 12:12 p.m. with CNA 6, CNA 6 stated she was showering Resident 51 when he fell. CNA 6 stated Resident 51 was on his personal shower chair in the shower room. CNA 6 stated when she turned around to close the shower curtain, Resident 51's personal shower chair flipped on its side and threw Resident 51 on the floor. CNA 6 stated Resident 51 hit his head and face on the floor and started bleeding from his nose. CNA 6 stated Resident 51 was too heavy for his personal shower chair, which caused the chair to flip over. CNA 6 stated before showering Resident 51, she offered and advised Resident 51 to use the facility's shower bed for safety reasons, but Resident 51 requested to use his personal shower chair. CNA 6 stated Resident 51 personal shower chair was unsafe for him to use. During an observation [DATE] at 3:35 p.m. in the 300 hall, Resident 51 returned from the hospital to the facility, brought back by EMS on a stretcher. During a concurrent observation and interview on [DATE] at 3:37 p.m. in Resident 51's room with the Director of Maintenance (DM), DM inspected and measured Resident 51's shower chair. The shower chair was composed of a metal frame with a slanted/tilted back seat, a plastic back support, both footrests, both armrests, and four wheels. The two back wheels had foot-operated locks. DM stated the shower chair had a seat height of 20 inches. During a review of Resident 51's Rehab[ilitation] – Status Post-Fall Screen[ing] (RSPFS), dated [DATE] at 4:18 p.m., the RSPFS indicated, Resident [51] is quadriplegic with inability to use his B[ilateral] (both sides) UE [Upper Extremities] (arms) and B LE [Lower Extremities] (legs), and has no sitting balance. Recommended to use shower gurney for showers. to decrease the risk for falls. During a review of Resident 51's Interdisciplinary Team (IDT a group of health care professionals with various of expertise who work together to improve residents safety and outcome) Note dated [DATE] at 6:50 p.m., the IDT Note indicated Resident 51 had a witnessed fall on [DATE] at 11:46 a.m. The IDT Note indicated, [Resident 51] had a witnessed fall in the 400 hall shower room .IDT determined fall was due to inability to maintain safe seated posture during bathing related to impaired trunk control, combined with use of a personal shower chair per preference. During an interview on [DATE] at 9:05 a.m. with Resident 51 in his room, Resident 51 stated he fell from his personal shower chair because CNA 6 did not lock its wheels allowing his personal shower chair to roll inside the shower stall, causing his weight to shift to the right side and his personal shower to chair to flip over on its side, launching him towards the floor. Resident 51 stated when he fell he first hit his head on the side wall and then hit his face on the floor of the shower stall, causing pain and a nosebleed. Resident 51 stated he experienced pain 10/10 (on a scale of zero – 10 were zero is no pain and 10 the worst pain possible) on his face and head because of the fall. During an interview on [DATE] at 8:10 a.m. with DM, DM stated Resident 51 had brought a personal shower chair to the facility. DM stated the facility did not have or used that type of shower chair. DM stated he was first informed Resident 51 had a personal shower chair on [DATE] after Resident 51 fell, at which time he inspected the shower chair and found it to have no mechanical defects. DM stated he only inspected the shower chair for mechanical defects. DM stated he was not qualified to evaluate the shower chair for safety. During interviews with the Director of Rehabilitation (DOR) on [DATE] at 11:40 a.m. and at 11:53 a.m., DOR stated Resident 51's personal shower chair was only evaluated for safety on [DATE] after (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 51's fall. DOR stated Resident 51's personal shower chair was unsafe because the seat was off balance, meaning when Resident 51 shifted his weight the weight could cause the shower chair to flip over. DOR stated the facility did not use those shower chairs and it was the first time she had seen one. During an interview on [DATE] at 1:40 p.m. with CNA 6, CNA 6 stated Resident 51's personal shower chair was not a model the facility used and no other resident in the facility had it. CNA 6 stated when she took Resident 51 to the shower on [DATE], it was the first time she had operated that type of shower chair. CNA 6 stated she had not been trained on the use or operation of Resident 51's personal shower chair. During an interview on [DATE] at 8:08 a.m. with the Director of Staff Development (DSD), DSD stated CNAs were trained in the use of resident shower chairs. DSD stated Resident 51's personal shower chair was not a model the facility used. DSD stated the facility's CNAs had not been trained in the use of Resident 51's personal shower chair. During an interview on [DATE] at 10:27 a.m. with DON, DON stated Resident 51 brought his personal shower chair to the facility on [DATE] and requested it to be used for his showers. DON stated his personal shower chair was unsafe and for this reason Resident 51 signed a liability waiver assuming responsibility for its use and releasing the facility of responsibility for any injuries resulting from its use, which Resident 51 signed on [DATE]. During an interview on [DATE] at 1:45 p.m. with DON, DON stated the facility's process for residents who bring their own personal equipment to the facility, such as shower chairs, was for residents to sign a liability waiver assuming all responsibility for the use of the equipment and releasing the facility of responsibility for any injuries. DON stated Resident 51 had the right to keep and use personal property in the facility, including his personal shower chair. DON stated it was a resident rights issue and provided the facility's policy and procedure (P&P) on resident rights. During a review of the facility's P&P titled, Resident Rights, revised [DATE], the P&P indicated, Federal and state laws guarantee certain rights to all residents in the facility. These rights include the resident's right to: (k) Retain and use personal possessions to the maximum extent that space and safety permit. During a review of the facility's P&P titled, Job Description: Certified Nursing Assistant, undated, the P&P indicated, Perform only those nursing care procedures that you have been trained to do. During a review of the facility's P&P titled, Falls and Fall Risk, Managing, revised [DATE], the P&P indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes and try to prevent the resident from falling.