STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555265	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Post-Acute Rehab	2120 Stockton Blvd Sacramento, CA 95817

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to ensure care plans (a summary of a person's health conditions, specific care needs, and current treatments) were developed for three of 19 sampled residents (Resident 14, Resident 17, and Resident 27) when: 1. Resident 14 had no anticoagulant (a medicine that help prevent blood clots) monitoring care plan; 2. Resident 17 had no bed alarm and wheelchair alarm (pads that contains sensors that trigger an alarm when they detect a change in pressure) monitoring care plan; and, 3. Resident 27 had no bed alarm monitoring care plan. These failures had the potential to result in inaccurate and inadequate care being provided to Resident 14, 17, and 27. Findings: 1. Resident 14 was admitted to the facility in late 2024 with diagnoses which included heart failure and history of blood clots. During a review of Resident 14's Order Summary Report [OSR], dated 5/21/25, the OSR indicated, Apixaban .[an anticoagulant medication used to decrease the clotting ability of blood and prevents harmful clots]. Give 1 by mouth two times daily for DVT [deep vein thrombosis, blood clot in deep vein, usually in the legs] Prophylaxis [to prevent]. During a review of Resident 14's Medication Administration Record [MAR], dated 5/1/25-5/31/25, the MAR indicated Resident 14 received Apixaban 41 times. During a concurrent interview and record review on 5/21/25 at 9:19 a.m. with Licensed Nurse (LN 4) of Resident 14's record, LN 4 stated the use of an anticoagulant like Apixaban should have a care plan. LN 4 confirmed Resident 14 did not have a care plan for an anticoagulant. During a concurrent interview and record review on 5/21/25 at 10:29 a.m. with the Minimum Data Set Coordinator (MDSC) of Resident 14's record, the MDSC confirmed there was not a care plan and stated she would expect Resident 14 to have an anticoagulation care plan. It's important because she is at risk for bleeding. (continued on next page)

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedures (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 12/16, the P&P indicated, A comprehensive, person-centered care plan that include objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident .the comprehensive, person-centered care plan will .incorporate identified problem areas . 2. Resident 17 was re-admitted to the facility in February of 2025 for surgical aftercare following surgery on the circulatory system and had a memory problem. Resident 17 had a BIMS (Brief Interview for Mental Status-an assessment tool to screen and identify memory, orientation, and judgement status of the resident) score of 4 out of 15 which indicated Resident 17 was severely impaired in cognitive function. During a concurrent observation and interview on 5/19/25 at 12:26 p.m. in Resident 17's room with Certified Nursing Assistant 3 (CNA 3), CNA 3 was observed transferring Resident 17 from her bed to her wheelchair, when a loud alarm sounded. CNA 3 stated Resident 17 was being taken to therapy, and verified both a bed and wheelchair alarm were in use for Resident 17. During a concurrent observation and interview on 5/19/25 at 4:04 p.m. in Resident 17's room with CNA 4, CNA 4 verified both a bed and wheelchair alarm were in use for Resident 17. CNA 4 stated the expectation was to have Resident 17's alarms, on at all times. CNA 4 further stated the alarms were, Very loud .when we hear it we come running. During a review of Resident 17's medical record, there was no care plan in place for the use of either a bed alarm or wheelchair alarm for the resident. During a concurrent interview and record review on 5/19/25 at 4:14 p.m. with LN 6, Resident 17's medical record was reviewed. When asked if Resident 17 uses a bed alarm and/or wheelchair alarm, LN 6 stated, Yes, both, definitely. LN 6 verified there was no care plan for the use of a bed alarm or wheelchair alarm in Resident 17's medical record. LN 6 stated there should be a care plan for the use of the bed and wheelchair alarms. During an interview on 5/21/25 at 12:22 p.m. with Director of Nursing (DON), the DON acknowledged that some residents in the facility use bed and/or wheelchair alarms. The DON stated residents using a bed and/or wheelchair alarm should have a care plan, physician orders, and a signed consent. During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, dated December 2016, indicated, 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 .must review and update the care plan .when the resident has been readmitted to the facility from a hospital stay. 3. Resident 27 was admitted to the facility in mid-2024 with diagnoses which included a memory problem and had a history of joint replacement surgery. During a concurrent interview and observation on 5/20/25 at 2:41 p.m., in Resident 27's room with CNA 2, CNA 2 confirmed that Resident 27 had a bed alarm in place and stated, She tries to stand up and we use it to prevent her from falling down. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/25 at 10:09 p.m., with LN 4, LN 4 stated that a careplan was important because it summarized the health condition, the individual care, and intervention needed by the resident. During a concurrent interview and records review on 5/20/25 at 2:53 p.m., with the Director of Staff Development/Infection Preventionist (DSD/IP), the DSD/IP confirmed that Resident 27's bed alarm did not have a careplan in place. During an interview on 5/21/25 at 12:32 p.m., with the DON, the DON indicated that care plans should be initiated and implemented stating, so staff knows the specific needs of patients. The DON also confirmed that there was no careplan in place for Resident 27's bed alarm. During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, dated December 2016, indicated, 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 .must review and update the care plan .when the resident has been readmitted to the facility from a hospital stay.

