STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555286	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Orange Hills	5017 E. Chapman Avenue Orange, CA 92869

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to develop and/or implement the comprehensive care plans for two of 27 sampled residents (Residents 4 and 99) and three nonsampled residents (Residents 35, 118, and 124). * The facility failed to develop a care plan for Resident 118's use of buspirone HCl (an anxiety medication) and include the specific targeted behaviors in the care plan interventions for Resident 118's use of psychotropic medications. * The facility failed to implement the care plan intervention for Resident 99's bladder incontinence. * The facility failed to develop a care plan interventions to address when Resident 4 and 124 have tremors or was moving while being shaved during showers. * The facility failed to develop a care plan to address Resident 35's toenails. These failures posed the risk of not providing the residents' individualized, person-centered care and not meeting the residents' needs. Findings: Review of the facility's P&P titled Care Planning revised 1/2021 showed the interdisciplinary team shall develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives to meet the resident's medical, nursing, mental and psychosocial needs. Review of the facility's P&P titled Psychotropic Drug Use revised 8/2017showed an individualized, person-centered care plan will be initiated. 1. Medical record review for Resident 118 was initiated on 2/11/26. Resident 118 was admitted to the facility on [DATE]. Review of Resident 118's Order Listing Report showed the following physician's orders:- dated 2/4/26, for Ativan (an anxiety medication) 1 mg every six hours PRN for 14 days for anxiety as manifested by increased agitation;- dated 12/5/25, for olanzapine (an antipsychotic medication) 5 mg at bedtime for psychosis as manifested by angry outbursts as evidenced by resisting care;- dated 9/10/25, for buspirone HCl (an anxiety medication) 5 mg three times a day for anxiety as manifested by increased physical restlessness;- dated 12/7/25, for bupropion HCl (an antidepressant) 75 mg daily for depression as manifested by verbalization of sadness; and-dated 12/7/25, for paroxetine HCl (an antidepression medication) 10 mg daily for depression as manifested by outbursts of crying. Review of Resident 118's Care Plan Report showed a care plan problem to address the following:- anti-anxiety medication PRN use revised 8/19/25, the interventions included the use of Ativan medication. However, the care plan failed to address the resident's specific targeted behaviors of increased agitation for PRN Ativan use;- psychotropic medications related to behavior management/yelling/screaming behavior and angry outbursts revised 11/19/25, the interventions included the use of olanzapine medication. However, the care plan failed to include olanzapine's (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	targeted behavior of resisting cares; - anti-depression medication revised 3/3/24. The care plan failed to show the resident's use of bupropion HCl and paroxetine HCl medications. In addition, the care plan failed to address the resident's targeted behaviors of verbalization of sadness and outbursts of crying. Further review of Resident 118's care plan failed to show a focused problem for the resident's use of buspirone HCl and address the targeted behavior of increased physical restlessness. On 2/17/26 at 1317 hours, an interview and concurrent record review was conducted with the DON. The DON verified the resident's care plan did not address the specific psychotropic medications and the resident's targeted behaviors. The DON was made aware and acknowledged the above findings. 2. Medical record review for Resident 99 was initiated on 2/11/26. Resident 99 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 99's H&P examination dated 2/11/26, showed Resident 99 had recurrent urinary tract infection (UTI), left side hemiplegia and hemiparesis. Review of Resident 99's MDS assessment, Section GG dated 12/4/25, showed Resident 99 was dependent on the staff members for toileting hygiene care. Review of Resident 99's plan of care initiated 9/30/2025, showed a care plan problem addressing Resident 99's bowel and bladder incontinence related to her history of UTIs and impaired mobility due to hemiplegia. The interventions included to provide the use of disposable briefs and to change Resident 99's briefs every two hours and as needed. Review of Resident 99's Tasks – Bladder Continence for January 2026 failed to show Resident 99 was provided brief changes every two hours. On 2/12/26 at 1539 hours, an interview and concurrent medical record review for Resident 99 was conducted with LVN 1. LVN 1 verified the above findings. LVN 1 stated staff members caring for Resident 99 were expected to follow the resident's plan of care. On 2/12/26 at 1554 hours, an interview and concurrent medical record review for Resident 99 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated staff members were expected to follow the resident's plan of care. On 2/18/26 at 1325 hours, an interview and concurrent medical record review for Resident 99 was conducted with the DON. The DON verified the above findings and stated staff members should have implemented the interventions in Resident 99's plan of care including the brief changes every two hours because the interventions were specific to the resident's needs. The DON was informed and acknowledged the above findings. 3. On 2/13/26 at 1013 hours, an observation was conducted for Resident 4. Resident 4 was observed with multiple surficial cuts to his chin. On 2/13/26 at 1030 hours, an observation and concurrent interview was conducted with LVN 14. When asked about the cuts to Resident 4's chin, LVN 14 verbalized the cuts occurred while the resident was being shaved. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record for Resident 4 was initiated on 2/13/26. Resident 4 was readmitted to the facility on [DATE]. Review of Resident 4's H&P examination dated 12/13/25, showed Resident 4 did not have the capacity to understand or make decisions. Resident 4's diagnoses included cerebral palsy, seizure disorder, chronic respiratory failure with dependency on a ventilator, and post GT placement. On 2/18/26, at 1041 hours, an interview was conducted with CNA 7. CNA 7 verbalized she did shower Resident 4 on 2/13/26. CNA 7 verbalized she thought Resident 4's cuts were already present at that time. When asked if CNA 7 had reported to nursing staff, CNA 7 stated she assumed the cuts had already been reported. When asked how she would shave the residents that moved around a lot during showers, CNA 7 stated very carefully. Review of Resident 4's Plan of Care failed to show a care plan problem with interventions to address Resident 4's episodes of tremors when being shaved during showers. On 2/18/26 at 907 hours, an interview and concurrent medical record review was conducted with RN 3. RN 3 verified there was no care plan problem developed to address Resident 4's episodes of tremors when being shaved during showers. 4. On 02/17/2026 at 1344 hours, an observation for Resident 124 and concurrent interview was conducted with LVN 16 and CNA 8 at bedside. Resident 124 was observed in bed with a horizontal superficial cut measuring approximately 2.5 inches, running across the lower part of Resident 124's chin. The left corner of the cut was observed as a circular open wound with blood running down the left side of Resident 124's chin. When asked about Resident 124's cut, CNA 8 stated the cut occurred while CNA 8 was shaving Resident 124 in the shower. CNA 8 verbalized Resident 124 jumped while she was shaving his chin. LVN 16 and CNA 8 verified Resident 124 had an open cut that had blood flowing down the left side of Resident 124's chin. Medical record review for Resident 124 was initiated on 2/17/26. Resident 124 was admitted to the facility on [DATE]. Resident 124's diagnoses included diabetes, brain damage, and epilepsy. Review of Resident 4's' Plan of Care failed to show a care plan problem with interventions to address Resident 4's episodes of tremors/or moving when being shaved during showers. On 2/18/26 at 0914 hours, an interview and concurrent medical record review for Resident 124 was conducted with RN 3. RN 3 verified there was no care plan problem developed to address Resident 124's episodes of tremors and/or moving when being shaved during showers. 5. On 2/13/26 at 1533 hours, an observation was conducted for Resident 35. Resident 35 was observed in bed with Resident 35's responsible party at bedside. Responsible Party 1 verbalized concerns with Resident 35's toenails not being cared for. Resident 35's both first digit toenails were observed extended beyond the tip of the toes. Responsible Party 1 granted permission for a focused body check to be conducted for Resident 35 with the nursing staff. On 2/13/26 at 1545 hours, an observation for Resident 35 and concurrent interview was conducted with LVN 14 and CNA 6. A body check for Resident 35 was conducted by LVN 14 and CNA 6. Resident 35's toenails were observed with brown discoloration and his first digit toenails were long, approximately half of an inch beyond the tip of the resident's toes. LVN 14 verified the finding. LVN 14 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated she thought Resident 35 was visited by the podiatrist last month. Medical record review for Resident 35 was initiated on 2/13/26. Resident 36 was readmitted to the facility on [DATE]. Review of Resident 35's H&P examination dated 2/23/25, showed Resident 35's diagnoses included cerebral palsy with quadriplegia, post status tracheostomy placement, post status GT placement. Review of Resident 35's Podiatry Progress Note dated 12/18/25, showed Resident 35's diagnoses included nail dystrophy (abnormal changes in the shape, color, texture, or growth of fingernails or toenails, often causing thickened, brittle, or deformed nails), tinea unguium (common fungal infection of the fingernails or toenails caused by dermatophytes, resulting in thickened, discolored (yellow/brown), brittle, and crumbling nails) and toe pain. Review of Resident 35's plan of care failed to show a care plan problem was developed to address Resident 35's toe nails. On 2/18/26 at 852 hours, an interview and concurrent medical record review was conducted with RN 3. RN 3 verified there was no care plan problem developed to address Resident 35's toenails.