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and record review, the facility failed to ensure resident Hemodialysis Communication Observation/Assessment (HCOA) forms were accurately completed for three of three sampled dialysis (medical procedure that filters waste products and excess fluids from the blood when the kidneys no longer function adequately) residents (Resident 5, Resident 7, and Resident 83). This failure had the potential for Resident 5, Resident 7, and Resident 83 not to receive necessary care during and after dialysis, and for any adverse event to be addressed. Findings: During a review of Resident 7's admission Record (AR), undated, the AR indicated Resident 7 was admitted to the facility on [DATE] with a diagnoses of Diabetes Mellitus (uncontrolled sugar levels in the blood) due to underlying condition with hyperglycemia. During a review of Resident 7's Minimum Data Set (MDS a comprehensive assessment tool) dated 3/28/26, the MDS indicated Resident 7 had a Brief Interview for Mental Status (BIMS) (a cognitive assessment tool) score of 15 (scores of 13-15 indicate intact cognition). During a review of Resident 7's Order Summary Report (OSR). dated May 2026, the OSR indicated, Resident to receive Dialysis.The Dialysis schedule is 3 times per week on Monday, Wednesday, and Friday. During a concurrent interview and record review on 5/13/26 at 9:02 a.m. with Minimum Data Set Nurse (MDSN), Resident 7s HCOA dated APRIL and May 2026 was reviewed. The HCOA indicated the following: On 5/11/26 Resident 7's HCOA form was missing Resident 7's Arrival Time Post Dialysis, Licensed Nurse Signature, and date. On 5/8/26 Section to be completed by Licensed Nurse post dialysis was blank. On 5/4/26 Section to be completed by Licensed Nurse post dialysis was blank. On 4/29/26 Section to be completed by Licensed Nurse post dialysis was blank. On 4/27/26 Section to be completed by Licensed Nurse post dialysis was blank. On 4/22/26 Section to be completed by Licensed Nurse post dialysis was blank. On 4/17/26 Section to be completed by Licensed Nurse post dialysis was blank. MDSN stated Resident 7 should have had been assessed after dialysis and the HCOA form should have been fully completed. During a review of Resident 5's admission Record (AR), undated, the AR indicated Resident 5 was admitted to the facility on [DATE] with a diagnoses Type 2 Diabetes Mellitus and end stage renal disease (the finale, irreversible stage of chronic kidney disease. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5 had a BIMS score of 15. During a review of Resident 5's OSR, dated May 2026, the OSR indicated, Hemodialysis 3x a week every Tuesday, Thursday and Saturday. During a concurrent interview and record review on 5/13/26 at 9:28 a.m. with MDSN Resident 5s HCOA, dated APRIL and May 2026 were reviewed. The HCOA indicated the following: On 5/9/26 Resident 5's HCOA form was missing Licensed Nurse Signature and date. On 4/28/26 Section to be completed by Licensed Nurse post dialysis was blank. MDSN stated Resident 5's HCOA was missing the post dialysis treatment portion to be completed by the nurse and stated all residents returning from dialysis should be assessed for bleeding. During a concurrent interview and record review on 5/13/26 at 9:53 a.m. with Quality Assurance (QA Nurse), Resident 83's HCOA, dated April 2026 and May 2026 were reviewed. The HCOA indicated the following: On 5/9/26 Section to be completed by the Dialysis Center and Section to be completed by Licensed Nurse post dialysis were blank. On 4/29/26 Section to be completed by the Dialysis Center was blank. On 4/25/26 Section to be completed by the Dialysis Center and Section to be completed by Licensed Nurse post dialysis were blank. On 4/23/26 Section to be completed by Licensed Nurse post dialysis was blank. On 4/21/26 Section to be completed by Licensed Nurse post dialysis was blank. On 4/18/26 Section to be completed by the Dialysis Center and Section to be completed by Licensed Nurse post dialysis were blank. QA Nurse stated the HCOA's were blank and should be completed. QA Nurse stated the HCOA were blank and should have been completed. During a review of the facility's policy and procedure (P&P) titled, Dialysis Communication, dated 5/2025, the P&P indicated, The care of the resident receiving dialysis services must reflect ongoing communication, coordination and collaboration between the nursing home and the dialysis staff. Use of Dialysis Communication Form helps ensure the coordination of safe and effective care of residents who need dialysis treatments.If the Dialysis Center fails to send the at-dialysis communication form back to the facility, the receiving nurse may complete the form by taking a verbal report from the dialysis facility nurse.Post-Dialysis Communication: This observation/Assessment is auto scheduled to be completed once the pre-dialysis communication form has been saved, signed and locked. Electronically completed by the receiving nurse upon return to the facility following a Dialysis Treatment.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to follow their Facility Assessment (a document that indicates the facility's resources to meet resident needs), when Certified Nursing Assistant (CNAs) had more residents than it was planned. This failure had the potential for all residents not receiving sufficient nursing care.Findings:During a review of Nursing Staffing Assignment (NSA), dated 12/3/25, the NSA indicated there were 92 residents in the facility and there were total of nine CNAs scheduled in the morning shift [a ratio of 10 residents per CNA] and seven CNAs scheduled in the evening shift [a ratio of 13 residents per CNA].During a review of NSA, dated 12/10/25, the NSA indicated there were 99 residents in the facility and there were a total of seven CNAs scheduled in the morning shift [a ratio of 14-15 residents per CNA] and eight CNAs scheduled in the evening shift [a ratio of 12-13 residents per CNA].During a review of NSA, dated 12/24/26, the NSA indicated there were 94 residents in the facility and there were a total of seven CNAs scheduled in the morning shift [a ratio of 13-14 residents per CNA] and six CNAs scheduled in the evening shift [a ratio of 12-13 residents per CNA].During an interview on 5/13/26 at 9:22 a.m. with CNA 16, CNA 16 stated she has been working in the facility for over six months. CNA 16 stated she normally works in the morning shift and today, she had 11 residents. CNA 16 stated she normally has 11-13 residents. CNA 16 stated when the facility was short staff, she had up to 15 residents and sometimes showers or repositioning of residents gets missed.During an interview on 5/13/26 at 1:10 p.m. with CNA 17, CNA 17 stated she has been working at the facility for two years and she has been working the morning shift. CNA 17 stated she has 11 residents today.During an interview on 5/13/26 at 1:46 p.m. with CNA 18, CNA 18 stated she has been working the morning shift. CNA 17 stated she has 11 residents today. CNA 18 stated when facility was short staff, they had up to 18 residents. CNA 18 stated when they were short staff it takes longer to answer the call light and sometimes showers were being missed.During a concurrent interview and record review on 5/13/26 at 3:52 p.m. with Director of Staff Development (DSD), DSD stated she took over this position because the previous DSD was not scheduling enough CNAs to meet resident needs and she did not ensure the showers were being completed. DSD reviewed the shower sheets and stated there were no shower sheets on 12/3/25, 12/10/25 and 12/24/25.During a concurrent interview and record review on 5/13/26 at 4:19 p.m. with DSD, Facility Assessment (FA), dated 12/18/25 was reviewed. The FA indicated CNA/RNA [Restorative Nursing Assistant] has 1 to 8-9 residents' ratio for day shift, 1 CNA/RNA to 11 residents' ratio during evenings, and 1 CNA to 16 resident ratios during nights. DSD stated the facility did not meet the staffing requirements in the facility assessment.During a review of facility's policy and procedure (P&P) titled, Bath, Shower, dated 2/2018, the P&P indicated, Documentation 1. The date and time the shower was performed. 2. The name and title of the individual(s) who assisted the resident with the shower/tub bath. 3. All assessment data (e.g., any reddened areas, sores, etc., on the resident's skin) obtained during the shower/tub bath. 4. How the resident tolerated the shower/tub bath. 5. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken. 6. The signature and title of the person recording the data.During a review of facility's P&P, titled, Staffing, Sufficient and Competent Nursing, dated 8/2022, the P&P indicated, Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on interview and record review, the facility failed to provide documentation of competency and skills performance for three of five sampled Certified Nursing Assistants (CNA 8, CNA 10, and CNA 11). This failure had the potential to result in lack of competent and skilled staff and residents needs not being met.Findings:During a concurrent interview and record review on 5/12/26 at 2:11 p.m. with Director of Staff Development (DSD), CNA 8's Personnel File (PF) was reviewed. The PF indicated the last competency was completed on 3/1/25. DSD stated the next competency was due on 3/1/26 and it was not completed. DSD stated the competency was completed to ensure staff were competent to take care of residents and meet their needs.During a concurrent interview and record review on 5/12/26 at 2:22 p.m. with DSD, CNA 10's PF was reviewed. The PF indicated the last competency was completed on 3/23/25. DSD stated the next competency was due on 3/23/26 and it was not completed.During a concurrent interview and record review on 5/12/26 at 2:24 p.m. with DSD, CNA 11's PF was reviewed. The PF indicated the last competency was completed on 3/1/25. DSD stated the next competency was due on 3/1/26 and it was not completed.Policy was requested and the facility provided policy and procedure (P&P) titled Competency Evaluations dated 12/2026 but the P&P did not address how often the competencies should be completed.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete annual performance evaluations for five of five sampled Certified Nursing Assistants (CNA 7, CNA 8, CNA 9, CNA 10, and CNA 11). This failure had the potential for CNAs not being aware of their need for improvement in a certain area which could affect all the residents' care.Findings:During a concurrent interview and record review on 5/12/26 at 1:59 p.m. with Director of Staff Development (DSD), CNA 7's Personnel File (PF) was reviewed. The PF indicated CNA 7 was hired on 4/12/23 and there was no performance evaluation found in PF. DSD stated there was no performance evaluation completed for CNA 7.During a concurrent interview and record review on 5/12/26 at 2:11 p.m. with DSD, CNA 8's PF was reviewed. The PF indicated CNA 8 was hired on 3/1/23 and there was no performance evaluation. DSD stated there was no performance evaluation completed for CNA 8. DSD stated performance evaluation was completed to ensure how staff can grow.During a concurrent interview and record review on 5/12/26 at 2:17 p.m. with DSD, CNA 9's PF was reviewed. The PF indicated CNA 9 was hired on 3/1/23 and there was no performance evaluation. DSD stated there was no performance evaluation completed for CNA 9.During a concurrent interview and record review on 5/12/26 at 2:22 p.m. with DSD, CNA 10's PF was reviewed. The PF indicated CNA 10 was hired on 3/1/23 and there was no performance evaluation. DSD stated there was no performance evaluation completed for CNA 10.During a concurrent interview and record review on 5/12/26 at 2:24 p.m. with DSD, CNA 11's PF was reviewed. The PF indicated CNA 11 was hired on 3/1/23 and there was no performance evaluation. DSD stated there was no performance evaluation completed for CNA 11.During a review of the facility's policy and procedure (P&P) titled, Performance Evaluations, dated 9/2020, the P&P indicated, 1. A performance evaluation will be completed on each employee at the conclusion of his/her 90-day probationary period, and at least annually thereafter.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection control practices when:The residents' clean personal laundry was not stored in a designated space to reduce the risk of contamination.The portable air conditioner (AC) in the laundry room had thick grey colored debris in the front and side vent grills.Two of two Certified Nursing Assistants (CNA 12 and CNA 13), did not follow their policy and procedure (P&P) on Enhanced Based Precaution (EBP - an infection control intervention designed to reduce the spread of multidrug-resistant organisms [MDROs - These are germs-primarily bacteria-that have evolved to resist multiple classes of antimicrobial drugs, making the infections they cause highly difficult, and sometimes impossible, to treat with standard medications in nursing homes and long-term care facilities]).These failures had the potential to spread infections and diseases to residents, staff, and visitors.Findings:1.During a concurrent observation and interview on [DATE] at 8:03 a.m. with Housekeeping/Laundry Supervisor (HLS) in the laundry room, the residents' clean personal laundry was stored in the HLS office. There were chemicals, cleaning materials, office desk, microwave, filing cabinets, and personal belongings approximately two feet from the residents' clean personal laundry. HLS stated, We have nowhere else to store them.During a review of the facility's policy and procedure (P&P) titled, Laundry and Bedding, Soiled, dated [DATE], the P&P indicated, Storage: 3. Clean linen is kept separate from contaminated linen. The use of separate rooms, closets, or other designated spaces with a closing door are used to reduce the risk of accidental contamination.2. During a concurrent observation and interview on [DATE] at 8:12 a.m. with HLS, in the laundry room, there was a portable AC in the clean area. The portable AC had thick grey colored debris in the front and side vent grills. HLS stated, For me, it's [portable AC] not clean.During the review of the facility's P&P titled, Cleaning and Disinfecting Resident's Rooms, dated [DATE], the P&P indicated, 2. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled.3. During an observation on [DATE] at 2:42 p.m. in Resident 108's room, Resident 108's door had a sign for EBP. CNA 12 and CNA 13 entered Resident 108's room without wearing gowns. CNA 12 and CNA 13 went to change Resident 108's brief, clothing, and linens.During a review of Resident 108's Care Plan Report (CPR) dated [DATE], the CPR indicated, Resident [108] requires Enhanced Barrier Precautions during high contact resident care activities due to the presence of: -Chronic [long-lasting, persistent, or recurring frequently] Wound: arterial ulcer to left 2nd toe. Utilize PPE (gown and gloves, face shield as indicated) during high-contact resident care activities (e.g. dressing, bathing/showering transferring, hygiene, linen changes, brief changes, toileting assistance, device care, wound care).During an interview on [DATE] at 2:49 p.m. with CNA 12 and CNA 13, CNA 12 stated they were doing patient care, and not wearing a gown. CNA 13 stated they should have worn a gown. CNA 13 stated they changed Resident 108's brief, linen, and gown.During an interview on [DATE] at 11:05 a.m. with Infection Preventionist (IP), IP stated residents on EBP, staff should wear a gown and gloves during high contact care including transferring, bathing, brief changes, turning, and bed baths.During a review of the facility's P&P titled, Enhanced Barrier Precautions, dated February 2025, the P&P indicated, 2. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). b. Personal protective equipment (PPE) is changed before caring for another resident. c. Face protection may be used if there is also a risk of splash or spray. 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; b. bathing/showering; c. transferring; d. providing hygiene; e. changing linens; f. changing briefs or assisting with toileting; g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and h. wound care (any skin opening requiring a dressing).