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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 meet professional standards for one of 19 sampled residents (Resident 8) when Resident 8's oxygen order was not implemented according to physician orders. This failure had the potential to result in respiratory failure (low oxygen levels in the blood and difficulty breathing) for Resident 8. Findings: Resident 8 was admitted to the facility in May of 2024 with medical diagnoses of acute and chronic respiratory failure with hypoxia (low levels of oxygen in your body tissues), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and pneumonia. Resident 8 had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 10 out of 15 which indicated Resident 8 was moderately impaired in cognitive function. Review of physician orders indicated Resident 8 had a physician order for, O2 @ 2L per minute via NC every shift for SOB (oxygen at two liters per minute via nasal cannula every shift for shortness of breath). During an observation on 5/19/25 at 12:01 p.m. in Resident 8's room, Resident 8 was observed wearing a nasal cannula (flexible tubing that delivers oxygen to the nose with two prongs that fit inside the nostrils) attached to an oxygen concentrator that was in use. Resident 8 was receiving one liter of oxygen via nasal cannula. During a concurrent observation and interview on 5/19/25 at 12:20 p.m. at Resident 8's bedside, with Director of Staff Development/Infection Preventionist (DSD/IP), DSD/IP verified Resident 8 was using one liter of oxygen. DSD/IP stated the physician orders indicated Resident 8 should be using two liters of oxygen and that physician orders should be followed. DSD/IP further indicated Resident 8 was at risk of hypoxia. During an interview on 5/21/25 at 12:22 p.m., with Director of Nursing (DON) in the conference room, DON stated oxygen was a medication and required physician orders. The DON indicated staff was expected to follow physician orders. During a review of the facility's policy and procedure titled, Medication Administration-General Guidelines, dated October 2017, indicated, Medications are administered as prescribed in accordance with good nursing principles and practices.

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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 observation, interview, and record review, the facility failed to ensure pharmacy services were maintained for one of 50 residents when two controlled drug record forms (count sheet forms for medication that may be abused or cause addiction) were not accurately completed for Resident 12. This failure had the potential in diversion of the Resident's 12 controlled medications and increased risk of medication error. Findings: During an inspection of medication cart 1 on 5/19/25 at 3:33 p.m. with Licensed Nurse 2 (LN 2), two controlled drug count sheets were identified to have inaccurate counts for Resident 12's buprenorphine patch (a medication patch delivers opioid through the skin to control chronic pain) 10 mcg/hr (microgram per hour, unit of measure). During an interview on 5/19/25 at 3:33 p.m. with LN 2, LN 2 stated a buprenorphine patch was given to Resident 12 on 5/18/25 at 9 a.m.; however, it was inaccurately documented on the wrong count sheet for the wrong prescription count sheet. LN 2 acknowledged because of this error both count sheets had incorrect counts on them and the issue was not identified during nurses inventory count during shift change. During an interview on 5/22/25 at 9:30 a.m. with the Director of Nursing (DON), the DON acknowledged the issue with the controlled medication count sheet and the identified discrepancies. The DON stated, Training was provided to the nurses to check the prescription number before documenting the dose on the count sheet. During a review of the facility's policy and procedure (P&P) titled, Medication Storage In The Facility, dated 2014, the P&P indicated, The director of nursing and the consultant pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications .At each shift change, a physical inventory of all controlled medications .is conduced by two licensed nurses and is documented on the controlled medications accountability record .Any discrepancy in controlled substance medication counts is reported to the director of nursing immediately.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure the medication rate did not exceed 5% (percent, unit of measure) for two of three sampled residents (Resident 302 and Resident 40). 1. For Resident 302, a Licensed Nurse (LN) did not administer resident's lidocaine patch (medication patch used to treat pain) 5 % as it was prescribed by the doctor. 