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, medical record reviews, and facility P&P review, the facility failed to provide the necessary respiratory care services for three sampled residents (Residents 23, 49, and 55) and two nonsampled resident (Residents 25 and 64) reviewed for respiratory care. * The facility failed to ensure Resident 23 was administered with oxygen as ordered by the physician. * The facility failed to notify the physician and hospice care when Resident 49 was not provided the BiPAP machine nightly as ordered due to a missing piece of the BiPAP mask. * The facility failed to ensure Resident 25's nasal cannula was stored in a sanitary condition when not in use. *The facility failed to ensure Resident 64's nasal cannula was stored in a sanitary condition. * The facility failed to ensure Resident 55 was not left unattended during administration of albuterol treatment (bronchodilator medication). These failures had the potential to affect the respiratory health and well-being of the residents in the facility.Findings: Review of the facility's P&P titled Oxygen Administration (Mask, Cannula, Catheter, Use of Humidifier) revised 12/2023 showed oxygen therapy is administered as ordered by the physician or as an emergency measure until the order can be obtained. 1. On [DATE] at 1432, an observation was conducted for Resident 23. Resident 23 was observed in bed in his room. Resident 23 was receiving oxygen at a rate of 2.5 liters per minute via nasal cannula. Medical record review for Resident 23 was initiated on [DATE]. Resident 23 was readmitted to the facility on [DATE]. Review of Resident 23's Order Summary Report showed a physician's order dated [DATE], to administer continuous oxygen at a rate of two liters per minute via nasal cannula. On [DATE] at 1554 hours, a follow-up observation, concurrent interview and medical record review for Resident 23 was conducted with RN 1. RN 1 verified Resident 23 was receiving 2.5 liters per minute rate of oxygen. RN 1 stated Resident 23 should only receive oxygen at a rate of two liters per minute as per the physician's order. On [DATE] at 0821 hours, another follow-up observation was conducted for Resident 23. Resident 23 was observed in bed in his room. Resident 23 was receiving oxygen at a rate of 2.5 liters per minute via nasal cannula. On [DATE] at 1325 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 49 was initiated on [DATE]. Resident 49 was readmitted to the facility on [DATE] and expired on [DATE]. Review of Resident 49's H&P examination dated [DATE], showed Resident 49 was receiving hospice care and had diagnoses of COPD and obstructive sleep apnea. Review of Resident 49's Order Summary Report showed the following physician's orders: -dated [DATE], to admit the resident to hospice care for her diagnosis of COPD, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-dated [DATE], to call the hospice care for any changes in condition or for new orders, and -dated [DATE], to apply the BiPAP to the resident at bedtime with the following settings: IPAP =12 cmH2O, EPAP = 5 cmH2O, pressure support 4 cmH2O with 3 liters per minute of oxygen. Review of Resident 49's Progress Notes - Respiratory Therapy progress notes showed Resident 49 was not provided the BiPAP machine due to a missing piece of the BiPAP mask which provided comfort and complete seal for Resident 49. In addition, the progress notes showed the licensed nurses were made aware Resident 49 was not placed on the BiPAP machine on the following dates and times: - dated [DATE] at 2343 hours;- dated [DATE] at 2211 hours; - dated [DATE] at 0225 hours;- dated [DATE] at 0022 hours;- dated [DATE] at 0404 hours;- dated [DATE] at 0533 hours; - dated [DATE] at 0229 hours;- dated [DATE] at 0400 hours;- dated [DATE] at 0425 hours;- dated [DATE] at 0514 hours; and- dated [DATE] at 0040 hours. On [DATE] at 1554 hours, an interview and concurrent medical record review for Resident 49 was conducted with RN 1. RN 1 reviewed Resident 49's medical record and verified there was no documentation if a staff member followed up with the hospice care team or informed the physician when Resident 49 was not placed on the BiPAP machine due to a missing piece of the BiPAP mask. When asked who was responsible for informing the hospice care team or the physician, RN 1 stated the licensed nursing staff. On [DATE] at 1325 hours, an interview and concurrent medical record review for Resident 49 was conducted with the DON. The DON stated Resident 49 refused to wear the BiPAP mask because she was not comfortable. When asked if the physician was made aware of Resident 49's refusals, the DON stated no. The DON verified and acknowledged the above findings. The DON stated the expectation was to follow up with the hospice care team and physician regarding the missing piece of the BiPAP mask. 3. On [DATE] at 1008 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 25 at bedside. Resident 25 was observed in bed, awake with oxygen via nasal cannula from concentrator machine at a rate of 2 liters per minute. Resident 25 stated he would use oxygen at night and he could take it off anytime when he was awake during the day. Resident 25 was observed removing his nasal cannula attached to the oxygen tubing and placed the tubing on the hook attached to the over the bed table. Resident 25 stated the staff placed the hook on the table so it will not end up on the ground. Medical record review for Resident 25 was initiated on [DATE]. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25's MDS assessment dated [DATE], showed a BIMS score of 15, meaning cognitively intact. Review of Resident 25's Order Summary Report dated [DATE] showed a physician order dated [DATE] to administer oxygen at a rate of 2 liters per minute via nasal cannula continuously every shift. On [DATE] at 1109 hours, an observation and concurrent interview was conducted with LVN 7 at (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 25's bedside. Resident 25 was observed not using oxygen and the nasal cannula was hanging on the hook attached to the over the bed table. LVN 7 verified the nasal cannula was hanging on the hook attached to the over the bed table. On [DATE] at 0851 hours, an interview and concurrent medical record review for Resident 25 was conducted with RN 2. RN 2 stated the oxygen tubing should be placed in a clear plastic bag with label when not in use. RN 2 verified Resident 25 had a physician order for the use of oxygen therapy. RN 2 was informed of the above findings. 4. On [DATE] at 1223 hours, during the dining observation, Resident 64 was observed in bed eating her lunch meal. Resident 64's nasal cannula attached to the oxygen tubing was observed in the floor. On [DATE] at 1344 hours, a follow-up observation and concurrent interview was conducted with LVN 13 at Resident 64's bedside. Resident 64's nasal cannula attached to the oxygen tubing was observed on the floor. LVN 13 verified Resident 64's nasal cannula was on the floor. LVN 13 stated she will change the oxygen tubing. Medical record review for Resident 64 was initiated on [DATE]. Resident 64 was admitted to the facility on [DATE]. Review of Resident 64's MDS assessment dated [DATE], showed a BIMS score of 15, meaning cognitively intact. Review of Resident 64's Order Summary Report dated [DATE], showed a physician order dated [DATE], to administer oxygen at 2 liters per minute via nasal cannula as needed to keep oxygen saturation above 90%. On [DATE] at 0856 hours, an interview and concurrent medical record review for Resident 64 was conducted with RN 2. RN 2 verified Resident 64's used oxygen therapy as needed as per the physician's order. RN 2 was informed Resident 64's nasal cannula attached to the oxygen tubing was observed on the floor. RN 2 acknowledged the findings. On [DATE] at 1006 hours, an interview and concurrent medical record review for Residents 25 and 64 was conducted with the DON. The DON was informed and acknowledged the above findings. 5. Review of the facility's P&P titled Respiratory Medications (undated) showed RT and RN only who are administering respiratory medications shall assess and document side effects of and reaction to the medication given, and report to nursing and the resident's physician any reaction to the medication; and staff shall administer medications according to the policy above. On [DATE] at 1033 hours, an observation and concurrent interview was conducted with Resident 55. RT 2 was observed entering Resident 55's room to administer breathing treatment to Resident 55. RT 2 was observed exiting Resident 55's room and leaving Resident 55 with his breathing treatment on. When asked if the staff would leave the room with his breathing treatment on other occasions, Resident 55 whispered sometimes the staff would leave him while he receive his breathing treatment. RT 2 was observed pacing in the hallway outside Resident 55's room and then observed standing outside Room C. On [DATE] at 1047 hours, RT 2 was observed returning to Resident 55's room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident 55 was initiated on [DATE]. Resident 55 was readmitted to the facility on [DATE]. Review of Resident 55's H&P examination dated [DATE], showed Resident 55 had the capacity to understand and make decisions. Resident 55's diagnoses included ALS, chronic respiratory failure requiring tracheostomy and ventilator dependence, history of shortness of breath, history of pneumonia, and functional quadriplegia. Review of Resident 55's Order Summary Report showed the following physician's order for wheezing and shortness of breath: - dated [DATE], for albuterol solution 3 ml via Resident 55's ventilator every six hours; and - dated [DATE], for albuterol solution 3 ml via Resident 55's tracheostomy three times daily. On [DATE] at 1505 hours, an interview was conducted with RT 2. When asked about leaving Resident 55 unattended with his breathing treatment, RT 2 stated it was okay for RT 2 to exit Resident 55's room and leave Resident 55 with his albuterol treatment because Resident 55's visitor was inside the room with Resident 55. RT 2 stated as long as RT 2 was within