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review, the facility failed to ensure:1. One of 53 sampled resident's (Resident 51) call light was within reach. This failure had the potential for Resident 51's care needs, health and safety concern not to be addressed timely.2. One of 53 sampled residents (Resident 49) had access to a working call light. This failure prevented Resident 49 from calling staff to bring him water. 3. Three of four resident shower rooms (shower rooms in halls 200, 400 and 500) had call lights inaccessible to residents. This failure had the potential to prevent residents from calling for assistance. Findings: 1.During a review of Resident 51's Minimum Data Set (MDS - an assessment tool), dated 3/27/26, the MDS indicated, Resident 51's Brief Interview for Mental Status (BIMS - standardized assessment tool used to evaluate the mental processes that allow individuals to think, learn, and remember) score was 15 (13 to 15 points indicates the resident has cognitive intactness). During an interview on 4/15/26 at 1:58 p.m. with Resident 51, Resident 51 stated that sometimes the staff do not give him his call light. During a concurrent observation and interview on 4/16/26 at 9:43 a.m. with Certified Nursing Assistant (CNA) 3, inside Resident 51's room, Resident 51 was sleeping in bed. Resident 51's call light was on his nightstand approximately three feet from the bed. CNA 3 stated the call light was on the night stand and Resident 51 could not reach his call light. During a review of the facility's policy and procedure (P&P) titled, Call System, Residents, revised September 2022, the P&P indicated, Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station. Policy Interpretation and Implementation 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. 2. During a concurrent observation and interview on 5/11/26 at 11:52 a.m. with Resident 49 in his room, Resident 49 was lying in his bed and stated his water jug was empty. Resident 49 pressed his call light to request his water jug refilled. Resident 49's call light did not activate. Resident 49 stated his call light was not working. During a concurrent observation and interview on 5/11/26 at 11:55 a.m. with the Director of Maintenance (DM) in Resident 49's room, DM inspected Resident 49's call light system and stated it was not operational. DM stated Resident 49's call light cable needed to be replaced. 3. During a concurrent observation and interview on 5/13/26 at 8:15 a.m. with DM, the resident call light systems in shower rooms in hall 200, hall 400 and hall 500 were inspected. The shower room in hall 200 had two shower stalls and the call lights in both stalls did not have a string to activate it, making the call lights inaccessible to residents on the floor. The shower room in hall 400 had two shower stalls. The call light in the stall closest to the door did not have a string, making the call light inaccessible to residents on the floor. In the stall farthest from the door, the call light was placed outside the shower stall and was inaccessible to residents on the floor in the shower stall. The shower room in hall 500 had two shower stalls. The call light in the stall closest to the door did not have a string, making the call light inaccessible to residents on the floor. In the stall farthest from the door the call light was placed outside the shower stall and was inaccessible to residents on the floor in the shower stall. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Call System, Residents, revised September 2022, the P&P indicated, Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station. Policy Interpretation and Implementation 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to maintain a safe environment when cardboard boxes containing detergents, bleach and soap, were being stored behind the washing machine. This failure had the potential for increasing the fire hazard affecting all residents, staff, and visitors in the facility. Findings:During an observation on 5/13/26 at 8:03 a.m., in the laundry room, there were multiple cardboard boxes containing commercial detergents, bleach, and soap solutions stored behind the washing machine. The cardboard boxes were stored behind the washing machine approximately one to two inches from the back of the washing machine. The back of the washing machine had electrical wiring, tubing, water hoses, and a heat emitting motor. During an interview on 5/13/26 at 8:12 a.m. with the Housekeeping and Laundry Supervisor (HLS), in the laundry room, HLS stated, They [cardboard boxes] should not be there.During an interview on 5/13/26 at 8:55 a.m. with the Housekeeping and Laundry Manager (HLM), HLM stated there was no policy for safely storing supplies.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure three of 53 sampled residents (Resident 79, Resident 23, and Resident 81) were treated with respect and dignity when facility staff converse in a language other than the resident's primary language while providing care. This failure had the potential to negatively affect Resident 79, Resident 23, and Resident 81's psychosocial well-being.Findings:During a review of Resident 79's Minimum Data Set, (MDS - an assessment tool), dated 12/18/25, the MDS indicated Resident 79's BIMS (Brief Interview for Mental Status-standardized assessment tool used to evaluate the mental processes that allow individuals to think, learn, and remember) score was 15 (13 to 15 points indicates the resident has cognitive intactness).During a review of Resident 79's admission Record, (AR), the AR indicated, Resident 79's primary language was English.During an interview on 4/9/26 at 2:34 p.m. with Resident 79, Resident 79 stated Certified Nursing Assistants (CNAs) will speak other languages in his room. Resident 79 stated, It makes me feel disrespected and isolated because I am singled out. Resident 79 stated he believes the staff are talking about him based on the looks they give each other while providing care. During a review of Resident 23's MDS, dated [DATE], the MDS indicated Resident 23's BIMS score was 15.During a review of Resident 23's AR, the AR indicated, Resident 23's primary language was English.During an interview on 4/9/26 at 3:57 p.m. with Resident 23, Resident 23 stated, I don't like when they [CNAs] come in here [Resident 23's room] and speak their own language to each other. Resident 23 stated, I am not stupid I know they are talking about me. Resident 23 stated they have their clicks the Hispanic and Filipino CNAs.During an interview on 4/9/26 at 4:38 p.m. with CNA 1, CNA 1 stated it is not ok to speak other languages in front of residents because they may think you are talking about them.During a review of Resident 81's MDS, dated [DATE], the MDS indicated Resident 81's BIMS score was 15.During a review of Resident 81's AR, the AR indicated, Resident 81's primary language was English.During an interview on 4/15/26 at 12:32 p.m. with Resident 81, Resident 81 stated the CNAs speak Spanish while providing care. Resident 81 stated, I don't like it [speaking another language] because I think they are talking about me sometimes.During an interview on 4/15/26 at 2:46 p.m. with CNA 2, CNA 2 stated the facility staff should not speak languages the resident does not speak, the resident can take it wrong and think they are talking about them.During a review of the facility's policy and procedure (P&P) titled, Residents Rights, revised August 2009, the P&P indicated, Employees shall treat all residents with kindness, respect, and dignity.During a review of the facility policy and procedure (P&P) untitled and undated, the policy indicated, It is the facility's policy to affirm the residents' and employees' rights to be free of discrimination. At the same time, all employees have the right to communicate in their primary language when not engaged in direct communication with or caring for a resident. Staff are required to comply with the following guidelines. Procedure: 1. Speak clearly to residents in a language they can understand. 