STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555283	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crystal Ridge Care Center	396 Dorsey Drive Grass Valley, CA 95945

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review the facility failed to ensure an irregularity was identified during the medication regimen review for one of 26 sampled residents (Resident 82) when Resident 82 had an order for a PRN (as needed) psychotropic medication (a drug that affects brain activities associated with mental processes and behavior) without a stop date. This failure had the potential for Resident 82 to receive unnecessary medication. Findings: A review of an admission record indicated Resident 82 was admitted in September 2024 with diagnoses including anxiety. A review of Resident 82's Order Summary Report dated 3/6/25 indicated, an order for lorazepam (an anti-anxiety medication) 0.5 milligrams (mg, a unit of measurement) every four hours PRN. A review of Resident 82's Medication Administration Record (MAR) revealed, Resident 82 received lorazepam 31 times in March 2025, 38 times in April 2025, and 27 times in May 2025. In an interview on 5/22/25 at 3:36 p.m. with the Pharmacy Consultant (PC), the PC after reviewing Resident 82's clinical record confirmed that the PRN order for lorazepam did not have an end date. PC stated a medication regimen review should have been completed for Resident 82's lorazepam order with a recommendation to the doctor to put a 14 day stop date per regulation. A review of the facility's policy titled Psychotropic Medication Use revised in October 2024 indicated The need to continue PRN orders for psychotropic medications requires . the physician . clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences. A review of the facility's policy titled Medication Regimen Review revised in October 2024 stipulated The pharmacist shall review each resident's medication regimen monthly . when a clinically significant adverse consequence is confirmed or suspected . the pharmacist and/or physician . will identify situations where medications should be tapered, discontinued, or changed.

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

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on interview and record review the facility failed to ensure a significant change in status assessment (SCSA, an assessment that indicates major decline or improvement in the resident's status) was initiated for one of 26 sampled residents (Resident 294) when Resident 294 developed a stage four pressure ulcer (PU, deep wound reaching the muscles, ligaments, and bones) to the sacrococcyx (joint that connects the sacrum- triangular bone and the coccyx - tail bone). This failure decreased the facility's potential to provide appropriate care and services to Resident 294 based on his status. Findings: A review of an admission record indicated Resident 294 was admitted in February 2025 with diagnoses including Guillain-Barre Syndrome (GBS, a rare neurological disorder where the body's immune system attacks the peripheral nervous system resulting in muscle weakness or temporary paralysis) and adult failure to thrive (FTT, a decline in an older adult's overall health and function). A review of the Skilled Wound Care consult notes for Resident 294 on 4/3/25, 4/10/25, and 4/17/25 indicated that a stage four PU to the sacrococcyx area had already developed, was evaluated and treated by the wound doctor. A review of Resident 294's Order Summary Report dated 5/16/25 indicated an order for the treatment of a stage four PU to Resident 294's sacrococcyx daily and as needed. In a concurrent interview and record review on 5/21/25 at 10:10 a.m. with the Minimum Data Set (MDS, a federally mandated resident assessment tool) Coordinator 1 (MDSC 1), Resident 294's MDS assessments were reviewed, MDSC 1 confirmed that an SCSA was not done for Resident 294 and should have been initiated 14 days after the stage four PU was established by the wound doctor. In an interview on 5/22/25 9:07 a.m. with the Director of Nursing (DON) DON stated it was her expectation that the MDSCs should complete resident assessments properly and on time. A review of the facility's policy titled Change in a Resident's Condition or Status revised in October 2024 indicated If a significant change in the resident's physical or mental or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted as required by current OBRA [Omnibus Budget Reconciliation Act, for Nursing Homes] regulations governing resident assessments and as outlined in the MDS RAI [Resident Assessment Instrument] Instruction Manual.

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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 - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the care plan to monitor newly identified behaviors was followed for one of 26 sampled residents (Resident 50). This failure increased the potential for Resident 50 to take medications without a physician's order and potentially cause side effects or adverse effects to resident. Findings: A review of the clinical records indicated Resident 50 was admitted [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), post- traumatic stress disorder (PTSD- a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), and mental disorder (a condition that affects thinking, feeling, mood, and behavior). A review of Resident 50's Minimum Data Set (MDS- federally mandated resident assessment tool) dated 2/25/25 indicated Resident 50 had moderate cognitive impairment with a score of 11 out of 15 in the Brief Interview of Mental Status (BIMS- an assessment tool used screen and identify memory, orientation, and judgement status of the resident). In a concurrent observation and interview on 5/20/25 at 9:01 a.m., Resident 50 took out a medication bottle from his closet. The medication bottle indicated cholecalcif [sic, cholecalciferol] 25 mcg [microgram- unit of measurement] (D3- 1,000 units). The label on the bottle indicated to take one tablet every other day for Vitamin (Vit) D supplementation. Resident 50 stated the medication came from home and he was supposed to take it every day. An interview was conducted on 5/20/25 