earshot of Resident 55 he could exit Resident 55's room while Resident 55 was receiving his albuterol breathing treatment. RT 2 acknowledged he was outside Room C and was walking up and down in the hallway outside Resident 55's room. RT 2 further stated it was okay because Resident 55's family member could report any change in condition to RT 2. On [DATE] at 1430 hours, an interview was conducted with the DON. The DON was made aware of the findings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen. * The facility failed to ensure the kitchen utensils had a smooth cleanable surface and in good condition. * The facility failed to ensure the yellow cutting board used for cutting cooked meat, poultry, and fish was kept in a sanitary condition and with cleanable surface. * The facility failed to ensure the lid for the heavy-duty blenders used for pureed preparation was free from dust. * The facility failed to ensure the storage racks in the dry storage room were free from dust. * The facility failed to ensure the scoops used for food portioning and measuring cups were air dried prior to storing. * The facility failed to ensure the can opener was free from rust-like residue. * The facility failed to ensure the lids of the dry food storage containers were free from dust. * The facility failed to ensure the kitchen utensils were clean and free of food particles or residue. * The facility failed to ensure the floor drain for the three-compartment sink was clean and free from food particles. These failures had the potential for cross contamination and foodborne illnesses for the residents consuming the food prepared in the facility's kitchen.Findings: Review of the facility's Order Listing Report dated 2/11/26, showed 88 residents received food prepared from the facility's kitchen. 1. Review of the facility's P&P titled Sanitation dated 2023 showed:- The Food & Nutrition Services Department shall have equipment of the type and in the amount necessary for the proper preparation, serving, and storing of food. There shall be adequate equipment for cleaning and disposal of waste and general storage. All equipment shall be maintained as necessary and kept in working order.- All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosion, open seams, cracks, and chipped areas.- Separate chopping boards are to be used for preparing meats and vegetables. After each use, chopping boards shall be thoroughly cleaned and sanitized.- The kitchen staff is responsible for all the cleaning with the exception of ceiling vents, light fixtures, and the hood over stove, which will be cleaned by the maintenance staff. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2017, 4-602.13, Non-Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 2/11/26 at 0823 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The following was observed:- One yellow cutting board was observed without a cleanable surface;- The plastic lid for the heavy-duty blender was stored upside down on top of the blender and was coated in dust;- Multiple storage racks in the dry storage area were coated in dust;- The lid for the dry storage container for the sugar was observed coated in dust;- One stainless steel scoop was observed stored with dry watermarks and food residue;- One stainless steel measuring cup was observed stored with dry watermarks and food residue; and- The floor drain for the three-compartment sink had food particles in the drain, and dried brown water residue around the edges.The DSS acknowledged the above findings and stated the dirty items above would be washed again to prevent cross-contamination and the floor drain would be cleaned. 2. According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 2/11/26 at 0823 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The following was observed:- One stainless steel pizza cutter with a melted black handle;- T wo stainless steel spatulas with melted cream handles; and- One hand-held can opener was observed stored with rust-like residue on the edges.The DSS verified the above findings and stated the damaged items would be disposed of. 3. Review of the facility's P&P titled Dishwashing (undated) showed:- All dishes will be properly sanitized through the dishwasher.- Dishes are to be air dried in racks before stacking and storing According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required, that after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food. According to the USDA Food Code 2022, 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, cleaned equipment and utensils shall be stored in a self-draining position that allows air drying. On 2/11/26 at 0823 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The following was observed:- Three stainless steel scoops were observed stored with water inside the scoops.The DSS verified the above findings and stated the items above were supposed to be air-dried.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to implement the infection control practices designed to provide the safe and sanitary environment and help prevent the development and transmission of diseases and infections. * The facility failed to implement the infection control surveillance program for the months of July 2025 through January 2026. The facility conducted surveillance of resident infections only when the residents were prescribed antimicrobial medications and/or if the residents were diagnosed with an infection. The facility failed to determine whether the residents who exhibited signs and symptoms of infection and were not prescribed antimicrobial medications or had not been diagnosed with an infection, met the facility's criteria for infection utilizing McGeer's Criteria. The facility failed to include these residents in the facility's infection control surveillance program. * The facility failed to ensure the clean linen sorting counter was kept in a sanitary manner and free from personal belongings. In addition, the facility failed to ensure the clean linens in the linen cart were stored properly. * The facility failed to ensure the staff followed the infection control practices when passing out of the meal tray for Resident 15. * The facility failed to maintain infection control practices when Vendor Employee 1 was instructed to enter the kitchen without wearing the proper beard restraint. * The facility failed to ensure Resident 14's indwelling urinary catheter drainage bag was not touching the floor mat. * The facility failed to ensure Residents 21, 44, and 137's personal belongings were stored in a sanitary manner. These failures posed the risk of not identifying resident infections and controlling the potential transmission of communicable diseases to other residents, staff, and visitors throughout the facility.Findings: 1. Review of the facility's P&P titled Infection Prevention and Control Program revised 2/11/26, showed an infection prevention and control program is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The infection prevention and control program is coordinated and overseen by the IP. Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring adherence to infection prevention and control practices, and detecting unusual pathogens with infection control implications. The information obtained from infection control surveillance activities is compared with acknowledged standards and used to assess effectiveness of established infection prevention and control practices. On 2/17/26 at 1332 hours, an interview and concurrent facility document review was conducted with the IP. The IP was asked to explain the facility's resident infection surveillance program. The IP stated when a resident was prescribed antimicrobial medications or was diagnosed with an infection, the facility would then initiate a McGeer's Criteria form. The IP stated the McGeer's Criteria was utilized to determine if a resident had a true infection. Review of the facility's Infection Prevention and Control Surveillance Logs showed the number of the residents who were classified for HAIs, CAIs, and the residents who did not meet McGeer's Criteria (DNMC). The infection surveillance data from July 2025 through January 2026 showed the following: - for 7/2025: HAI – 35, CAI – 22, and DNMC – 1 with prescribed antimicrobials; - for 8/2025: HAI – 33 , CAI – 18, and DNMC – 1 with prescribed antimicrobials; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- for 9/2025: HAI – 32 , CAI – 17 , and DNMC – 2 with prescribed antimicrobials; - for 10/2025: HAI – 32, CAI – 14, and DNMC – 1 with prescribed antimicrobials; - for 11/2025: HAI - 30 , CAI – 14, and DNMC – 0; - for 12/2025: HAI - 28 , CAI – 13, and DNMC – 1 with prescribed antimicrobials; and - for 1/2026: HAI – 28, CAI – 13, and DNMC – 1 with prescribed antimicrobials. Further review of the facility's monthly Infection Prevention and Control Surveillance Logs from July 2025 through January 2026 showed all the residents included in the facility's infection surveillance program were determined to have either an HAI or CAI (with prescribed antimicrobial medications or having been diagnosed with an infection). The Infection Prevention and Control Surveillance logs failed to show any residents who did not meet McGeer's criteria and were not prescribed antimicrobials. The IP verified no residents in the facility were classified as having not met the McGeer's Criteria between the months of July 2025 through January 2026. The IP was asked if the facility's infection surveillance program included the residents who exhibited signs and/or symptoms of an infection and were not prescribed antimicrobial medications (or were not diagnosed with an infection) when the McGeer's criteria form was initiated. The IP stated the facility did not initiate the McGeer's criteria form for the residents who exhibited signs and/or symptoms of infection and were not prescribed antimicrobial medications (or were not diagnosed with an infection). The IP was asked how many residents had met the McGeer's criteria and were not prescribed antimicrobial medications from July 2025 through January 2026 (excluding residents who were diagnosed with an infection). The IP stated she was uncertain, as the facility did not initiate the McGeer's criteria form for those residents who exhibited signs and/or symptoms of infections and were not prescribed antimicrobial medications (or had not been diagnosed with an infection). 