3. Staff should not appear to be distracted when they are interacting with or providing care to residents. 4. There should never be a social conversation between staff members while staff members are providing services to residents. 5. Staff members may converse with each other in their native tongue when they are not in residents' area such as the employees [sic] lounge. English must be spoken at all times when in resident areas.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, when allegations of abuse were not investigated timely for one of 53 sampled residents (Resident 81). This failure resulted in Resident 81's abuse allegation not being investigated timely.Findings:During a review of the facility provided document titled, Resident to Resident Altercation Investigation for [Resident 81] (RRAI), dated 4/9/26, the RRAI indicated, Interview with [Certified Nursing Assistant (CNA) 1] PM Shift. [CNA 1] stated that on 04/03/2026, [Resident 81] informed him that his roommate had hit him. During an interview on 4/15/26 at 4:21 p.m. with Director of Nursing (DON), DON stated the alleged abuse occurred on 4/3/26. DON stated the abuse allegations were not reported to the facility until 4/9/26. DON stated the investigation did not start until 4/9/26 (6 days after the alleged abuse was reported to facility's staff).During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised September 2022, the P&P indicated, All reports of resident abuse. Investigating Allegations 1. All allegations are thoroughly investigated. 11. Upon conclusion of the investigation, the investigator records the findings of the investigation on approved documentation forms and provides the completed documentation to the administrator. Follow-up Report 1. Within five (5) business days of the incident, the administrator will provide a follow-up investigation report.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, interview, and record review, the facility failed to ensure allegations of abuse were reported timely for one of three sampled residents (Resident 81). This failure resulted in Resident 81's abuse allegation not being reported timely and delaying the investigation.Findings:During a review of Resident 81's Minimum Data Set, (MDS - an assessment tool) dated 2/1/26, the MDS indicated, Resident 81's BIMS (Brief Interview for Mental Status-standardized assessment tool used to evaluate the mental processes that allow individuals to think, learn, and remember) score was 15 (13 to 15 points indicates the resident has cognitive intactness).During a concurrent observation and interview on 4/9/26 at 2:17 p.m. with Resident 81, outside of Resident 81's room, Resident 81 stated that his roommate hit him last week. Resident 81 stated he blocked the hit from Resident 109 with his right forearm and he sustained a bruise to his right forearm; several bruises were observed on right forearm of various stages of healing. Resident 81 stated he informed his Certified Nursing Assistant (CNA) 1 on the day of the altercation (4/3/26).During an interview on 4/9/26 at 4:38 p.m. with CNA 1, CNA 1 stated on that day (4/3/26) Resident 81 told him that Resident 81 had a physical altercation with Resident 109. CNA 1 stated Resident 81 told him they had fought a little, that Resident 109 struck Resident 81 on his right forearm. CNA 1 stated there was what looked like a fresh mark on Resident 81's right forearm on that day.During a review of Resident 109's Notice of Room Change, (NRC) dated 4/3/26, the NRC indicated Resident 109 was moved to another room.During an interview on 4/15/26 at 4:21 p.m. with Director of Nursing (DON), DON stated the abuse allegations (4/3/26) were not reported to the facility until 4/9/26. DON stated CNA 1 assumed the nurse was aware of the abuse allegations and did not report Resident 81's allegations of abuse to the nurse.During an interview on 4/15/26 at 4:34 p.m. with DON, DON stated abuse allegations with injuries should be reported within 2 hours and no injuries within 24 hours to the state (licensing agency), Long Term Care (LTC) Ombudsman (a trained advocate who investigates complaints, protects the rights, and promotes the safety, health, and welfare of residents in nursing homes), and the local law enforcement. DON stated the alleged abuse occurred on 4/3/26 was not reported to state, LTC Ombudsman, and local law enforcement until 4/9/26 (6 days after the alleged abuse was reported to facility's staff).During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised September 2022, the P&P indicated, All reports of resident abuse. are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Reporting Allegations to the Administrator and Authorities 1. If resident abuse . is suspected, the suspicion must be reported immediately to the administrator and other officials according to state law. 2.The administrator or individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; c. The resident's representative; . e. Law enforcement officials; f. The resident's attending physician; and g. The facility medical director. 3. Immediately is defined as: a. within two hours of the allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or results in serious bodily injury.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview, and record review, the facility failed to accurately complete the Pre-admission Screening and Resident Review (PASRR - federal requirement to help ensure that individuals are not incorrectly placed in nursing homes or long-term care instead of a psychiatric setting), for one of two sampled residents (Resident 4). This failure had the potential for Resident 4 to be placed in an inappropriate setting and not receive required services.Findings:During a review of Resident 4's Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 2/20/24, the PASRR indicated, Level I- Positive.During a concurrent interview and record review on 5/13/26 at 10:34 a.m. with Quality Assurance (QA) Nurse, Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 2/20/24 was reviewed. QA Nurse stated Resident 4's PASRR was positive for mental health evaluation but there was no Level II PASRR completed for Resident 4.During a review of Resident 4's admission Record (AR), dated 5/14/25, the AR indicated Resident 4 had diagnosis of Bipolar disorder (a mental condition characterized by extreme, cyclical shifts in mood, energy, and activity level), psychosis (a collection of symptoms that indicate a loss of contact with reality), dementia (a decline in mental abilities severe enough to interfere with daily life), and adjustment disorder with mixed anxiety (an emotion characterized by feeling of tension, worried thoughts) and depressed mood (persistent feeling of sadness and loss of interest).During a review of Resident 4's Order Summary Report (OSR), dated 4/24/26, the OSR indicated Resident 4 was on Divalproex Sodium (to treat bipolar disorder) 125 milligram, give 8 capsules by mouth one time a day.During a concurrent interview and record review on 5/13/26 at 10:36 a.m. with QA Nurse, Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 11/14/25 was reviewed. The PASRR indicated on question 9. Diagnosed Serious mental Illness. Does the individual have a serious diagnosed mental disorder? Answer was marked No. QA Nurse stated Resident 4's PASRR was filled incorrectly because Resident 4 had diagnosis of mental illness and Resident 4 was taking medication for mental illness.During a review of facility's policy and procedure (P&P) titled, admission Criteria PASARR, dated 3/2019, the P&P indicated, 9. All new admissions and readmissions are screened for mental disorder (MD), intellectual disabilities (ID) or related disorders (RD).b. If the level I screen indicated that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process.