at 9:38 a.m. with LN 4 outside Resident 50's room. LN 4 confirmed there was a bottle of Vit D3 medication in Resident 50's room and he was not aware of it. In a follow up interview on 5/20/25 at 1:24 p.m., Resident 50 stated there was probably 50 pills inside the bottle of the Vit D3. Resident 50 further stated he had been taking 1 pill from this bottle since he had been in the facility and he did not know if nurses were aware he was taking the medication. A subsequent observation and interview was conducted on 5/20/25 at 1:54 p.m., inside Resident 50's room. Resident 50 took out a plastic container inside his closet then placed the contents in a piece of napkin. Resident 50 stated these were the medications he had collected since admission. Resident 50 stated he did not take these medications because he had no idea what they were. Resident 50 further stated he did not report not taking these medications. Resident 50 further stated these medications were left at bedside and he was not sure what they were. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/21/25 at 4:32 p.m., the LN 5 stated if a resident was admitted from the hospital, the admitting nurse sends a list of medications to the pharmacy and the pharmacy delivered the medications. The LN 5 further stated they never allowed medications to be kept at resident's bedside including over the counter medications. The LN 5 answered no when she was asked if residents can self-administer medication. A concurrent interview and record review was conducted on 5/21/25 at 4:42 p.m. with LN 5. LN 5 accompanied State surveyor in Resident's 50's room. Resident 50 refused to talk with LN 5 and State surveyor. Once outside Resident 50's room, the State surveyor showed LN 5 the picture of Resident 50's medications taken on 5/20/25. LN 5 stated that's concerning after LN 5 saw the picture and LN 5 stated she would inform the Director of Nursing regarding the medications in Resident 50's room. In an interview on 5/21/25 at 4:52 p.m., the Infection Preventionist (IP) stated she worked with Resident 50 since admission. The IP described Resident 50 as very delusional, resident comes off as very alert and oriented but has extreme behaviors, such as accusing kitchen of poisoning his food. The IP further stated Resident 50's capacity (ability to use and understand information to make a decision) was taken away and he was conserved (a legal process where court determines an individual cannot manage their own affairs and appoints a conservator on their behalf). The IP stated she was not aware of Resident 50's storing medications in his room. The IP further stated Resident 50 would not take medications from her if he did not see [IP] prepare them. A concurrent interview and record review was conducted on 5/23/25 starting at 9:49 a.m. with the Director of Nursing (DON). The DON stated this was the first time the facility was made aware of the medications in Resident 50's room. The DON's concern was for Resident 50 to have an escalation of behavior. The DON reviewed Resident 50's care plan at 10:25 a.m. and stated the care plan was updated on 5/22/25 for psychosocial behavior of hiding medications in the room, ordering over the counter medications from outside sources and refusing staff to enter the room and retrieve item. The DON further stated her expectation was for staff to be monitoring these behaviors. The DON confirmed she could not find Resident 50's behavior monitoring in the clinical records. In an interview on 5/23/25 at 11:35 a.m., the Medical Records Director (MRD) stated there was no monitoring for Resident 50's behaviors in the MAR. A review of the facility's policy & procedure reviewed October 2024 and titled, Care Plans, Comprehensive indicated, A comprehensive 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 .The care plan interventions are derived from analysis of the information gathered as part of the comprehensive assessment.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure care and services were provided according to accepted standard of practice for three of 26 sampled residents (Resident 50, Resident 88, and Resident 74) when: 1. Resident 50's medications were left at bedside; 2. Resident 88 had no physician's order on the use of neck brace; and 3. Resident 74's order to check placement of resident's Gastrostomy Tube (GT, tube inserted into the stomach to deliver nutrition, and medications) was not followed. These failures had the potential to negatively impact the physical, mental, and psychosocial wellbeing of Resident 50, Resident 88, and Resident 74. Findings: 1. A review of the clinical records indicated Resident 50 was admitted [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), post- traumatic stress disorder (PTSD- a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), and mental disorder (a condition that affects thinking, feeling, mood, and behavior). A review of Resident 50's Minimum Data Set (MDS- federally mandated resident assessment tool) dated 2/25/25 indicated Resident 50 had moderate cognitive impairment with a score of 11 out of 15 in the Brief Interview for Mental Status (BIMS- an assessment tool used to screen and identify memory, orientation, and judgement status of the resident). A review of Resident 50's physician order dated 5/19/25 indicated Amoxicillin-Pot (Potassium) Clavulanate (antibiotic) 875-125 mg (milligram, unit of measurement) give one tablet by mouth two times a day for sinusitis (inflammation of the sinuses or the hallow spaces in the bones surrounding the nose) for 10 days. During a concurrent observation and interview conducted on 5/20/25 at 8:58 a.m., inside Resident 50's room. Observed a medication cup containing eight medications in Resident 50's meal tray. Resident 50 stated the medications were given this morning. Resident 50 further stated he had an antibiotic, a decongestant, two of his vitamins he brought with him, a stool softener, and 3 other medications he was not able to identify inside the medication cup. In a subsequent observation and interview on 5/20/25 at 9:01 a.m., Resident 50 took out a medication bottle from his closet. The medication bottle indicated cholecalcif [sic, cholecalciferol] 25 mcg [microgram- unit of measurement] (D3- 1,000 units). The label on the bottle indicated to take one tablet every other day for Vitamin D supplementation. Resident 50 stated the medication came from home and he was supposed to take it every day. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A concurrent interview and record review was conducted on 5/20/25 starting at 9:19 a.m. with Licensed Nurse 4 (LN 4). LN 4 confirmed he gave Resident 50's medications at around 7:55 a.m. LN 4 opened the electronic Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) and he stated he gave Resident 50 a total of eight pills namely Vitamin B12 (Cyanocobalamin-keeps nerve cells healthy), docusate sodium (stool softener), Men's vitamins (provides essential vitamins and minerals), Amoxicillin, Mucinex (helps reduce chest congestion), Multivitamins with minerals, Vitamin D3 (for healthy bones) and Osteo joint health triple strength (to support joint health). LN 4 stated he observed Resident 50 take his medications this morning. In an interview on 5/20/25 at 9:27 a.m., LN 4 stated he saw Resident 50 take his antibiotic and the rest of his medications were set side by resident. In an interview on 5/20/25 at 9:29 a.m., LN 4 stated they were not allowed to leave medications at bedside and since Resident 50 was waiting for the food, LN 4 left seven pills at bedside. In a concurrent interview, and record review on 5/20/25 at 9:32 a.m., LN 4 stated he took the antibiotic from the bubble pack and the count sheet for Resident 50's antibiotic was signed by LN 4 on 5/20/25 at 8:20 a.m. A follow up observation and interview was conducted on 5/20/25 at 9:33 a.m. inside the room with LN 4 and Resident 50. LN 4 saw the medication cup in Resident 50's meal tray. LN 4 stated he saw Resident 50 take his antibiotic and Resident 50 responded he did not take any medications. LN 4 clarified he gave the medication cup to Resident 50 and LN 4 did not see [Resident 50] take his medications. LN 4 further stated Resident 50 told LN 4 he wanted to take his medications with meals. A follow up interview was conducted on 5/20/25 at 9:38 a.m. with LN 4 outside Resident 50's room. LN 4 stated Resident 50 specifically wanted his privacy, and resident would refuse medications if [LN 4] was with him. LN 4 confirmed there was a bottle of Vitamin D3 medication in Resident 50's room and he was not aware of it. LN 4 further stated he cannot leave medications at bedside. LN 4 stated Resident 50 was by himself in the room, nobody can take the medications, and he trusted Resident 50. In a review of Resident 50's 'Medication Admin [Administration] Audit Report' dated 5/20/25, LN 4 documented the administration time for the eight medications was from 8:12 a.m. to 8:18 a.m. and the LN 4's documentation time was 5/20/25 at 8:20 a.m. In an interview on 5/21/25 at 4:32 p.m., LN 5 stated if a resident was admitted from the hospital, the admitting nurse sends a list of medications to the pharmacy and pharmacy delivered the medications. LN 5 further stated they never allowed medications to be kept at bedside including over the counter medications. LN 5 answered no when she was asked if residents can self-administer medication. In an interview on 5/21/25 at 4:37 p.m., the Assistant Director of Nursing (ADON) stated the facility had one resident who can self-administer medications, and it was not Resident 50. The ADON further stated they have interdisciplinary (IDT) conference, care plan, and a physician order if a resident is able to self-administer medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a subsequent interview on 5/21/25 with LN 5, LN 5 stated all medications refused by a resident were crushed and placed in a bottle stored in the narcotic box inside the medication cart. LN 5 further stated medications are not left at bedside. A concurrent interview and record review was conducted on 5/21/25 at 4:42 p.m. with LN 5. LN 5 accompanied State surveyor in Resident 50's room. Resident 50 refused to talk to LN 5 and State surveyor. Once outside Resident 50's room, the State surveyor showed LN 5 the picture of Resident 50's medications taken on 5/20/25. LN 5 stated that's concerning when LN 5 saw the picture and LN 5 stated she would inform the Director of Nursing regarding the medications in Resident 50's room. In an interview on 5/21/25 at 4:52 p.m., the Infection Preventionist (IP) stated she worked with Resident 50 since admission. The IP described Resident 50 as very delusional, resident comes off as very alert and oriented but has extreme behaviors such as accusing kitchen of poisoning his food. The IP further stated Resident 50's capacity (ability to use and understand information to make a decision) was taken away and he was conserved (a legal process where court determines an individual cannot manage their own affairs and appoints a conservator on their behalf). A review of Resident 50's Attending physician's notes dated 5/22/25 indicated, .Records show that currently [Resident 50] is conserved because has been determined that patient does not have capacity. In an interview on 5/23/25 at 9:49 a.m., the Director of Nursing (DON) stated her expectation was for licensed nurses to stay at bedside and make sure resident swallowed the medications before leaving the resident's room. The DON further stated the signing of the eMAR should be done after the resident had taken the medications. The DON further expected licensed nurses (LNs) to not leave medications at bedside and if a resident refused, LNs should take away the refused medications. A review of the facility's policy and procedure revised October 2024 and titled, Administering Medications indicated, Medications are administered in a safe and timely manner, and as prescribed .If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall make a note in the eMAR .Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. 