2. On 2/12/26 at 0829 hours, an observation of the facility's laundry room and concurrent interview was conducted with Housekeeping 1 and the Maintenance Director. The counter designated for clean laundry sorting was observed with three facility communication devices (walkie-talkies) with charger, a personal water bottle, and a personal cellphone. Additionally, a clean linen cart was observed adjacent to the clean laundry sorting counter. The top shelf of the clean linen cart contained clean linens. However, a portable speaker was observed on the top shelf of the clean linen cart. Housekeeping 1 verified the findings and stated the facility staff personal items should not be stored on the clean laundry sorting counter, for infection control purposes. The Maintenance Director was informed about the observation in the laundry area and verified the findings. On 2/18/2026 at 1016 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. On 2/12/26 at 1242 hours, an observation of the passing out of meal trays to the residents was conducted with the DSS. The Business Office Manager was observed holding the tray for Resident 15 close to her body and allowing her hair to hang over the milk cartons on the tray. The DSS stated the department managers usually would assist with passing out the meal trays during mealtimes. On 2/17/26 at 1401 hours, an interview was conducted with the Admissions Director. The Admissions Director stated a new program called Angel Rounds was initiated about four months ago. The program rotates the department managers to assist the staff with passing out of the meal trays. The (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Admissions Director stated he received an in-service during a stand-up meeting on how to pass out the meal trays. The Admissions Director stated they were trained on hand hygiene and to keep their hair pulled back and away from the trays. On 2/17/26 at 1409 hours, an interview was conducted with the Business Office Manager. The Business Office Manager acknowledge she did not have her hair properly pulled back and allowed her hair to hang over Resident 15's meal tray. The Business Office Manager verified she received training on how to wear her hair while passing out the meal trays but did not follow procedure that day. On 2/17/26 at 1418 hours, an interview was conducted with the DSD. The DSD verified that an in-service was provided on how to pass out the meal trays during the stand-up meeting. The DSD verified staff were trained on pulling their hair back when passing out meal trays to residents. 4. Review of the facility's P&P titled Dress Code (undated) showed the following: - Personal hygiene and appropriate dress are a very important part of the total appearance of the Food & Nutrition Services Department. - Hat for hair, if hair is short, which completely covers the hair. - If applicable, beards and mustaches (any facial hair) must wear beard restraint. On 2/12/26 at 1010 hours, a tray line observation and concurrent interview was conducted in the kitchen with the DSS. During the tray line observation, an individual wearing a hat and had no beard restraint was observed entering the kitchen and walked past the yellow food and safety line. The individual was identified to be a vendor employee. An interview was conducted with Vendor Employee 1. Vendor Employee 1 stated it was his first time at the facility, and the receptionist had told him to enter the kitchen to pick up the items. Vendor Employee 1 stated he was not aware and was not supposed to cross the yellow food and safety line in the kitchen without the proper hair coverings. The DSS verified Vendor Employee 1 entered the kitchen without the proper hair coverings. The DSS also verified there was no signage at the kitchen entry to notify the people entering the kitchen were required to wear the proper hair coverings. 5. Medical record review for Resident 14 was initiated on 2/11/26. Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's Order Summary Report showed a physician's order dated 10/6/25, for an indwelling urinary catheter size 16 Fr to gravity drainage bag for skin management. On 2/17/26 at 1322 hours, an observation was conducted for Resident 14. Resident 14 was observed lying in bed. Resident 14 was observed with an indwelling urinary catheter attached to a drainage bag which was inside the dignity bag (a bag used to cover and hold the catheter drainage bag so it was not visible). The drainage bag was observed hanging on the side of the bed; however, the drainage bag was touching the floor mat. On 2/17/26 at 1341 hours, an observation and concurrent interview for Resident 14 was conducted with CNA 1. CNA 1 verified Resident 14's indwelling urinary catheter drainage bag was touching the floor mat. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/17/26 at 1349 hours, another observation and concurrent interview for Resident 14 was conducted with LVN 2. LVN 2 verified Resident 14's indwelling urinary catheter drainage bag was touching the floor mat. On 2/18/26 at 1325 hours, an interview was conducted with the DON. The DON stated the urinary drainage bags should not touch the floor. The DON further stated she expected the staff members to place a basin under the urinary drainage bag to prevent the urinary drainage bag from having contact with the floor. The DON was informed and acknowledged the above findings. 6. Review of the facility's P&P titled Resident's Personal Property dated 5/2007 showed it is the property of the facility to provide space and safety for resident's personal property and to store all items in appropriate place, as space permits. a. On 2/11/2026 1048 hours, during the initial tour to the facility, three bags of clothing were observed in between two closets in Resident 21's room with one bag and clothing touching the floor. Medical record review for Resident 21 was initiated on 2/13/26. Resident 21 was admitted on [DATE]. Review of Resident 21's H&P examination dated 4/9/25, showed Resident 21 had the capacity to understand and make decisions. b. On 2/11/26 at 1100 hours, an observation was conducted for Resident 44. There were three paper brown bags observed on the floor against the wall on the left side of Resident 44's bed. The bags contained clothing and personal belongings covered by a white plastic bags which Resident 44 did not want to be touched. Medical review for Resident 44 was initiated on 2/ 18/25. Resident 44 was admitted to the facility on [DATE]. Review of Resident 44's H&P examination dated 7/23/25, showed Resident 44 can make her needs known. c. On 2/11/26 at 1115 hours, an observation and concurrent interview was conducted with Resident 137. Resident 137's personal belongings in a bag was observed on the floor. Resident 137 stated I do not have enough space in the closet. Medical review for Resident 137 was initiated on 2/18/26. Resident 137 was admitted to the facility on [DATE]. Review of Resident 137's H&P examination dated 2/11/26, showed Resident 137 had the capacity to understand and make decisions. On 2/11/26 at 1133 hours, an observation and concurrent interview was conducted with CNA 2 and LVN 3. CNA 2 and LVN 3 verified the observations of the personal belongings on the floor for Residents 21, 44 and 137. LVN 3 stated these personal belongings should not be on the floor, for infection control. On 2/12/26 at 1136 hours, an interview was conducted with the IP. The IP acknowledged the above (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	findings and stated the CNAs were supposed to be putting the personal belongings away. On 2/18/26 at 1342 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the above findings.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one sampled resident (Resident 81) and two non-sampled residents (Resident 41 and 130) were assessed, had a care plan and a physician's order to self-administer the medications. * A ketoconazole (antifungal medication) cream was observed on top of Resident 81's bedside drawer. There were no assessment, care plan or physician's order to self-administer the medication. * A bottle of Hydrogen Peroxide (antiseptic solution) topical solution and a jar of Desitin (anti rash medication) maximum strength was observed on top of Resident 41's night stand. There were no assessment, care plan or physician's order to self-administer the medication. * A Debrox earwax removal aid was observed on top of Resident 130's nightstand. There were no assessment, care plan or physician's order to self-administer the medication. These failures had the potential for the residents to administer the medication inaccurately and negatively impact the residents' physiological well-being.Findings: Review of the facility's P&P titled Self-Administration of Medication (undated) showed the residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. The P&P further showed the following: - Medications to be self-administered are specifically ordered and monitored by the facility nursing staff. - If a resident requests to self-administer drugs the IDT will determine if the practice is safe before the resident may exercise this right. - The IDT will determine who is responsible for the storage of the drugs and documentation of the administration of the drugs, as well as the location of drug administration. 1. On 2/11/26 at 0910 hours, during the initial tour of the facility, Resident 81 was observed asleep in bed. A tube of ketoconazole cream (anti-fungal medication) was observed on top of the bedside drawer. On 2/11/2026 at 1023 hours, a follow-up bedside observation and concurrent interview was conducted with LVN 13 for Resident 81. LVN 13 verified the ketoconazole medication was on top Resident 81's bedside drawer. LVN 13 stated Resident 81's parents were both doctors and wanted to treat their son on what they wanted, including applying the medication to the resident by themselves. Medical record review for Resident 81 was initiated on 2/12/26. Resident 81 was admitted to the facility on [DATE]. Review of Resident 81's Physician Progress Note dated 2/12/26, showed Resident 81 does not have the capacity to make medical decisions. Review of Resident 81's Order Summary Report dated 2/12/26, showed a physician's order dated 2/12/26, to administer Ketoconazole cream 2% to the perineal area topically every day. However, review of the Order Summary Report failed to show documented evidence for a physician order for the medication to be stored at bedside. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medical records failed to show documented evidence a self-administration assessment was conducted. On 2/18/2026 at 0859 hours, an interview and concurrent medical record review for Resident 81 was conducted with RN 2. RN 2 stated an assessment of the resident who wished to self-administer the medication should be conducted and a physician order should be obtained with special instruction for the self-administration of the medication. RN 2 was informed of the observation of Resident 81's topical medication at bedside. RN 2 verified and acknowledged Resident 81 have no physician order to self-administer or to leave the medication at bedside. In addition, RN 2 verified there was no assessment of self-administration of the medication conducted. On 2/18/26 at 1018 hours, an interview and concurrent medical record review for Resident 81 was conducted with the DON. The DON was informed and acknowledged the above findings. 2. On 2/11/26 at 0932 hours, during the initial tour of the facility, a bottle of Hydrogen Peroxide topical solution and a jar of Desitin maximum strength paste were observed on top of Resident 41's nightstand. When asked about the medication at bedside, Resident 41 was unable to respond to the questions. Medical record review for Resident 41 was initiated on 2/12/26. Resident 41 was admitted to the facility on [DATE]. Review of Resident 41's H&P examination dated 11/1/25, showed Resident 41 does not have full medical capacity to make decisions due to significant cognitive impairment secondary to traumatic brain injury. Review of Resident 41's Order Summary Report dated 2/12/26, failed to show the orders for the use of Desitin paste and Hydrogen Peroxide topical solution. On 2/11/25 at 1018 hours, an observation and concurrent interview was conducted with CNA 2. CNA 2 verified the Hydrogen Peroxide topical solution and Desitin paste was on top of Resident 41's nightstand. CNA 2 stated there should be no medications at bedside, and I am not assigned to this resident though. On 2/11/26 at 1043 hours, an observation and concurrent interview was conducted with LVN 2. LVN 2 verified the Desitin paste and Hydrogen Peroxide bottle were on top of Resident 41's nightstand. LVN 2 stated the family would bring and use their own products. LVN 2 stated they would brush the resident's teeth using Hydrogen Peroxide and then would clean him and use the Desitin cream. LVN 2 further stated the family was aware there should be no medications at bedside, but they would continue to bring the medications. LVN 2 acknowledged the Desitin paste and Hydrogen Peroxide topical solution should have been locked, if kept at bedside it would need a physician's order. 3. On 2/11/26 at 1038 hours, during initial tour of the facility, a box of Debrox earwax removal aid was observed on top of Resident 130's nightstand. Resident 130 stated he bought it himself and would use it to remove the earwax. Resident 130 further stated the staff were aware that he would use the eardrops by himself and the last time he used them was this morning. On 2/11/26 at 1040 hours, an observation and concurrent interview was conducted with LVN 2. LVN 2 verified there was a box of Debrox earwax removal aid on top of Resident 130's nightstand. LVN 2 (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	opened the box and there was a white bottle inside the box labeled Debrox earwax removal aid, 15 ml. LVN 2 stated there should be no medications at bedside. Medical record review for Resident 130 was initiated on 2/12/26. Resident 130 was admitted to the facility on [DATE]. Review of Resident 130's H&P examination dated 9/26/25, showed Resident 130 had full capacity to make his own healthcare decisions and provide informed consent. Review of Resident 130's Order Summary Report dated 2/12/26, failed to show a physician's order for the use of Debrox earwax removal aid. Further review of Resident 130's medical record failed to show an assessment and care plan to address Resident 130's use of Debrox earwax. On 2/11/2026 at 1054 hours, an interview was conducted with the ADON. The ADON was informed of the Debrox earwax removal aid at Resident 130's nightstand. The ADON acknowledged the observation and stated there should be no medication at bedside. On 2/18/26 at 1342 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the above findings.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility record review, and facility P&P review, the facility failed to provide privacy to two non- sampled residents (Resident 56 and 129). * The facility failed to ensure the privacy curtain was completely closed while providing care for Residents 56 and 129. These failures posed the risk of exposing the resident's body to other residents, staff and visitors, and had the potential to negatively affect the resident's well-being. Findings: Review of the facility's P&P titled Resident Rights dated 11/2021 showed residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtain shields the resident from passers- by. Review of the facility's undated P&P titled Suctioning Via Tracheostomy Tube Using an Inline (Closed System) Catheter (undated) showed to provide the resident privacy during the procedure. Review of the facility's undated P&P titled Tracheostomy Care (undated) showed to provide resident privacy during the procedure. 1. On 2/13/2026 at 0844 hours, a medication administration observation for Resident 129 was conducted with LVN 9. a. During the medication administration observation, LVN 9 was observed administering Resident 129's medications via GT with the privacy curtain not completely closed. The privacy curtain was closed only up to the left side of the foot board of the bed. Resident 129's abdominal area was exposed and a staff member walked by to go to Resident 129's roommate. When asked about the privacy curtain, LVN 9 stated the curtain should cover the resident completely. LVN 9 further stated I forgot. b. On 2/13/26 at 0920 hours, a medication preparation was conducted with LVN 2. While LVN 2 was preparing the medications outside Resident 129's room, RT 1 went in Resident 129's room and performed tracheostomy care and suctioning to Resident 129. RT 1 did not completely close the privacy curtain, and RT 1 could be seen outside the room performing the procedures. Medical record review for Resident 129 was initiated on 2/13/26. Resident 129 was admitted to the facility on [DATE]. Review of Resident 129's Progress Notes dated 2/12/26, showed Resident 129 was alert, oriented to time, place and persons, communicates verbally with clear speech and is able to understand and be understood when speaking. Review of Resident 129's Medication Review Report dated 2/13/26, showed the following physician's order:- dated 1/30/25, tracheostomy care every day and night shift; and- dated 11/9/25, to assess the need to suction the tracheostomy and/or oral secretions every two hours and PRN for pulmonary toilet management. On 2/13/26 at 0938 hours, an interview was conducted with RT 1. RT 1 was asked why the privacy curtain was not completely closed during the tracheostomy care and suctioning, RT 1 stated I did not know I have to fully close the curtain; I am not aware. 2. On 2/13/26 at 0934 hours, a medication administration observation for Resident 56 was conducted with LVN 9. When LVN 9 was in the process of administering Resident 56's GT medications, the privacy curtain was observed less than halfway closed and did not cover Resident 56 completely. LVN 9 was asked about the privacy curtain and LVN 9 stated I should have closed it completely to provide privacy. Medical record review for Resident 56 was initiated on 2/13/26. Resident 56 was admitted to the facility on [DATE]. Review of Resident 56's H&P examination dated 12/8/25, showed Resident 56 does not have the capacity to understand and make decisions. Review of LVN 9's New Employee Orientation Checklist dated 11/4/25, showed LVN 9 was educated on Resident's Rights which included personal privacy. Review of RT 1's Orientation Program completed on 4/2/25, showed RT 1 was educated on Patient's Rights; Resident Rights and Person-Centered Care. On 2/13/26 at 0945 hours, an interview was conducted with RN 5. RN 5 was informed of the above observations of LVN 9 and RT 1's failure to completely close the privacy curtain when providing care to Residents 129 and 56. RN 5 acknowledged the above findings and stated the privacy curtain should have been fully closed. On 2/18/26 at 1108 hours, an interview and facility record review was conducted with the DRT. The DRT stated he would educate the RTs upon employment and during meetings. The DRT stated for any respiratory care procedure being done, the curtains have to be closed at all times. The (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DRT was informed and acknowledged the above findings. On 2/18/26 at 1342 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the above findings.