2. For Resident 40, an LN did not administer resident's finasteride (hazardous medication used to treat an enlarged prostrate) 5 mg (milligram, unit of measure) as prescribed by the doctor. These failure resulted in a medication error rate of 6.45 % with two errors occurring out of 31 opportunities during the observation of medication administration. Findings: 1. During an observation of medication administration on 5/19/25 at 8:43 a.m., LN 4 was observed to prepare and administer Resident 302's morning medications which included two lidocaine 5% patches. The two patches were applied on Resident 302's lower back. Reconciliation of the observed medication administration for Resident 302's current Physician Orders, dated 5/9/25, indicated to apply 3 lidocaine 5% patches to lower back topically in the morning for lower back pain and remove per schedule. During a review of Resident 302's Medication Administration Record (MAR), dated 5/19/25, the MAR indicated that 3 lidocaine 5% patches were administered to Resident instead of 2 patches. During an interview and concurrent record review on 5/19/25 at 1:51 p.m. with LN 4, LN 4 stated, the Physician Order was for 3 lidocaine 5% patches, but only two patches were administered in the morning instead of three. During an interview on 5/21/25 at 11:38 with the Director of Nursing (DON), the DON acknowledged the lidocaine patches were not administered per the physician orders. During a review of facility's policy and procedure (P&P) titled, Administering Medications, dated 2001, the P&P indicated, Medications must be administered in accordance with the orders . and The individual administering the medication must check the label THREE (3) times to verify the right resident, right dosage . before giving the medication. 2. During an observation of medication administration on 5/19/25 at 9:04 a.m., LN 5 was observed to prepare and administer Resident 40's morning medications which included finasteride, without wearing gloves. Reconciliation of the observation of medication administration with Resident 40's current Physician Orders dated 4/26/25, indicated, 1 tablet daily, use gloves to handle. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 40's Medication Administration Record (MAR), dated 5/19/25, the MAR indicated a dose of finasteride was administered to Resident 40. During an interview on 5/19/25 at 9:17 a.m. with LN 5, LN 5 stated, s/he was not aware of special handling requirements for administering finasteride and thought the gloves were only to prevent infection. LN 5 acknowledged s/he did not wear gloves when handling and administering finasteride. During an interview on 5/21/25 at 11:38 with the DON, the DON acknowledged the finasteride tablet was not administered per the physician orders. During a review of facility's policy and procedure (P&P) titled, Administering Medications, dated 2001, the P&P indicated, Medications must be administered in accordance with the orders . and The individual administering the medication must check the label THREE (3) times to verify the right resident, right dosage before giving the medication. A review of finasteride's Safety Data Sheet (a document that provides detailed information about the hazards of a chemical substance), dated 2/12/24, indicated, reproductive toxicity .consider double gloves .or other impervious gloves if skin contact is possible .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were stored correctly, when: 1. The medication refrigerator temperature was out of range in the medication room which put medication requiring specific temperature at risk of degradation, 2. Resident 36's opened inhaler (used to administer medication by breathing in) in the medication cart 1 was not dated when opened, which put Resident 36 at risk of receiving ineffective expired or outdated medication, 3. An opened, undated multidose container of glucose test strip was found in medication cart 1, which had the potential risk of using expired, or inaccurate glucose test strips to monitor resident's blood glucose levels. These failures had the potential to result in ineffective medication therapy for residents receiving medications stored in the medication refrigerator, for Resident 36 and for residents using glucose test strips from the medication cart 1. Findings: 1. During a concurrent observation and interview on [DATE] at 2:26 p.m. with the Director of Staff Development/Infection Preventionist (DSD/IP), the DSP/IP stated, the medication refrigerator temperature was at 32 degrees F (Fahrenheit, unit of measure). The refrigerator contained medications which included insulin (medication to treat high blood sugar), and nemolizumab (an injectable specialty medication used to treat skin lesions). The DSP/IP also stated, the medication's shelf-life and effectiveness could be shortened when stored outside of the temperature storage guidelines specified by the manufacturers. During an interview on [DATE] at 3:27 p.m. with Licensed Nurse (LN) 2, LN 2 stated when the medication refrigerator was too cold the medications could not be given. The medication would freeze and crystallized and it would not work. During an interview on [DATE] at 11:38 a.m. with the Director of Nursing (DON), the DON acknowledged the refrigerator temperature was out of range and the temperature should had been within the range of 36 to 46 degrees F. A review of an article by Consumer Med Safety (a nationally recognized medication safety organization) titled, Insulin Safety Center, dated 2025, stated, Do not keep insulin in places that freeze. If insulin is frozen, do not use it even after thawing. Freezing temperatures will breakdown the insulin .it will not work well to lower .blood sugar. During a review of the manufacturer's prescribing information for nemolizumab, dated 12/24, indicated, Storage and Handling .store prefilled pen in a refrigerator at 36-46 degree F .Do not freeze . (continued on next page)