3. A review of Resident 74's admission Record, indicated Resident 74 was admitted to the facility on [DATE] with diagnosis that included, Dysphagia, Oropharyngeal Phase, (swallowing disorder that affects the ability to move food from the mouth to the throat). During a concurrent observation and interview with LN 1 on 5/21/25 at 1:45 p.m., LN 1 took out the medications for Resident 74 from her medication cart, prepared the medications to be given via GT, and went inside Resident 74's room. LN 1 connected the 60 ml Enteral Syringe (ES, device used to administer nutrition and medications) to the GT, and poured the crushed pill, mixed with water into the ES. LN 1 did not check the placement of the GT and did not flush the GT with 30 cc of water before medication administration as ordered by the physician. LN 1 stated she forgot to bring her stethoscope (instrument used to listen of someone's heartbeat or breathing), however, she decided to administer Resident 74's medication via GT without knowing if the GT is in the correct position inside Resident 74's stomach. LN 1 acknowledged she did not do a pre flush to the GT prior infusing Resident 74's medication. LN 1 stated, for Resident 74's safety, she should have checked the placement of the GT and flushed the GT with water before giving his medication. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 5/23/25 at 7:45 a.m., the DON stated, the licensed nurses must follow the physicians' orders. The parameters indicated in the physician's order must be followed for the resident's safety. The DON continued, nurses must check the placement of the GT, flush the GT with water before and after medications administration and practice infection control to promote quality of care. A review of Resident 74's Order Summary Report, indicated, Enteral Feed Order every shift for GTUBE CHECK TUBE PLACEMENT & PATENCY before each feeding. A review of Resident 74's Medication Administration Record, indicated, Enteral Feed Order every shift for GTUBE CHECK TUBE PLACEMENT & PATENCY before each feeding. A review of Resident 74's Order Summary Report, indicated, Enteral Feed Order every shift for GTUBE FLUSH TUBE FEEDING WITH 30 CC/H2O [cubic centimeters, measurements, water] BEFORE AND AFTER EACH MEDICATION ADMINISTRATION . A review of Resident 74's Medication Administration Record, indicated, Enteral Feed Order every shift for GTUBE FLUSH TUBE FEEDING WITH 30 CC/H2O BEFORE AND AFTER EACH MEDICATION ADMINISTRATION. A review of the facility's policies and procedures, titled, enteral Feedings, revised September 2024, indicated, Purpose To ensure the safe administration of enteral nutrition . The facility will remain current and follow accepted best practices I enteral nutrition . 1. Always maintain strict aseptic technique when working with enteral nutrition systems . Preventing misconnection error . 2. Regularly inspect tubing for proper and secure connections . Preventing aspiration 1. Check enteral tube placement prior to feeding or administration of medication . 2. A review of an admission record indicated Resident 88 was admitted in March 2025 with diagnoses that included cervical [neck] disc disorder after a cervical spine fusion. During a concurrent observation and interview on 5/20/25 at 9 a.m. Resident 88 was observed wearing a cervical collar while lying in bed. According to Resident 88 the nurse told him to always wear the collar per doctor's order due to the surgical incision at the back of his neck. A review of Resident 88's Order Summary Report (OSR) indicated an order for the use of a cervical collar dated 3/26/25 and an order to discontinue its use dated 4/24/25. A review of Resident 88's Skin/Wound Note dated 4/24/25 indicated that Resident 88's surgical incision at the back of the neck has been resolved and no further treatment was ordered by the doctor. In a concurrent interview and record review on 5/21/25 at 11:50 a.m. with MDS Coordinator 2 (MDSC 2) Resident 88's OSR and Progress Notes were reviewed, MDSC 2 confirmed Resident 88 wears a cervical collar. MDSC 2 added that the order for the use of the cervical collar had been discontinued. In an interview on 5/23/25 at 9:07 a.m. with the DON, the DON stated the nurse should have clarified the order, nurses should follow the doctor's order to safely care for the residents. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled Physician Orders revised in October 2024 indicated, Prescribed medication and treatment orders will be carried out in accordance with the physician order . The licensed staff shall carry out physician/nurse practitioner's orders as prescribed.

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. Based on observation, interview and record review, the facility failed to ensure resident's needs were met for one of 19 sampled residents (Resident 77) when the dining room table was too high for the resident during the lunch meal. This failure had the potential to diminish Resident 77's self-esteem and self-worth. Findings: A review of an admission Record indicated Resident 77 was admitted to the facility in May 2025 with multiple diagnoses including dementia (a progressive decline in mental abilities) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor would healing). Review of Resident 77's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 3/28/25 indicated Resident 77 had severely impaired cognition. Further review of MDS indicated that Resident 77 needed set up or clean-up assistance for eating. A review of Resident 77's Care Plan dated 5/12/25, indicated Resident 77 had Nutritional Risk: Moderate . interventions . assist resident to the dining room for all meals as tolerated for queuing and feeding assistance as needed. During a concurrent observation and interview on 5/20/25 at 12:20 p.m., observed Resident 77 in the main dining room at a table. A staff member brought Resident 77's lunch tray and placed it on the table. The table was noted at chest level and too high for Resident 77 to eat his food comfortably. Licensed Nurse 3 (LN 3) confirmed that the table was too high for Resident 77. During an interview on 5/22/25 at 11:20 a.m. with the Director of Nursing (DON), the DON stated her expectation was for the staff to assist residents to a comfortable position while dining. Review of the facility's Policy and Procedure (P&P) titled, Assistance with Meals, dated October 2024, the P&P indicated, Residents will be encouraged to eat in the dining room .assistance will be provided as needed.