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide a homelike environment for two of 27 sampled residents (Residents 55 and 132) and one nonsampled resident (Resident 79). * Stack of mattresses, boxes, and other miscellaneous items were stored outside; however, the items could be seen from Resident 55's window and were visible from the hallway. * Stack of wooden boards and orange traffic cones were stored outside; however, the items could be seen from Resident 79's window and were visible from the hallway. * Resident 132's room was not thoroughly cleaned. These failures had the potential for the residents to not have a home-like environment that could negatively affect the resident's well-being. Findings: 1. On 2/11/2026 1250 hours, anobservation was conducted in the hallway outside Resident 55's room. A stack of mattresses, boxes, and other miscellaneous items could be seen outside Resident 55's window and were visible from the hallway. Resident 55 was observed glancing outside the window facing the stack of mattresses, boxes, and miscellaneous items. An observation and concurrent interview was conducted with Resident 55. When asked about the stack of mattresses, boxes, and other miscellaneous items visible from his window, Resident 55 answered with a gesture which appeared to be a dislike to what he was seeing. When asked how long the items had been stored outside, Resident 55 whispered I did not know what that (the items) all was. On 02/11/2026 at 1258 hours, concurrent observation and interview was conducted with the Maintenance Director and Resource Maintenance. When asked about the items stored outside Resident 55's window, the Maintenance Director stated the area outside Resident 55's window was a storage area. The Maintenance Director stated there used to be a curtain to cover the area so the items stored were not visible from the resident's window. When asked about the stack of mattresses, the Maintenance Director stated the mattresses were to be thrown into the trash. When asked how long the stack of mattresses had been there, the Maintenance Director was unable to determine for how long. When asked how long the area had been without a curtain, the Maintenance Director stated about two weeks. Medical record review for Resident 55 was initiated on 2/11/26. Resident 55 was readmitted to the facility on [DATE]. Review of Resident 55's H&P examination dated 1/29/26, showed Resident 55's diagnoses included ALS, functional quadriplegia, chronic respiratory failure, post status tracheostomy placement with dependency on a ventilator. Resident 55 was bedbound. Further review of Resident 55's H&P examination showed his social preference included to remain in his room. 2. On 02/11/2026 at 1553 hours, an observation was conducted in the hallway outside Resident 79's room. A pile of wooden boards and orange traffic cones could be seen outside Resident 79's window and were visible from the hallway. Resident 79 was observed up on her wheelchair facing the window. An observation and concurrent interview was conducted with Resident 79. When asked about the visible items from her window, Resident 79 verbalized she did not like seeing the pile of wood boards and orange cones outside her window. When asked about her activities, Resident 79 verbalized she liked staying in her room and her activities included sketching inside her room. When asked how long the items had been there, Resident 79 stated maybe since she was admitted to the facility. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/11/2026 at 1605 hours, an observation and concurrent interview was conducted with RN 4. When asked about the pile of wood boards and orange traffic cones visible from Resident 79's window, RN 4 stated she did not know and would ask maintenance staff. On 02/11/2026 at 1620 hours, an observation and concurrent interview was conducted with the Maintenance Director. The Maintenance Director verified the findings. When asked about the pile of wooden boards and orange traffic cones stored outside Resident 79's window, the Maintenance director stated he did not know for how long the items had been stored outside. On 2/11/26, medical record review for Resident 79 was initiated. Resident 79 was readmitted to the facility on [DATE]. Review of Resident 79's H&P examination dated 12/22/25, showed Resident 79's diagnoses included respiratory failure, asthma, and anxiety. Resident 79 did not have cognitive impairment. 3. On 2/11/26 at 1107 hours, during the initial tour of the facility, an observation was made of an insect crawling near Resident 132's bed. While attempting to secure the insect, the floor under and surrounding Resident 132's bed was observed to have a thick layer of dust under the bed and on the baseboard behind the bed. Additionally, there was crumpled trash and IV caps on the floor. LVN 15 and Consultant 3 verified the dust under the bed and on Resident 132's headboard and trash on the floor. Medical record review for Resident 132 was initiated on 2/11/26. Resident 132 was admitted to the facility on [DATE]. Review of Resident 132's MDS Section C assessment dated [DATE], showed Resident 132 was severely impaired and never/rarely made decisions. Review of the Daily Deep Cleaning to a Room Per Day Log for January 2026 showed Resident 132's room was deep cleaned on 1/26/26. Review of the facility's document titled Housekeeping Cleaning showed EVS (Environmental Services) were responsible for cleaning and disinfecting the baseboard and headboard and dusting and mopping the floor daily and as needed. On 2/17/26 at 1130 hours, an interview was conducted with the DON. The DON stated there was a standard of cleaning the housekeepers should be doing daily. The DON was made aware and acknowledged the amount of dust under Resident 132's bed was more than just one day of missed cleaning. On 2/18/26 at 1045 hours, an interview was conducted with Housekeeper 2. Housekeeper 2 verified it was their job responsibility to sweep and mop in the residents' room daily, including under the beds. *Cross Reference F925

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the residents were free from unnecessary medications for one of five sampled residents (Resident 118) reviewed for unnecessary medications. * The facility failed to ensure Resident 118 had appropriate targeted behaviors and a documented clinical rationale for the continued use PRN Ativan use. In addition, monthly psychotropic medication behavior summaries were incomplete for bupropion HCl, olanzapine, paroxetine HCl, and not completed for Ativan and buspirone HCl. This failure had the potential for the resident to receive unnecessary medication, as well as an undesirable outcome.Findings: Review of the facility's P&P titled Psychotropic Drug Use revised August 2017 showed PRN psychotropic medication orders are limited to 14 days unless the prescriber documents a clinical rationale in the resident's medical record for continued use. Medical record review for Resident 118 was initiated on 2/11/26. Resident 118 was admitted to the facility on [DATE]. Review of Resident 118's Order Listing Report showed the following physician's orders:- dated 1/27/25, for Ativan 1 mg every 12 hours PRN for 14 days, for agitation;- dated 2/13/25, for Ativan 1 mg every six hours PRN for 14 days, for anxiety manifested by agitation;- dated 2/24/25, for Ativan 1 mg every six hours PRN for anxiety. The order was discontinued on 3/10/25;- dated 3/10/25, for Ativan 1 mg every six hours PRN for 14 days, for anxiety manifested by physical restlessness;- dated 4/1/25, for Ativan 1 mg every six hours PRN for 14 days, for anxiety manifested by physical restlessness;- dated 4/22/25, for Ativan 1 mg every six hours PRN for 90 days, for anxiety manifested by physical restlessness; - dated 7/22/25, for Ativan 1 mg every six hours PRN for 90 days, for anxiety manifested by agitation. The order was discontinued on 9/10/25;- dated 9/10/25, for Ativan 1 mg every six hours PRN for 14 days, for anxiety manifested by agitation;- dated 9/10/25, for buspirone HCl (an anxiety medication) 5 mg three times a day for anxiety, manifested by increased physical restlessness;- dated 10/5/25, for Ativan 1 mg every six hours PRN for 14 days, for anxiety manifested by agitation;- dated 11/21/25 to monitor for episode of anxiety as evidenced by increased physical restlessness (buspirone) every shift. The ordered behavior to monitor failed to match the behavior targeted by buspirone;- dated 12/3/25, for Ativan 1 mg every six hours PRN for increased agitation. The order was discontinued on 12/7/25;- dated 12/5/25, for olanzapine (an antipsychotic medication) 5 mg at bedtime for psychosis manifested by angry outbursts evinced by resisting care;- dated 12/7/25, for bupropion HCl (an antidepressant medication) 75 mg daily for depression manifested by verbalization of sadness;- dated 12/7/25, for paroxetine HCl (an antidepressant medication)10 mg daily for depression manifested by outbursts of crying;- dated 12/8/25, for Ativan 1 mg every six hours PRN for 14 days, for anxiety manifested by increased agitation;- dated 12/12/25 to monitor for episode of anxiety as evidenced by verbalization of anxiousness (Ativan) every shift. The ordered behavior to monitor failed to match the behavior targeted by Ativan;- dated 1/1/26, for Ativan 1 mg every six hours PRN for 14 days, for increased agitation;- dated 1/20/26, for Ativan 1 mg every six hours PRN for 14 days, for anxiety manifested by increased agitation;- dated 2/4/26, for Ativan (an anxiety medication) 1 mg every six hours PRN for 14 days, for anxiety manifested by increased agitation and- dated 2/4/26, for Ativan 1 mg every six hours PRN for 14 days, for anxiety manifested by increased agitation. Review of Resident 118's Behavior Data sheets for psychotropic medication monthly monitoring showed the following:- a data sheet for olanzapine initiated for February 2025, had no monthly data for January 2026;- a data sheet for bupropion HCl initiated for February 2025, had no monthly data for January 2026; and- a data sheet for paroxetine HCl initiated for February 2025, had no monthly data for January 2026. Furthermore, there were no monthly Behavior Data sheets for Resident 118's use of buspirone HCl and Ativan. Review of Resident 118's medical record failed to show the prescriber's documented rationale for continued use of the PRN Ativan. On 2/17/26 at 1139 hours, an interview (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and concurrent medical record review for Resident 118 was conducted with the DON. The DON reviewed Resident 118's medical record and verified the Behavior Data sheets for olanzapine, bupropion HCl, and paroxetine HCl were incomplete for January 2026. The DON stated the monthly behaviors were ideally completed by the end of the first week of the following month. The DON verified there were no Behavior Data sheets for Resident 118's buspirone HCl and Ativan, and should have been completed. On 2/17/26 at 1317 hours, a follow-up interview and concurrent medical record review for Resident 118 was conducted with the DON. The DON verified Resident 118's ordered behavior monitoring and verbalization of anxiousness for Ativan use did not match the behavior of increased agitation in the Ativan order. The DON also verified the targeted behavior of increased agitation was not an appropriate specific targeted behavior and should have been clarified to a more quantifiable behavior. In addition, the DON verified Resident 118's medical record failed to show the prescriber's rationale for the continued use of PRN Ativan.