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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. Based on observation, interview, and record review, the facility failed to implement care plans for two of 53 sampled residents (Resident 51 and Resident 70). This failure had the potential for Resident 51 and Resident 70's safety to be at risk.Findings:During a review of Resident 51's care plan (a comprehensive, personalized document that outlines the specific needs of an individual requiring care, detailing the type of support, how it will be provided, and the goals of the care) with the focus on Falls: (Resident 51) is at risk for falls, initiated 3/23/26. The care plan indicated a few of the interventions were Floor mat to left and right side, initiated 4/2/26 and Keep call light within reach. initiated 3/23/26. During a concurrent observation and interview on 4/16/26 at 9:43 a.m. with Certified Nursing Assistant (CNA) 3, inside Resident 51's room. Resident 51 was sleeping in bed. CNA 3 located Resident 51's call light pad on his nightstand approximately three feet from the bed. CNA 3 stated Resident 51 would not been able to reach his call light.During a concurrent observation and interview on 4/16/26 at 10:27 a.m. with CNA 3, outside of Resident 51's room, CNA 3 stated Resident 51 did not have fall mats at bedside.During a concurrent observation, interview, and record review, on 5/11/26 at 10:33 a.m. with Director of Staff Development (DSD) outside of Resident 70's room. Resident 70's care plan with the focus on Falls: Resident had an unwitnessed fall on 4/20/26 initiated 4/20/26. The care plan indicated, Falling Star fall prevention program (place Falling Star identifier on the outside of room door and on assistive devices as applicable). DSD stated no falling star on Resident 70's name plate. During a review of the facility's policy and procedure (P&P) titled, Care plans, Comprehensive Person-Centered, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 4. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: .g. receive the services and/or items included in the plan of care.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to administer medication according to the physician order for one of six sampled residents (Resident 23) when Resident 23 had an order for the administration of one inhalation (drawing the medication into the lungs) of Trelegy Ellita inhalation Aerosol Powder (a medication to treat inflammation of the lungs) 100-62.5-25 MCG (micrograms-unit of measurement)/ACT (actuation - refers to a single spray, puff, or activation of an inhaler) and Resident 23 did not receive the medication. This failure had the potential for Resident 23 to experience negative health outcomes due to breathing problems.Findings:During a review of Resident 23's Order Summary Report (OSR), dated 3/25/26, the OSR indicated, Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 100-62.5-25 MCG/ACT I inhalation inhale orally one time a day.During a review of Resident 23's Communication Result Report (CRR), dated 5/12/26 at 2:47 p.m., the CRR indicated Trelegy was reordered from the pharmacy on 5/12/26.During a concurrent observation and interview on 5/13/26 at 8:20 a.m. with Registered Nurse (RN) 1 in 400 hall, RN 1 prepared the medications for administration to Resident 23, but no inhaler to administer. RN 1 stated there was no Trelegy inhaler available to administer.During a review of the facility's policy and procedure (P&P) titled, Medication Ordering and Receiving from Pharmacy, dated 3/2026, the P&P indicated, i. Reorder medication (three to four) days in advance of need to assure an adequate supply is on hand.

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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. Based on interview and record review, the facility failed to ensure one of 53 sampled residents (Resident 51) was turned and repositioned every two hours. This failure had the potential for delayed wound healing and worsening of pressure injuries (localized injury to the skin and/or underlying tissue usually over a bony prominence, from pressure, or pressure in combination with shear and/or friction) for Resident 51.Findings:During an interview on 4/23/26 at 1:27 p.m. with Treatment Nurse (TN), TN stated turning and repositioning every two hours was the facility's standard for residents with pressure injuries. TN stated everyone with a pressure injury should have a care plan for turning and repositioning every two hours. During a review of Resident 51's Minimum Data Set (MDS - an assessment tool), dated 3/27/26, the MDS indicated, Resident 51 was dependent (helper does all the effort) for rolling left and right (the ability to roll from lying on back to left and right side and return to lying on back on the bed), sit to lying (the ability to move from sitting on side of bed to lying flat on the bed). The MDS indicated Resident 51 had a stage four pressure injury (a severe, full-thickness skin and tissue loss where underlying muscles, tendons [flexible tissue, like a rope], ligaments [a band of tissue that connects bones, joints or organs], cartilage [a strong, flexible connective tissue that protects joints and bones are exposed) upon admission. During a review of Resident 51's Order Summary Report (OSR), dated 4/28/26, the OSR indicated, Q [every] 2hr [2 hours] repositioning while in bed during day time with wedge [foam or bead-filled support devices designed for people with limited mobility, providing critical support to reduce pressure sores, improve circulation, and maintain proper body position] every day shift . Start Date 04/08/2026 and Q 2hr repositioning while in bed during day time with wedge every evening shift . Start Date 04/08/2026.During a review of Resident 51's care plan with the focus on Skin: [Resident 51] has Impaired skin integrity present on admission as evidenced by . Stage 4 Pressure ulcer to coccyx, initiated 3/23/26. The care plan indicated a few of the interventions were to Administer treatments as ordered and monitor for effectiveness, and Low air loss mattress. (turn and repositioning were not included in care plan).During a concurrent interview and record review, on 4/30/26 at 12:30 p.m. with QA Nurse and MDSN. Resident 51's care plan was reviewed. QA Nurse and MDSN stated Resident 51's care plan did not indicate turn and reposition. Resident 51's Documentation Survey Report (DSR), dated February, March, and April of 2026, the DSR indicated for the task of Turn and Reposition, were reviewed. The DSR indicated the following:On 2/12/26, the DSR indicated Resident 51 was not turned or repositioned (T&R) at 6 a.m., 8 a.m., 10 