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of 26 sampled residents (Resident 86) was evaluated and treated by a podiatrist (foot doctor) when Resident 86's toenails were thick, discolored and long. This failure resulted in Resident 86 having pain when walking and had the risk potential to cut the skin. Findings: A review of the facility's document titled admission Record indicated Resident 86 was admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities). During an interview on 5/21/25, at 11:25 a.m., Responsible Party 1 (RP 1) stated she was concerned about her father's long toenails. She stated she noted the toenails were long and had fungus in March. RP 1 further stated she was going to cut them myself but realized his toenails were too thick to do it safely. During an observation and concurrent interview in Resident 86's room with Resident 86 and Certified Nurse Assistant 2 (CNA 2) on 5/21/25, at 1:04 p.m., CNA 2 removed socks from Resident 86's feet. The toenails on both feet were thick, long and curved inward toward the toe, they were discolored yellow and black. Resident 86 stated my feet hurt. CNA 2 acknowledged Resident 86's toenails were discolored, long and thick. During an interview on 5/21/25, at 1:08 p.m., Licensed Nurse 1 (LN 1) stated Resident 86's toenails should have been addressed by the Podiatrist. LN 1 confirmed Resident 86's toenails were long, curved towards the toes and discolored. LN 1 stated Resident 86's toenails looks like he has fungus on all his nail beds. LN 1 further acknowledged toenails of this length could cause pain and had the potential to cut Resident 86's skin. During an interview on 5/22/25, at 10:55 a.m., the Social Services Director (SSD) stated a Podiatrist was scheduled every month and treated all residents who needed foot care. The SSD stated a binder titled Ancillary Services was at each nurse's station and provided the name of those residents who needed ancillary treatment. The SSD found no evidence of Resident 86 having received podiatric visit since his admission to the facility in January 2025. During a record review of the facility's policy titled Social Services, dated September 2024, indicated, Our facility provides medically related social services to assure that each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well-being .the social services department may be responsible for .making referrals for ancillary services such as .Podiatry .

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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. Based on interview and record review, the facility failed to ensure physician visits were provided timely for one of 26 sampled residents (Resident 14) when Resident 14 was not seen by the attending physician every 30 days during the first 90 days of admission. This failure had the potential to delay detection of declining health and the provision of care. Findings: A review of the facility's document titled admission Record, indicated Resident 14 was admitted to the facility late 2024 with diagnoses of Diastolic Heart Failure (the heart cannot pump enough blood to meet the body's needs causing multiple symptoms), Sleep Apnea (a disorder characterized by repeated pauses in breathing during sleep) and Peripheral Vascular Disease (a condition where circulating blood has difficulty in reaching the body's tissues due to narrowing of blood vessels). A review of Resident 14's Minimum Data Set (MDS-a federally mandated assessment tool), dated 5/5/25 indicated a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation and judgement status of the resident) score of 12, which indicated moderate cognitive (related to processes of thinking and reasoning) impairment. During an interview on 5/22/25, at 8:45 a.m., Resident 14 stated I'm not sure how often I get to see my doctor. There are so many people in and out of here. During an interview on 5/22/25 at 9:45 a.m., the Director of Nursing (DON) stated physicians were expected to visit residents every 30 days for the first 90 days upon admission and every 60 days thereafter. During a concurrent interview and record review on 5/22/25, at 12:49 p.m., the Medical Records Director (MRD) confirmed there was no documented evidence of a physician or nurse practitioner (an advanced practice Registered Nurse who has advanced clinical education and training to diagnose, treat, and manage various health conditions) visit in Resident 14's medical chart for the months of November and December of 2024. During an interview on 5/22/25 at 1:48 p.m., the Medical Director (MD) stated he tried to be here every month to see the residents but found it difficult to find practitioners to assist with this facility. During a review of the facility's document titled Physician Visits, dated September 2024, indicated The attending physician must make visits in accordance with applicable state and federal regulations. 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.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure its medication error rate was less than five percent (5%) for three of 26 sampled residents, Resident 32, Resident 74, and Resident 194, when: 1. Licensed Nurse 3 (LN 3) did not follow the physician's order in administering Resident 32's prescribed medication; and 2. LN 1 did not perform a pre-flush (flushing the tube with water before administering medication, to ensure the tube remains clear and patent) to Resident 74's Gastrostomy Tube (GT, tube inserted into the stomach to deliver nutrition, and medications. GT has 2 ports called feeding port and balloon port which is not used for feeding or medications. These ports are covered with red caps); and 3. LN 5 did not follow the physician's order in administering Resident 194's prescribed medication. These failures resulted in the facility's medication error rate of 12%, and had the potential for harm, worsening of existing conditions or develop new illnesses for Resident 32, Resident 74, and Resident 194. Findings: 1. During a concurrent observation of the medication administration and interview with LN 3 on 5/21/25 at 12:35 p.m., LN 3 removed Resident 32's Dilaudid 6mg (opioid, used for pain, may cause serious or life-threatening breathing problems) tablet from her medication cart and placed it in a plastic cup. LN 3 went into the room of Resident 32 and instructed her to take