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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 medical record review, the facility failed to provide foot care for one of non-sampled resident (Resident 35). * Resident 35's toenails were long and had brown discoloration. This failure posed the risk of further deterioration to Resident 35's toenails. Findings: On 2/13/26 at 1533 hours, Resident 35 was observed in bed with Resident 35's responsible party (Responsible Party 1) at bedside. Responsible Party 1 verbalized concerns with Resident 35's toenails not being cared for. Resident 35's first digit toenail was observed extended beyond the tip of the toes. Responsible Party 1 granted permission for a focused body check for Resident 35 to be conducted with the nursing staff. On 2/13/26 at 1545 hours, a body check for Resident 35 was conducted with LVN 14 and CNA 6. Resident 35's toenails were observed with brown discoloration and his first digit toenail was extended approximately one half inch beyond the resident's tip of the toe. LVN 14 verified the finding. LVN 14 stated she thought Resident 35 was visited by the podiatrist last month. Medical record review for Resident 25 was initiated on 2/13/26. Resident 36 was readmitted to the facility on [DATE]. Review of Resident 35's H&P examination dated 2/23/25, showed Resident 35's diagnoses included cerebral palsy with quadriplegia (permanent impairment of motor function in all four limbs, the neck, and the trunk due to brain damage), post status tracheostomy placement, post status GT placement. Review of Resident 36's Podiatry Progress Note dated 12/18/25, showed Resident 36's diagnoses included nail dystrophy (abnormal changes in the shape, color, texture, or growth of fingernails or toenails, often causing thickened, brittle, or deformed nails), tinea unguium (common fungal infection of the fingernails or toenails caused by dermatophytes, resulting in thickened, discolored (yellow/brown), brittle, and crumbling nails) and toe pain. On 2/17/26 at 1140 hours, an interview and concurrent medical record review for Resident 35 was conducted with the SSD. The SSD stated Resident 35's last podiatry visit was on 12/18/25. The SSD stated Resident 35's insurance covered podiatry visits every 90 days and as needed. The SSD stated no one informed her of the concern with Resident 35's toenails for her to arrange an appointment.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the appropriate care and services for the use of an indwelling urinary catheter for one of three final sampled residents (Resident 15) reviewed for indwelling urinary catheter care. * Resident 15's indwelling urinary catheter was observed to be cloudy and had a lot of sediments in the tubing. In addition, the indwelling urinary catheter had no label when the drainage bag was changed. This failure had the potential for the resident to develop complications associated with the use of indwelling urinary catheter.Findings: Review of the facility's P&P titled Indwelling Catheter Care revised 6/2025 showed the facility will provide each resident with indwelling catheter care daily and as needed. On 2/11/26 at 0937 hours, Resident 15 was observed to have an indwelling urinary catheter connected to a urinary drainage bag placed at the side of the bed. The indwelling urinary catheter was observed to be cloudy and had a lot of sediments in the tubing. In addition, the indwelling urinary catheter had no label of when the drainage bag was changed. Medical record review for Resident 15 was initiated on 2/11/26. Resident 15 was readmitted to the facility on [DATE]. Review of Resident 15's Order Summary Report dated 2/12/26, showed a physician's order dated 10/20/25, for indwelling urinary catheter care every day for maintenance, urinary drainage bag change as needed, and indwelling urinary catheter change as needed for soiled, clogged, leaking and comes out. Review of Resident 15's MDS assessment dated [DATE], showed Resident 15's use of indwelling urinary catheter. Review of Resident 15's plan of care showed a care plan problem to address the use of the indwelling urinary catheter initiated on 10/17/25. The interventions included to monitor the indwelling urinary catheter for the signs and symptoms of infections. Further review of Resident 15's medical record failed to show documented evidence on when the indwelling urinary catheter was changed. On 2/12/26 at 1100 hours, an observation and concurrent interview was conducted with LVN 7. LVN 7 was asked about the indwelling urinary catheter care for Resident 15. LVN 7 verified the indwelling urinary catheter tubing had whitish color streaks and the urine in the urinary drainage bag was brownish to dark brown in color with a lot of sediments, and cloudy. LVN 7 acknowledged the urinary drainage bag needed to be changed because the resident was prone to infection. LVN 7 was asked when the catheter drainage bag was changed, LVN 7 was uncertain. LVN 7 verified the urinary drainage bag had no label on when it was last changed. On 2/18/26 at 0901 hours, an interview and concurrent medical record review for Resident 15 was conducted with RN 2. RN 2 verified Resident 15 had an indwelling urinary catheter and a physician's order for the indwelling urinary catheter care and maintenance. RN 2 reviewed the medical record and verified there was no documentation on when the indwelling urinary catheter of Resident 15 was changed. RN 2 acknowledged the above findings. On 2/18/26 at 1006 hours, an interview and concurrent medical record review was conducted with the DON. The DON was informed and verified the above findings.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility document review, the facility failed to ensure necessary care and services related to GT feeding were provided for two of two final sampled residents (Residents 2 and 144) and one nonsampled resident (Resident 30) reviewed for tube feedings. * The facility failed to ensure Resident 2 was administered the water flush via GT at the correct rate according to the physician's orders. * The facility failed to ensure Resident 30 was administered the enteral feeding via GT at the correct rate according to the physician's orders. * The facility failed to ensure Resident 144's HOB was elevated at least 30 degrees or greater during the enteral feeding to reduce the risk of aspiration. In addition, the failed to failed to ensure the GT residual monitoring was accurately documented. These failures posed the risk for complications related to use of the GT.Findings: 1. On 2/11/26 at 0930 hours, during the initial tour of the facility, Resident 2's GT feeding and water flush pump was connected to Resident 2. The water flush was set at 30 cc/hr. Medical record review for Resident 2 was initiated on 2/11/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 1/15/26, showed Resident 2 did not have the capacity to make needs known and or make medical decisions. Review of Resident 2's Order Summary Report showed a physician's order dated 8/3/25, to provide 500 cc water at 25 cc/hr x 20 hours via PEG-tube one time a day. Start at 1500 hours, run until total volume delivered. Change water bag every 24 hours. 2. On 2/11/26 at 1005 hours, during the initial tour of the facility, Resident 30's GT feeding and water flush pump was connected to Resident 30. The GT feeding was set at 65 cc/hr. Medical record review for Resident 30 was initiated on 2/11/26. Resident 30 was admitted to the facility on [DATE]. Review of Resident 30's H&P examination dated 8/6/25, showed Resident 30 did not have the capacity to understand and make decisions. Review of Resident 30's Order Summary Report showed a physician's order dated 1/16/26, to provide 1200 cc Diabetisource AC formula at 60 cc/hr x 20 hours, to provide 1440 kcal via PEG-tube. Start at 1500 hours, run until total volume delivered. On 2/11/26 at 1430 hours, an observation of Residents 2 and 30's GT feeding and water flush pump, interview and concurrent medical record review for Residents 2 and 30 was conducted with LVN 12. LVN 12 verified the water flush rate for Resident 2 was incorrect and should be set at 25 cc/hr. LVN 12 verified the GT feeding rate for Resident 30 was incorrect and should be set at 60 cc/hr. LVN 12 stated night shift nurses set up the GT feeding, but she should have verified the rates to the physician's orders when doing patient rounds. On 2/17/26 at 1130 hours, an interview and concurrent medical record review for Residents 2 and 30 (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was conducted with the DON. The DON verified the water flush rate set for Resident 2 did not match the physician's order. The DON also verified the GT feeding rate set for Resident 30 did not match the physician's order. On 2/18/26 at 1455 hours, a follow-up interview was conducted with the DON. The DON stated it was the responsibility of the charge nurse or the nurse supervisor to verify the water flush and GT feeding rates are set according to the physician's orders. 