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F 0761 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, Medication Storage in the Facility, dated 2008, the P&P indicated, Medications requiring refrigeration or temperatures between 36 F and 46 F [degrees] are kept in a refrigerator with a thermometer to allow temperature monitoring . During a review of the facility's policy and procedure (P&P) titled, Medication Storage in the Facility, dated 2008, the P&P indicated, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of suppliers. 2. During an inspection of medication cart 1 on [DATE] at 3:27 p.m. with LN 2, an open a multidose unit of umeclidinium and vilanterol inhalation powder (combination of two medications used for breathing issues) was found without an open date (date the medication was removed from the protective foil pouch). During an interview on [DATE] at 3:27 p.m. with LN 2, LN 2 was unable to find the open date and therefore was unable to provide the product's expiration date. LN 2 acknowledged that the product should have been removed and discarded from the active medication area. During an interview on [DATE] at 11:38 a.m. with the DON, the DON acknowledged multidose pharmaceutical products needed to be labeled when opened with the date to ensure effectiveness. During a review of the umeclidinium and vilanterol inhalation manufacturer box and label, the box and label indicated, discard within 6 weeks after removing from foil pouch [opening] . During a review of the facility's P&P titled, Administering Medications, dated 2012, the P&P indicated, The expiration/beyond use date on the medication label must be checked prior to the administering. When opening a multi-dose container, the date opened shall be recorded on the container. During a review of the facility's P&P titled, Specific Medication Administration, dated 2008, the P&P indicated, Read medication label before administrating. During a review of the facility P&P titled, Medication Storage in the Facility, dated 2008, the P&P indicated, . Outdated, contaminated or deteriorated medications .are immediately removed from stock. 3. During an inspection of medication cart 1 on [DATE] at 3:30 p.m. with LN 2, an open bottle of glucose test strips (strip that can be used to measure blood sugar level) was found without an open date label. During an interview on [DATE] at 3:30 p.m. with LN 2, LN 2 was unable to find the open date and therefore was unable to provide the product's expiration date. LN 2 acknowledged that the product should have been removed and discarded from the active medication area. During a review of the manufacturer's label printed on the bottle, the label indicated, use within 3 months after opening. During a review of the facility's P&P titled, Administering Medications, dated 2012, the P&P indicated, When opening a multi-dose container, the date opened shall be recorded on the container. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Specific Medication Administration, dated 2008, the P&P indicated, Read medication label before administrating. During a review of the facility's P&P titled, Medication Storage in the Facility, dated 2008, indicated, . Outdated, contaminated or deteriorated medications .are immediately removed from stock.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, the facility failed to provide alternative meal options of similar protein/calorie value to the meal entrée when grilled cheese sandwich or cheese quesadilla were provided in place of the entree. This failure had the potential of leading to protein/calorie malnutrition for those choosing these alternatives for census of 50. Findings: During the initial kitchen tour on 5/19/25 at 8:15 a.m., the alternative menu was observed hanging in the kitchen over the preparation counter. This menu included the option of a grilled cheese sandwich as an alternate meal. During an observation of the lunch meal plating on 5/20/25 at 12:10 p.m., a cheese quesadilla was prepared as an alternative to the main entrée. Later two grilled cheese sandwiches were also prepared and given instead of the entree. One cheese sandwich was for a resident who requested no pork or chicken. The sandwich was made with two slices of bread and one slice of cheese. The quesadilla was made with two corn tortillas and one-fourth cup shredded cheese, the equivalent of two