her medication. Resident 32 swallowed her Dilaudid. LN 3 went back to her medication cart that was parked in the doorway of Resident 32's room. LN 3 stated she did not count the respiration of Resident 32 before giving Dilaudid 6 mg tablet as ordered. LN 3 acknowledged she should have counted Resident 32's respiration before giving the Dilaudid as ordered by the physician as this medication could cause respiratory depression. A review of Resident 32's admission Record, indicated Resident 32 was admitted to the facility on [DATE] with diagnosis that included, Contracture of Muscle (condition where the muscles, tendons tighten and shorten, restricting movement and causing pain) right upper arm and right lower leg. A review of Resident 32's Order Summary Report, indicated, Dilaudid [controlled substance, powerful pain reliever] Oral Tablet 4 mg . Give 6 mg by mouth six times a day for Chronic Pain hold for RR < 12 (respiration less than 12) . A review of Resident 32's Medication Administration Record, indicated, Dilaudid Oral Tablet 4 mg . Give 6 mg by mouth six times a day for Chronic Pain hold for RR <12 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a concurrent observation and interview with LN 1 on 5/21/25 at 1:45 p.m., LN 1 took out the medications for Resident 74 from her medication cart, prepared the medications to be given via GT, and went inside Resident 74's room. LN 1 connected the 60 ml Enteral Syringe (ES, device used to administer nutrition and medications) to the GT, and poured the crushed pill mixed with water into the ES. LN 1 did not check the placement of the GT and did not flush the GT with 30 cc of water before medication administration as ordered by the physician. LN 1 stated she forgot to bring her stethoscope (instrument used to listen of someone's heartbeat or breathing), however, she decided to administer Resident 74's medication via GT without knowing if the GT is in the correct position inside Resident 74's stomach. LN 1 acknowledged she did not do a pre flush of the GT prior to infusing Resident 74's medication. LN 1 stated, she should have checked the placement of the GT and flush the GT with water before giving his medication for Resident 74's safety. A review of Resident 74's admission Record, indicated Resident 74 was admitted to the facility on [DATE] with diagnoses that included, Dysphagia, Oropharyngeal Phase, (swallowing disorder that affects the ability to move food from the mouth to the throat). A review of Resident 74's Order Summary Report, indicated, Enteral Feed Order every shift for GTUBE CHECK TUBE PLACEMENT & PATENCY before each feeding. A review of Resident 74's Medication Administration Record, indicated, Enteral Feed Order every shift for GTUBE CHECK TUBE PLACEMENT & PATENCY before each feeding. A review of Resident 74's Order Summary Report, indicated, Enteral Feed Order every shift for GTUBE FLUSH TUBE FEEDING WITH 30 CC/H2O [cubic centimeters, measurements, water] BEFORE AND AFTER EACH MEDICATION ADMINISTRATION . A review of Resident 74's Medication Administration Record, indicated, Enteral Feed Order every shift for GTUBE FLUSH TUBE FEEDING WITH 30 CC/H2O BEFORE AND AFTER EACH MEDICATION ADMINISTRATION. 3. During a concurrent observation of the medication administration and interview with LN 5 on 5/22/25 at 7:50 a.m., LN 5 was observed, without wearing gloves, to take out Resident 194's Finasteride 5 mg (hazardous drugs) tablet medication from the Bubble Pack/Medication Blister Pack (BP/MBP, method of organizing medications into individual doses). LN 5 gave the medications to Resident 5 and instructed him to take his medications. LN 5 acknowledged that she did not wear gloves when she took out the Finasteride 5 mg tablet from the BP/MBP. LN 5 agreed the instructions written in the BP/MBP indicated, . BPH [benign prostatic hyperplasia enlarged prostate] NIOSH [National Institute for Occupational Safety and Health, hazardous drugs] medication, wear gloves . During a review of the medication instructions written on the BP/MBP on 5/22/25 at 7:55 a.m., indicated, Give 1 tablet by mouth one time a day for BPH NISOH medication, wear gloves, do not manipulate (split/crush/chew) tablet. This Bubble Pack had a yellow sticker on the top left corner of the card that indicated, Do not handle this medication if you are pregnant, planning to become pregnant or are breast-feeding. A review of Resident 194's admission Record, indicated Resident 194 was admitted to the facility on [DATE] with diagnoses that included, Malignant Neoplasm of Male Genital Organ, (cancerous tumor). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 194's Order Summary Report, indicated, Finasteride (hazardous drug) Oral Tablet 5 mg Give 1 tablet by mouth one time a day for BPH, NIOSH medication, wear gloves, do not manipulate (split/crush/chew) tablet. During an interview with the Director of Nursing (DON) on 5/23/25 at 7:45 a.m., the DON stated, the licensed nurses must follow the physicians' orders. The parameters indicated in the physician's order must be followed for the resident's and staff safety, such as counting respirations before giving medications that can cause respiratory depression and to wear gloves for biohazard medications. The DON continued, nurses must check the placement of the GT, flush the GT with water before and after medications administration and practice infection control to promote quality of care. A review of the facility's policies and procedures, titled, Administering Medications, revised October 2024, indicated, Medications are administered in a safe and timely manner . 2. Medications are administered in accordance with prescriber orders .16. Staff follows established facility infection control procedures (.gloves .) for the administration of medications, as applicable . A review of the facility's policies and procedures, titled, enteral Feedings, revised September 2024, indicated, Purpose To ensure the safe administration of enteral nutrition . The facility will remain current and follow accepted best practices I enteral nutrition . 1. Always maintain strict aseptic technique when working with enteral nutrition systems . Preventing misconnection error . 2. Regularly inspect tubing for proper and secure connections . Preventing aspiration 1. Check enteral tube placement prior to feeding or administration of medication .