a.m., and 12 p.m. (total of 10 hours). The DRS indicated Resident 51 self-repositioned at 6 p.m. (total four hours, Resident 51 was not T&R for a total 14 out of a 24 hour period).On 2/18/26, the DSR indicated Resident 51 was not turned and repositioned at 2 p.m., 4 p.m., 6 p.m. and 8 p.m. (Resident 51 was not T&R for 10 hours out of a 24 hour period).On 2/20/26, the DSR indicated Resident 51 self -repositioned at 2 p.m., 4 p.m., 6 p.m., and 8 p.m. (Resident 51 was not T&R for 10 hours out of a 24 hour period).On 2/21/26, the DSR indicated Resident 51 self -repositioned at 2 p.m., 4 p.m., and 6 p.m. (Resident 51 was not T&R for eight hours out of a 24 hour period). On 2/22/26, the DSR indicated Resident 51 self -repositioned at 2 p.m., 4 p.m., and 6 p.m. (Resident 51 was not T&R for eight hours out of a 24 hour period).On 2/23/26, the DSR indicated Resident 51 self -repositioned at 10 p.m. (Resident 51 was not T&R for four hours out of a 24 hour period).On 2/24/26, the DSR indicated Resident 51 self -repositioned at 12 a.m. and 2 a.m. (Resident 51 was not T&R for six hours). The DSR indicated Resident 51 self-repositioned at 6 a.m. and 8 a.m., 10 a.m., and 12 p.m. (Resident 51 was not T&R for eight hours for a total of 14 hours out of a 24 hour period). On 2/26/26, the DSR indicated Resident 51 was not turned and repositioned at 6 a.m., 8 a.m., 10 a.m., and 12 p.m. (Resident 51 was not T&R for eight hours). the DSR indicated Resident 51 self -repositioned at 2 p.m., 4 p.m., and 6 p.m. and 8 p.m. (Resident 51 was not T&R for 10 hours for a total of 18 hours out of a 24 hour period).On 2/27/26, the DSR indicated Resident 51 self-repositioned at 2 p.m. and 4 p.m., 6 p.m., and 8 p.m. (Resident 51 was not T&R for 10 hours out of (continued on next page)

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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. Based on observation, interview, and record review, the facility failed to ensure nutritional assessment was accurate for one of two sampled residents (Resident 11). This failure had the potential for Resident 11 to not meeting her nutritional needs.Findings:During an observation on 5/11/26 at 8:50 a.m. in Resident 11's room, Resident 11 was lying in bed with a feeding tube (a soft, flexible, medical device used to deliver liquid nutrition, fluids, and medications directly into the stomach or small intestine) attached to a pole. Resident 11's feeding tube was connected to a bottle with a label of Jevity 1.5 (liquid nutrition formula).During a review of Resident 11's Dietitian Note (DN), dated 4/9/26, the DN indicated, Enteral [the administration of food, fluids, or medication directly into the stomach, typically through the mouth via a feeding tube]: Jevity 1.2 @ [at] 72 ml [milliliter]/hr [hour] x [times] 20 hrs [hours] provides 1440 ml/day, 1728 kcal [kilocalorie]/day, 80 gm [gram] protein/day, 1152 ml FW [free water]/day.During a review of Resident 11's Medication Administration Record (MAR), dated March, April, and May 2026, the MAR indicated Resident 11 received Jevity 1.5 from 3/3/26 to 5/12/26. During a review of Resident 11's Order Summary Report (OSR), dated 3/3/26, the OSR indicated, Enteral Feed Order every shift TUBE FEEDING FORMULA: Jevity 1.5 @72 ML/HR x 20hrs. continuous VIA g-tube [medical device inserted through the abdomen directly into the stomach] =1440ml/1728 kcals per 24hrs, on at 1800 [6 p.m.], off at 0400 [a.m.]; on at 0600 [a.m.], off at 1600 [6 p.m.] am shift=432cc [cubic centimeter], pm shift=432cc, noc [night] shift=576cc.During a concurrent interview and record review on 5/13/26 at 3:32 p.m. with Registered Dietitian (RD), RD reviewed Resident 11's OSR. RD stated she recommended Jevity 1.2. RD stated she was not aware the Jevity 1.2 was changed to Jevity 1.5. RD stated, I did not look at my notes, we need a better system and self-audit myself. RD stated Jevity 1.5 has more calories than Jevity 1.2. During an interview on 5/14/26 at 8:46 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated, There was a time we had no supply of Jevity 1.2, the doctor was called and okayed for Jevity 1.5. LVN 2 stated there was no documentation notifying the RD of the change in formula.During the review of the facility's policy and procedure (P&P) titled, Nutritional Assessment, dated January 2025, the P&P indicated, 2. As part of the comprehensive assessment, the nutritional assessment will be a systematic, multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition. 3. The nutritional assessment will be conducted by the multidisciplinary team and shall identify at least the following components: d. Dietitian: (1) An estimate of calorie, protein, nutrient and fluid needs; (2) Whether the resident's current intake is adequate to meet his or her nutritional needs; and (3) Special food formulations.

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	555260	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bakersfield Post Acute	6212 Tudor Way Bakersfield, CA 93306

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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** Based on interview and record review, the facility failed to ensure physician progress notes (PPN) were completed for the months of February, March, and April 2026 for one of three sampled residents (Resident 90). This failure had the potential for a change in condition to go unnoticed and a delay in care.Findings:During a review of Resident 90's admission Record (AR), undated, the AR indicated Resident 90 was admitted to the facility on [DATE].During a concurrent interview and record review on 5/13/26 at 3:41 p.m. with Medical Records Director (MRD), Resident 90's PPN dated 2026 were reviewed. MRD stated there were no PPN for the months of February, March, and April 2026. MRD stated, They (physicians) usually fax them (PPN).During an interview on 5/14/26 at 9:16 a.m. with Minimum Data Set Nurse (MDSN), MDSN stated she could not find the PPN for the last three months. MDSN stated PPN should be completed monthly. During a review of the facility's policy and procedure (P&P) titled, Physician Visits, dated April 2013, the P&P indicated, 2. The Attending Physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter. 5. The Attending Physician must perform relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation.During a review of the facility's P&P titled, Physician Progress Notes, dated February 2008, the P&P indicated, 2. Physician progress notes reflect the resident's progress and response to his or her care plan, medications, etc. 3. The resident's Attending Physician must write, sign, and date the physician progress notes upon each visit.