ounces. This provided approximately 9 to 15 grams of protein (in the alternative entrees) as opposed to the 21 grams provided in the main entrée. During an interview on 5/20/25 at 3:38 p.m. with the Registered Dietician (RD), RD stated alternate meals should have the equivalent protein content as the meal being provided. During an interview on 5/21/25 at 10:20 a.m., with the Dietary Supervisor (DS), DS stated that adding an item to the side of a grilled cheese sandwich such as yogurt, soup, cottage cheese, or beans with the quesadilla could provide an equivalent nutritional value for the lower protein alternative choices. During a review of the facility's policy titled, Menus, revised 10/17, the policy indicated, If a food group is missing from a resident's daily diet (e.g., dairy products), the resident is provided an alternative means of meeting his or her nutritional needs .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare and serve food in accordance with professional standards for food service safety when: 1. Sanitation was compromised by rust-colored stains under the hand wash sink, and there were unpainted patches on several walls in kitchen and dry storage, 2. Food items were found with incomplete labeling, 3. Expired foods were found in the reach-in refrigerator, 4. A wet steam table pan was found stored wet, 5. Dumpster lid was propped open on two difference occasions, and 6. Tuna salad made from room temperature tuna was not monitored and cool-down to 41 degrees F (Fahrenheit, a unit of measure). These failures had the potential to lead to the growth of microorganisms (bacteria, virus, or fungus) and foodborne illness for the 50 residents eating facility prepared meals. Findings: 1. During the initial kitchen tour on 5/19/25 at 8:15 a.m., rust-colored stains were noted under the hand washing sink and unpainted patches were seen on several walls in the kitchen and dry storage areas. During a concurrent observation and interview on 5/19/25 at 9:55 a.m. with the Maintenance Manager (MM), the rust under the sink was discussed. He confirmed the rust and the patches on the wall in the storage areas and over the fruit and vegetable wash sink. MM stated he recently worked on the wall but had not had a chance to paint it yet. During an interview on 5/20/25 at 3:38 p.m. with the Registered Dietician (RD), RD stated the walls needed to be cleaned and sanitized to prevent cross-contamination which could only happen when the walls were smooth and free of defects. Review of the US Food and Drug Administration's 2022 Food Code section 6-201.11 on (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Post-Acute Rehab	2120 Stockton Blvd Sacramento, CA 95817

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Floors, Walls, and Ceilings indicated that Except as specified under § 6-201.14 . walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are smooth and easily cleanable. During a review of the facility's policy titled, Sanitization, revised 10/08, the policy indicated, All .shall be kept clean, maintained in good repair and shall be free from . chipped areas that may affect their used or proper cleaning . During a review of the facility's policy titled, Kitchen Maintenance Policy, revised 5/19/25, the policy indicated, To ensure the kitchen area is maintained in a clean, safe, and sanitary condition at all times to support the health and well-being of residents and staff, and to comply with all applicable federal, state, and local regulations, including CMS (Centers for Medical/Medicaid Services), FDA (Food and Drug Administration) Food Code, and health department standards. 2. During the initial kitchen tour observation and concurrent interview with the Dietary Supervisor (DS), on 5/19/25 at 8:15 a.m., a container of ground rosemary had no date, containers of ground mustard and rubbed sage were labeled 3/24, and a container of Jamaican jerk seasoning had a date that was rubbed off. DS confirmed there was no date and stated labels should include a year, as seasonings were good for one year. During an observation on 5/20/25 at 8:56 a.m., a box of mixed fruit cups and three containers of peach cups were marked with 7B, no date or name. Directions on the outside of the resident refrigerator door indicated to label food items with the resident's name, date brought to facility and date to discard. During an interview on 5/20/25 at 9:14 a.m. with the Director of Nursing (DON), the DON acknowledged that there was no name or date for the two fruit items in the refrigerator. The DON also stated that without a name the items could be given to the wrong residents, as residents (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	changed rooms periodically or might be discharged to home and a new resident might be in that bed. During an interview on 5/20/25 at 3:38 p.m., with the RD, RD stated staff were expected to label all resident food with a name, date that it was placed in the refrigerator, and the date to discard. Food provided by the facility needed an opened date, expiration date, and/or used by date. The RD further stated that the date must include the month, day, and year as it would be hard to know the exact time it is no longer safe without a complete date. During a review of the facility policy titled, Refrigerators and Freezers, revised 12/14, the policy indicated, All food shall be appropriately dated to ensure proper rotation by expiration dates. 