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on observation, interview and record review the facility failed to ensure one of 26 sampled residents (Resident 14) received timely dental treatment when prior dental visits indicated that follow up dental services was necessary. This failure had the potential to place Resident 14 at risk for further oral decline and overall health. Findings: A review of the facility's document titled admission Record, indicated Resident 14 was admitted to the facility on 10/2024 with diagnoses of Diastolic Heart Failure (the heart cannot pump enough blood to meet the body's needs causing multiple symptoms), Sleep Apnea (a disorder characterized by repeated pauses in breathing during sleep) and Peripheral Vascular Disease (a condition where circulating blood has difficulty in reaching the body's tissues due to narrowing of blood vessels). A review of the facility's document from a traveling hygienist, dated 12/3/24, indicated Resident 14 had, . heavy calculus and heavy inflammation. [Resident 14] will need additional cleaning visits to fully improve the health of his tissue. This document also recommended Resident 14 receive a follow up visit in three months, a fluoride varnish, and a, medical necessity for regular [preventative maintenance]. During an observation on 5/21/25, at 8:55 a.m., Resident 14 was sitting in his wheelchair watching television and observed several decayed and missing teeth. He stated his mouth and teeth hurt him at times, and understood oral health is important. During an interview on 5/22/25, at 10:55 a.m., the Social Services Director (SSD) stated a hygienist and a [brand name dental company] visited the facility monthly. The SSD stated a binder titled Ancillary Services was at each nurse's station and provided the name of those residents who needed dental services. The SSD did not find evidence of treatment for Resident 14 as recommended. A review of the facility's document titled Social Services, dated September 2024, indicated, Our facility provides medically related social services to assure that each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well-being .the social services department may be responsible for .making referrals for ancillary services such as .Dental.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, interview and record review, the facility failed to provide adaptive eating equipment (specialized tools and devices designed to assist individuals with disabilities or physical limitations in eating and drinking independently. These aids help make mealtimes easier, more enjoyable, and promote independence) to one out of 26 sampled residents, Resident 10, when Resident 10 did not have a plate guard (a device that clips onto a plate to prevent food from accidentally sliding off) and a two handled cup with a lid during his meals. This failure had the potential to cause dehydration, malnutrition and increased dependency on staff for feeding for Resident 10. Findings: A review of Resident 10's admission Record, indicated, Resident 10 was admitted to the facility on 2/2023 with diagnoses that included Dysphagia, Oropharyngeal Phase (swallowing disorder) and generalized muscle weakness. A review of Resident 10's Minimum Data Set (MDS, an assessment tool used to guide care) Cognitive Patterns, dated 5/5/25, indicated Resident 10 had short-term and long-term memory problem and had severely impaired cognitive skills for daily decision making. During a concurrent observation and interview in the dining room with Certified Nursing Assistant 4 (CNA 4), and Speech Language Pathologist (SLP) on 5/20/25 at 12:17 p.m., CNA 4 was seated beside Resident 10 who was observed eating lunch. Resident 10's plate did not have a plate guard, and his food had spilled off and around his plate, on the table, and on his clothes. Resident 10's beverages were all served in a plastic transparent cup. The CNA stated, she constantly reminded the kitchen staff to provide Resident 10 with handled cups with lids and plate guard during meals as it helped him feed himself. The SLP confirmed that Resident 10 did not have the plate guard and the handled cups with lids. The SLP stated that Resident 10 should have those assistive devices during meals as she recommended, to encourage Resident 10 feed himself and to prevent him from spilling his food and drinks. In a review of Resident 10's meal ticket, under preferences, indicated, Resident 10 should have 2 handled cups w/lid [with] Plate Guard. In a review of Resident 10's SLP Evaluation and Plan of Treatment, with start of care on 2/2/25, indicated, . ST rec [recommends] 2 handled cup with spout all meals . In a review of Resident 10's Order Summary Report, order date 5/15/25 indicated, . Adaptive Feeding Equipment plate guard and 2 handled cups with lid to be provided during all meals to facilitate independence with self-feeding . (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedures, revised October 2024, indicated, Adaptive Devices, Purpose Residents will receive adaptive devices to maintain or improve their ability to eat or drink independently. Procedure 1. The PT, OT, or ST, and/or designated person will evaluate residents for the need of an adaptive device. 2. A physician's order is recommended. Examples of commonly used self-feeding devices may include: e. Plate guard . 3. The Food & Nutrition Services Department will store adaptive devices. Residents needing devices will receive them as ordered. Tray cards will record which device is needed .

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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 ensure that food was stored in accordance with professional standards for food service when expired or undated food was observed in freezer and dry food cupboards. These failures placed 94 residents out of a census of 95 who received food served by the facility at risk for receiving expired foods. Findings: During an Initial Kitchen tour on 5/20/25 at 8:23 a.m. with the Dietary Supervisor (DS), the following was observed: -in the dessert freezer, a bag of cream puffs was found in a plastic bag that was undated, -in the cupboards dried parsley in a shaker container, a bag of brown gravy mix and bowl of cereal in a covered plastic container were undated and, - powdered cherry jello mix in a shaker container prepared 12/1/24 and be used by 5/1/25. During an observation and interview on 5/20/25 at 8:30 a.m. the DS confirmed the above observations and stated her expectation was that dietary staff should properly label and throw away expired foods. The DS stated that if these items were served to residents, they may not be palatable or safe for residents to eat. During an interview on 05/21/25 at 2:20 p.m. with the Registered Dietician (RD), the RD stated the expectation was that staff should throw out food that was undated or expired. RD further stated that for those food items the issue would be lack of palatability for the residents. Review of the Policy and Procedure (P&P) titled, Storage of Food Supplies dated October 2024, the