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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. Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, MedBank [automated medication dispensing system] Policies & Procedures when narcotic medications (controlled drugs - those drugs highly regulated by the government that carry a high potential for abuse, addiction or physical and psychological dependence) were not counted and documented consistently. This failure had the potential for the facility not to have prompt identification of loss or diversion of narcotic medication.Findings:During an interview on 5/12/26 at 11:31 a.m. with Director of Nursing (DON), DON stated there was no process in place to count the narcotics in MedBank. DON stated facility was not counting the narcotics daily in the MedBank. DON stated MedBank narcotics should be counted daily.During a review of facility's P&P titled MedBank Policies & Procedures, dated 10/2025, the P&P indicated, b. The DON [Director of Nursing] is responsible for ensuring that the cycle counting of controlled drugs in the MedBank system is performed and documented on a daily basis.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure two of six sampled residents' (Resident 51 and Resident 6) clinical documentation was complete and accurate. This failure resulted in Resident 51 and Resident 6's clinical records to be incomplete and inaccurate.Findings: 1.During a review of Resident 51's Minimum Data Set (MDS - an assessment tool), dated 3/27/26, the MDS indicated, Resident 51's Brief Interview for Mental Status (BIMS - standardized assessment tool used to evaluate the mental processes that allow individuals to think, learn, and remember) score was 15 (13 to 15 points indicates the resident has cognitive intactness). During an interview on 4/15/26 at 1:58 p.m. with Resident 51, Resident 51 stated he was dropped by a Certified Nursing Assistant (CNA 14) on Monday (4/13/26). Resident 51 stated he was supposed to be transferred with the use of a Hoyer lift (mechanical lift) and there should always be two CNAs but on Monday CNA 14 came in and transferred him alone. Resident 51 stated the Hoyer lift tipped over and he hit his head and neck on the foot board of the bed. Resident 51 stated the CNA 14 left the room and returned with CNA 15 who assisted him back to bed. Resident 51 stated he asked to be transferred back to the Geri-chair [specialized padded medical chairs on wheels designed for patients with limited mobility] so he could go and talk to the nurse and tell her what happened. He stated when he spoke to the nurse, the CNAs had already told her a whole different story. During a review of Resident 51's Change in Condition Evaluation (CICE), dated 4/13/26, the CICE indicated, [Resident 51] stated that when he was getting transferred by two CNAs to the Geri chair he hit his neck, and shoulder on the corner of the bed. [Resident 51] c/o [complained of] neck and back pain 8/10 [numeric pain scale - allow residents to rate their pain. Zero is considered no pain; 1 to 3 is mild pain; 4 to 6 is moderate pain and 7 to 10 is severe pain]. During a review of Resident 51's Alert Charting (AC), dated 4/14/26 at 4:14 a.m. the AC indicated Resident 51 was being monitored for a witnessed fall. During a review of Resident 51's AC, dated 4/14/26 at 2:35 p.m. the AC indicated, [Resident 51] also on monitoring for witnessed fall, [Resident 51] c/o of bilateral shoulder/neck pain. During a review of Resident 51's AC, dated 4/15/26 at 6:02 a.m. the AC indicated, [Resident 51] is on alert charting for a witnessed fall. During a review of Resident 51's AC dated 4/15/26 at 7:34 p.m. the AC indicated [Resident 51] on alert charting .for fall. During a concurrent interview and record review, on 4/16/26 at 1:02 p.m. with Director of Nursing (DON), Resident 51's CICE dated 4/13/26 was reviewed. Resident 51's AC dated 4/14/26, and 4/15/26 was reviewed. DON stated Resident 51's AC indicated Resident 51 sustained a fall. DON stated there was no fall that occurred, Resident 51 was sent to the acute hospital for neck and back pain at his request. DON stated Resident 51 did not hit the floor there was not a fall per the CNAs statement there was an incident but not a fall. DON stated Resident 51's AC documentation was a mistake; there were a lot of falls and the nurses got confused. Resident 51's Discharge Instructions Document (DID), dated 4/13/26 was reviewed. The DID indicated, Reason for Visit Fall. DON stated, The hospital does not put the reason we give them on the report they put what the resident says. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/11/26 at 3:54 p.m. with DON, DON stated the facility staff calls the paramedics anyone can call, Resident 51's Transfer Form (TF), dated 4/13/26, was reviewed. The TF indicated, Transfer/Discharge Details: . Reason(s) for [blank] 2. Is the reason for transfer: . 2.Unplanned. DON stated TF reason was blank. DON stated the reason is on the CICE. Resident 51's Prehospital Care Report (PCR), dated 4/13/26, was reviewed. The PCR indicated, Provider Impression . Cause of injury Fall from another level.Call Type: Falls. DON stated there was probably confusion maybe the person calling did not get the whole story. 2.During a concurrent observation and interview on 5/12/26 at 11:07 a.m. with Licensed Vocational Nurse (LVN) 3, at the nurses station, 200 hallway medication cart was audited. In the cart, there was a medication cup with eight pills in the cup. LVN 3 stated these medications were for Resident 6 and Resident 6 refused her medication. LVN 3 stated these medications were due at 9 a.m. During a concurrent interview and record review on 5/12/26 at 11:10 a.m. with LVN 3, Resident 6's Medication Administration Record (MAR), dated May 2026 was reviewed. LVN 3 stated she signed the MAR that medications were administered for 9 a.m., but medications were not administered. During a review of facility's policy and procedure (P&P) titled, Charting and Documentation, dated 4/2008, the P&P indicated, All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. During a review of the facility's policy and procedure (P&P) titled, Document Accuracy in the Health Record, dated November 2024, the P&P indicated, Clinical records should accurately reflect the care given by each member of the health care team as well as the response of the person receiving services. Accurate records are vital to the individual, to the staff and the facility administrators. For resident, the clinical record should ensure continuity of care; for the staff, it assists in coordination of services and serves as proof of work done; for administrators it substantiates cost, defends legal interest, . Clinical records are the facility personnel's mechanical memory for a resident. Coordination of this care in the records requires accurate information available to all members of the health care team. The clinical record is also a legal document. Under the doctrine of Respondent Superior, the health care institution is responsible for the actions of its employees. In litigation, the accurate recording of the facts of the situation is the best defense.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to ensure flu vaccines (an immunization to protect from the flu) were offered to two of five sampled residents (Resident 11, Resident 60). This failure had the potential for the flu spreading to all the residents in the facility due to not receiving immunizations.Findings:During a concurrent interview and record review on 5/13/26 at 1:45 p.m. with IP, IP reviewed Resident 11's immunization record. IP stated Resident 11 did not receive a flu vaccine. IP stated there was no documentation of Resident 11 was offered the flu vaccine. IP stated, Resident [11] missed the flu shot.During a concurrent interview and record review on 5/13/26 at 1:49 p.m. with IP, IP reviewed Resident 60's immunization record. IP stated Resident 60 has no record of immunization. IP stated, I missed it [to record Resident 60's immunization]. I did not get to verify.During the review of the facility's policy and procedure (P&P) titled, Influenza Vaccine, dated March 2022, the P&P indicated, All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. 1. Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated or the resident or employee has already been immunized .4. Prior to the vaccination, the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine .8. The infection preventionist will maintain surveillance data on influenza vaccine coverage and reported rates of influenza among residents and staff.