'Received' dates (dates of delivery) will be marked on cases and on individual items removed from cases for storage. 'Used by' dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and 'use by' dates indicated once food is opened. During a review of the facility policy titled, Foods Brought by Family/Visitors, revised 10/17, the policy indicated, Food brought by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that it is clearly distinguishable from facility-prepared food. Perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the 'use by' date. 3. During the initial kitchen tour observation and concurrent interview with DS, on 5/19/25 at 8:15 a.m., Feta cheese was dated 4/23/25, with a use by date of 4/26/25 that was still in the refrigerator. While the DS stated it was mislabeled and was good for thirteen days, the cheese was past the used by date. A plate of lettuce and tomato in the reach-in refrigerator had a use by date of 5/18/25. DS concurred it was expired and it should have been tossed by the AM cook. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/20/25 at 3:38 p.m., with the RD, RD stated, Expired food needs to be removed from the refrigerator. Expired food can cause food borne illness. During a review of the facility policy titled, Refrigerators and Freezers, revised 12/14, the policy indicated, Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates. Supervisors should contact vendors or manufacturers when expiration dates are in question or to decipher codes. 4. During the initial kitchen tour on 5/19/25 at 8:15 a.m., one steam table pan was found wet on the ready-to-use shelf. During an interview on 5/20/25 at 3:38 p.m. with the RD, RD stated staff were expected to allow the equipment to air-dry. The RD stated, Wet nesting (pans that are stacked and stored wet) leads to bacteria forming on the surface. According to the Federal Food and Drug Administration (FDA) 2022 Food Code, Section 4-901.11 on Equipment and Utensils, Air-Drying Required indicated, After cleaning and sanitize, equipment and utensils: (A) Shall be air-dried .before contact with food; and (B) May not be cloth dried . During a review of the facility's policy titled, Sanitization, revised 10/08, the policy indicated, All food preparation equipment and utensils that are . washed will be allowed to air dry . 5. During the initial kitchen tour on 5/19/25 at 8:15 a.m., the outside garbage dumpster was observed with one side propped open with no employees currently using it. During an observation on 5/20/25 at 8:43 a.m., the dumpster was observed with one side propped open again with no employee in sight. During an interview on 5/20/25 at 3:38 p.m., with the RD, RD stated dumpsters being left open could attract and harbor pests. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/21/25 at 1:35 p.m., with DS, DS stated that dumpsters should be closed unless in use. The RD stated, Having the dumpsters open so close to the kitchen could attract flies into the kitchen. During a review of the facility's policy titled, Food-Related Garbage and Refuse Disposal, revised 10/17, the policy indicated outside dumpsters by garbage pickup services will be kept closed and free of surrounding litter. 6. During an observation on 5/20/25 at 9:45 a.m., [NAME] 1 was observed making tuna salad. When questioned, cook 1 stated the can of tuna she was using had come from the dry storage and was not prechilled. During an interview on 5/20/25 at 9:54 a.m. with the DS, DS stated the facility did not keep a cool-down log (a log that measures cooling times of food), as they only heat and serve foods. During an interview on 5/20/25 at 3:38 p.m., with the RD, RD stated tuna salad that was not previously chilled, needed to have the temperatures monitored to ensure there would be no harmful bacterial growth. A review of the US FDA 2022 Food Code, section 3-501.14, titled, Cooling, 1/18/23 version, indicated, .(B) Time/temperature control for safety food shall be cooled within 4 hours to . 