P&P indicated, Food supplies will be stored properly and in a safe manner. Dry food items which have been opened, such as pudding, gelatin, pancake mix, dry cereal .will be tightly closed, labeled and dated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow guidelines for infection control practices and provide safe, and sanitary environment for two of 26 sampled residents, Resident 74 and Resident 40 when: 1. Resident 74's Gastrostomy Tube's (GT, tube inserted into the stomach to deliver nutrition, and medications. GT has 2 ports called feeding port and a balloon port which is not used for feeding or medications. These ports are covered with red caps) red cap fell on the floor, and Licensed Nurse 1 (LN 1) picked up the red cap and connected it back to one of the GT's ports; and 2. Certified Nursing Assistant (CNA 5) touched the inside of Resident 40's nosey cup (NC, designed with a nose cutout to encourage correct head position) with her bare hands. These failures had the potential to result in infections for vulnerable residents. Findings: 1. During a concurrent observation and interview with LN 1 on 5/21/25 at 1:45 p.m., LN 1 took out medications for Resident 74 from her medication cart, prepared the medications to be given via GT, and went inside of Resident 74's room. As LN 1 tried to connect the 60 ml Enteral Syringe (ES, device used to administer nutrition and medications) to the GT, one of the port's red caps fell on the floor under Resident 74's bed. LN 1 picked up the red cap and connected it back to one of the GT's ports. LN 1 acknowledged that she connected the contaminated/dirty red cap back on Resident 74's GT port. LN 1 stated that recapping resident 74's GT port with the contaminated/dirty cap may result in infection. A review of Resident 74's admission Record, indicated Resident 74 was admitted to the facility on [DATE] with diagnoses that included, Dysphagia, Oropharyngeal Phase, (swallowing disorder that affects the ability to move food from the mouth to the throat). A review of Resident 74's Order Summary Report, indicated, Enteral Feed Order every shift for GTUBE FLUSH TUBE FEEDING WITH 30 CC/H2O [cubic centimeters, measurements, water] BEFORE AND AFTER EACH MEDICATION ADMINISTRATION . A review of the facility's policies and procedures, titled, enteral Feedings, revised September 2024, indicated, Purpose To ensure the safe administration of enteral nutrition . The facility will remain current and follow accepted best practices I enteral nutrition . 1. Always maintain strict aseptic technique when working with enteral nutrition systems . Preventing misconnection error . 2. Regularly inspect tubing for proper and secure connections . Preventing aspiration 1. Check enteral tube placement prior to feeding or administration of medication . 2. A review of Resident 40's admission Record, indicated, Resident 40 was admitted to the facility on 6/2019, with diagnoses that included, history of COVID-19. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 40's Minimum Data Set (MDS, an assessment tool used to guide care) Cognitive Patterns, dated 5/5/25, indicated Resident 10 had short-term and long-term memory problem and severely impaired cognitive skills for daily decision making. During an observation in the dining room with Certified Nursing Assistant 5, (CNA 5), on 5/22/25 at 12:08 p. m., CNA 5 was seated beside Resident 40 and assisted Resident 40 with his lunch. Beside Resident 40's plate was two empty NC that were stuck together, CNA 5 pulled out the top plastic NC and by doing so, her fingers with long fingernails touched the inside of Resident 40's NC. CNA 5 then poured a drink in the cup and assisted Resident 40 to drink from the cup. During an interview with the Infection Preventionist (IP) in the dining room, on 5/22/25 at 12:15 p.m., the IP stated CNA 5 should not touch the inside of the nosey cup, and she should practice infection control. During an interview with CNA 5 on 5/22/25 at 12:45 p.m., CNA 5 acknowledged that her finger touched the inside of Resident 40's NC. CNA 5 stated she could have just obtained a new NC or separated the cups by pulling out from the bottom to avoid touching the inside of the NC. CNA 5 acknowledged her finger nails were about a quarter inch long (unit of measurement), and underneath her fingernails may not be clean and it was not sanitary that it touched the inside of Resident 40's NC. During an interview with the Director of Nursing (DON) on 5/23/25 at 7:45 a.m., the DON stated, she expected the staff to practice infection prevention all the time. The DON continued, CNA 5 should have pulled out the cup from the bottom and avoided touching the inside of the cup to maintain the cleanliness of the NC. A review of the facility's policy and procedures, titled Multidrug-Resistant Organisms; Infection Precaution & Enhanced Standard Precautions, undated, .Infection Precautions 1. Follow Standard Precautions in all situations .

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 call lights were placed within easy reach of residents for one of 26 sampled residents (Resident 34). This failure had the risk potential for the residents to be unable to call for staff assistance with their daily care needs. Findings: Review of an admission Record indicated Resident 34 was admitted to the facility March 2025 with several diagnoses including hemiplegia (total paralysis of the arm, leg and trunk on the same side of the body) and hemiparesis (weakness of one entire side of the body) following cerebral infarction (decreased blood flow and oxygen to the brain) affecting left side. Review of Resident 34's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 5/2/2025, indicated Resident 34 required substantial/maximal assistance (Helper does more than half the effort) with activities of daily living (ADLs-routine tasks/activities such as bathing, personal hygiene and dressing) and was dependent for toileting. During a concurrent observation and interview on 5/20/25 at 9:05 a.m. Resident 34 was in bed and the call light was on the floor and not within reach. Licensed Nurse 2 (LN 2) searched the bed and could not find the call light. LN 2 confirmed the call light was on the floor and stated the call light should be within reach of the Resident. Review of Resident 34's Care Plan, dated 7/31/2023, indicated Resident 34 is, at risk for ADL/mobility decline and requires assistance related to bed-bound status .interventions .Encourage to use call light for assistance. During an interview on 5/22/25 at 11:13 a.m. with the Director of Nursing (DON), the DON stated that her expectation was that the call light should be within reach and further stated that it could make it difficult for the resident to make requests for things such as pain medication, assistance with toileting and transferring and this could increase the risk for falling. Review of the facility's policy and procedure (P&P) titled, Answering the Call Light dated October 2024, the P&P indicated, When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident as much as practicable.