41 degrees F or less if prepared from ingredients at ambient (room) temperature, such as reconstituted foods and canned tuna . During a review of the facility's policy titled, Food Preparation and Service, revised 10/17, the policy indicated, The longer foods remain in the danger zone the greater the risk for growth of harmful pathogens. Therefore, PHF (potentially hazardous foods) must be maintained below 41 F or above 135 F. Potentially hazardous foods held in the danger zone for more than 4 hours (if being prepared from ingredients at room temperature) or 6 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow infection control policies for three sampled residents (Resident 12, Resident 24, and Resident 38) out of a census of 50 when: 1. Staff did not wear a gown when providing high contact care to one resident (Resident 12) on Enhanced Barrier Precautions (an infection control strategy used in healthcare settings to prevent the spread of multi-drug resistance organisms) nor did staff wash hands or change gloves between residents' care (Resident 12 and Resident 38); and, 2. Resident 24's oxygen tubing was not labeled with a start date. These failures had the increased potential to spread of infection for the residents in the facility. Findings: 1. Resident 38 was admitted to the facility early 2025 with diagnoses which included infection of spine hardware, respiratory failure, pneumonia, and bacterial infection resistant to common antibiotics. Resident 12 was admitted to the facility early 2025 with diagnoses which included brain dysfunction, inadequate control of blood sugars, kidney failure, thyroid cancer, and muscle weakness. During a review of Resident 38's Order Summary Report [OSR], dated 5/21/25, the OSR indicated Resident 38 received medications intravenously (IV) through a peripherally inserted central catheter (PICC, a thin flexible tube inserted into a vein in the arm). During a review of Resident 38's Care Plan (CP) created 4/16/25, the CP indicated, Potential for IV- related complications such as infection .Implement ENHANCED BARRIER PRECAUTIONS . During an observation on 5/19/25 at 9:05 a.m. of Resident 38's brief change, Certified Nursing Assistant (CNA 1), CNA 1 wore gloves, but did not wear a gown while she provided incontinent care. CNA 1 did not change her gloves or wash her hands and walked to Resident 12's bed, touched the curtain around the bed and re-arranged the pillows under Resident 12's head. During a concurrent observation and interview on 5/19/25 at 9:13 a.m. with CNA 1 of the sign outside Resident 38 and Resident 12's room, CNA 1 confirmed there was a sign posted that indicated, ENHANCED BARRIER PRECAUTION .PROVIDERS AND STAFF MUST ALSO .Wear gloves and gown for the following High-Contact Resident Care Activities. Dressing .Providing Hygiene, Changing briefs Do not wear the same gown and gloves for the care of more than one person. CNA 1 confirmed she was not wearing a gown when she provided care for Resident 38, and also confirmed she did not change her gloves or wash her hands between providing care for different residents. CNA 1 stated it was important to follow the EBP for the safety of residents and to not spread infection. During an interview on 5/19/25 at 9:35 a.m. with Licensed Nurse (LN 3), LN 3 stated staff should wear a gown and gloves when personal care was provided for residents on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/21/25 at 10:06 a.m. with the Director of Staff Development/Infection Preventionist (DSD/IP), the DSD/IP stated residents with IV's would be on EBP and a sign placed outside the door. The DSD/IP stated the staff should wear a gown and gloves when providing care, The whole reason it [EBP] was started was to prevent cross contamination. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precaution, dated 6/20/24, the P&P indicated, To maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections .Facility staff shall perform hand hygiene and will don gown and gloves before performing the following high-contact resident care activities .providing hygiene, changing linens, changing briefs or assisting with toileting .While caring for a resident, staff will change gloves after having contact with secretions or excretions, and hand hygiene will be performed in between . 2. Resident 24 was admitted to the facility in March of 2025 for aftercare following joint replacement surgery. Resident 24 was diagnosed with chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). Resident 24 had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 13 out of 15 which indicated Resident 24 was cognitively intact. During an observation on 5/19/25 at 12:43 p.m. in Resident 24's room, Resident 24 was wearing a nasal cannula (flexible tubing that delivers oxygen to the nose with two prongs that fit inside the nostrils) attached to an oxygen tank that was in use. The nasal cannula was not labeled. During an interview on 5/19/25 at 12:48 p.m. in Resident 24's room with LN 1, LN 1 verified the nasal cannula was not labeled with a start date and it was unknown how long the nasal cannula had been in use. LN 1 further indicated the nasal cannula should be labeled with a start date and changed weekly to prevent the accumulation of bacteria. During a review of Resident 24's physician orders, dated 5/9/25, the orders indicated, O2 1L NC PRN for SOB (oxygen one liter nasal cannula as needed for shortness of breath). During an interview on 5/21/25 at 12:22 p.m. with Director of Nursing (DON), the DON stated oxygen tubing should be clean, changed weekly and labeled with a start date.