3. Medical record review for Resident 144 was initiated on 2/12/26. Resident 144 was admitted to the facility on [DATE]. Review of Resident 144's H&P examination dated 5/29/25, showed Resident 144 was GT feed dependent. Review of Resident 144's Order Summary Report dated 2/17/26, showed the following physician's orders: - dated 6/5/25, to administer Fibersource HN (enteral feeding formula) at 50 ml/hr via the GT; - dated 6/5/24, to elevate HOB 30 to 45 degrees during and one hour after feeding; and - dated 6/5/24, to check residuals and hold tube feeding if residuals above 150 ml, and to resume after two hour period. a. On 2/17/26 at 0842 hours and 0952 hours, Resident 144 was observed lying in bed asleep with Fibersource HN infusing at 50 ml/hr via GT. The HOB was slightly elevated and not at least 30 degrees. On 2/17/26 at 1003 hours, an observation of Resident 144 and concurrent interview was conducted with LVN 6 at Resident 144's bedside. LVN 6 stated when the enteral feeding was infusing, the HOB should be elevated at 30 degrees or more to prevent aspiration. LVN 6 verified Resident 144's GT feeing was infusing and the HOB was not at least 30 degrees. LVN 6 stated she determined the elevation of the HOB by looking at the bed to see if it was high enough. LVN 6 further stated she was uncertain on how high the HOB specific measurement was because there was no leveler device. LVN 6 verified the above findings. On 2/18/26 at 0903 hours, an interview and concurrent medical record review for Resident 144 was conducted with RN 2. RN 2 stated the licensed nurses should check the physician order for the GT feeding, check the placement of the GT and make sure the HOB was elevated to 30 to 45 degrees to prevent the risk of aspiration. RN 2 verified there was no specific device to measure the height of the HOB. RN 2 was informed of and verified the findings. RN 2 stated the HOB should have been elevated to at least more than 30 degrees when the GT feeding was infusing. b. Review of Resident 144's MAR for January and February 2026 showed to monitor the GT feeding residual every shift to be conducted by the licensed nurses. However, there was no specific amount of gastric residual documented. On 2/17/26 at 1003 hours, an interview and concurrent medical record review for Resident 144 was conducted with LVN 6. LVN 6 verified she checked Resident 144's GT residual on her shift before (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility document review, the facility failed to ensure the facility staff (CNAs 7 and 8) were competent in providing the necessary care and services to the residents who needed to be shaved. * The facility failed to ensure CNAs 7 and 8 had completed the skills competencies on how to shave the residents with episodes of spasms. This failure resulted in residents' to have cuts to their chins and posed the risk of further injury to the residents. Findings: 1. On 2/13/26 at 1013 hours, an observation was conducted for Resident 4. Resident 4 was observed with multiple surficial cuts to his chin. On 2/13/26 at 1030 hours, an observation and concurrent interview was conducted with LVN 14. When asked about the cuts to Resident 4's chin, LVN 14 verbalized the cuts occurred while the resident was being shaved. Medical record for Resident 4 was initiated on 2/13/26. Resident 4 was readmitted to the facility on [DATE]. Review of Resident 4's H&P examination dated 12/13/25, showed Resident 4 did not have the capacity to understand or make decisions. Resident 4's diagnoses included cerebral palsy, seizure disorder, chronic respiratory failure with dependency on a ventilator, and post GT placement. Review of Resident 4's February 2026 MAR showed Resident 4 was being administered with baclofen (muscle relaxant) medication three times daily for his spasms. Review of Resident 4's Progress Notes dated 2/13/26, showed Resident 4 was observed with scabs post status shaving. On 2/18/26, at 1041 hours, an interview was conducted with CNA 7. CNA 7 verbalized she did shower Resident 4 on 2/13/26. CNA 7 verbalized she thought Resident 4's cuts were already present at that time. When asked if CNA 7 had reported to nursing staff, CNA 7 stated she assumed the cuts had already been reported. When asked how she would shave the residents that moved around a lot during showers, CNA 7 stated very carefully. Review of CNA 7's employee file was conducted and the file failed to show a skills check was conducted related to how to shave residents, including how to shave residents with episodes of moving around while shaving. 2. On 02/17/2026 at 1344 hours, an observation for Resident 124 and concurrent interview was conducted with LVN 16 and CNA 8 at bedside. Resident 124 was observed in bed with a horizontal superficial cut measuring approximately 2.5 inches, running across the lower part of Resident 124's chin. The left corner of the cut was observed as a circular open wound with blood running down the left side of Resident 124's chin. When asked about Resident 124's cut, CNA 8 stated the cut occurred while CNA 8 was shaving Resident 124 in the shower. CNA 8 verbalized Resident 124 jumped while she was shaving his chin. LVN 16 and CNA 8 verified Resident 124 had an open cut that had blood flowing down the left side of Resident 124's chin. Medical record review for Resident 124 was initiated on 2/17/26. Resident 124 was admitted to the facility on [DATE]. Resident 124's diagnoses included diabetes, brain damage, and epilepsy. Review of CNA 8's employee file was conducted and the file failed to show a skills check was conducted related to how to shave residents including residents with episodes of moving around while shaving. On 2/18/26 at 1000 hours, an interview was conducted with the DSD. When asked what devices were used to shave Residents 4 and 124, the DSD showed the razors and shaving cream being used to shave the residents. When asked about the skills competencies for CNAs 7 and 8, the DSD stated he would do a follow up. On 2/18/26 at 1019 hours, a follow-up interview and concurrent document review was conducted with the DSD. When asked what skills competency was conducted for staff to ensure they were competent in shaving the residents with episodes of moving around during shaving, the DSD showed a facility document titled Shaving. The document showed the steps on how to perform shaving and a section to indicate whether the staff satisfactory/unsatisfactory demonstrated the skill; however, the form did not show the process for shaving residents that move around (had spasms) during shaving. The DSD verified CNAs 7 and 8 had not completed a skills check on how to shave the residents including residents who had episodes of moving around while shaving. The DSD verified the document titled (continued on next page)

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	555286	A. Building B. Wing	02/18/2026

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Shaving used for skills check competency did not address how to shave residents with episodes of spontaneous moving around (spasms) during shaving such as Resident 4 and 124.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record, facility record review, and facility P&P review, the facility failed to provide the necessary pharmaceutical services for one of six nonsampled residents (Resident 56) observed for medication administration. * The facility failed to ensure Resident 56's baclofen (a muscle relaxant) was administered as per the physician's order. This failure posed a risk for the resident to experience muscle spasms and could negatively affect the resident's well-being.Findings: Review of facility's P&P titled Guidelines for Medication Administration (undated) showed routinely scheduled medications will be administered at the times specified in the Standard Times for Medication Doses. Review of facility's document titled Medication Administration Times showed twice a day schedule was to begiven at 0900 and 1700 hours. Review of the facility's P&P titled Obtaining and Refilling Medications Policy dated 2/2017 showed: - it is the policy of the facility to obtain medications from new physician orders and refill medications needed in a timely manner; and - it is the responsibility of each staff member who passes medications, to ensure each resident has an adequate amount of every prescribed medication at all times. On 2/13/26 at 0927 hours, a medication administration observation was conducted with LVN 9. During the medication preparation for Resident 56, LVN 9 stated she will not be able to administer the baclofen medication as scheduled at 0900 hours. LVN 9 further stated the baclofen medication was not available and should be delivered soon. Medical record review for Resident 56 was initiated on 2/13/26. Resident 56 was admitted to the facility on [DATE]. Review of Resident 56's H&P examination dated 12/18/25, showed Resident 56 does not have the capacity to understand and make decisions. Review of Resident 56's Order Summary Report dated 2/13/26 showed the following physician's orders:- dated 5/16/24, to give saccharomyces boulardii (a medication supporting gut health, boost immune system and aid digestion) oral capsule, one capsule via GT one time a day for probiotic;- dated 6/17/24, to give metoprolol tartrate (antihypertensive medication) 50 mg via GT two times a day for high blood pressure;- dated 9/8/24, to give carbidopa-levodopa (medication used to manage tremors, stiffness and slowness of movement) oral tablet 25-250 mg one tablet via GT five times a day for Parkinson's disease;- dated 5/19/25, to give hydroxyzine HCL (medication used to treat itching caused by allergic reaction) oral tablet, one tablet via GT two times a day for itching; and - dated 10/6/25, to give baclofen oral suspension 25mg/5 ml, two ml via GT two times a day. Review of Resident 56's MAR for February 2026 showed LVN 9's initial and a code 7 (other/see nurses notes) as the entry for the baclofen medication administration for 2/13/26 at 0900 hours. Review of Resident 56's Nurses Progress Notes dated 2/13/26, showed a documentation of the physician notification when the baclofen was not administered and pending pharmacy delivery. On 2/13/26 at 1439 hours, an interview was conducted with LVN 9. LVN 9 stated the baclofen was not delivered yet and the desk nurse LVN 11 had called the pharmacy and notified the physician. On 2/13/26 at 1457 hours, an interview and concurrent record review was conducted with LVN 11. LVN 11 was asked about the facility's usual practice for when the medication was unavailable medication. LVN stated as long as it gets delivered by the pharmacy for Resident 56, we could give the resident acetaminophen (pain medication) as an alternative for the meantime. LVN 11 was asked if the acetaminophen medication a muscle relaxant, LVN 11 stated no. LVN 11 acknowledged Resident 56's baclofen medication should have been refilled ahead of time.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to follow-up on the consultant pharmacist's recommendations for one of five final sampled residents (Resident 118) investigated for unnecessary medications.* The consultant pharmacist's report for December 2025 showed a recommendation to update Resident 118's behaviors for PRN Ativan (a medication for anxiety) to include specific and quantifiable behaviors targeted. This failure resulted in the continued deficient practice of inappropriate behavior being targeted by Resident 118's psychotropic medication use. Findings: Review of the facility's P&P titled Medication Regimen Review (MRR) revised 8/2027 showed the consultant pharmacist will review residents' medical records monthly, irregularities will be documented and provided to the facility within seven working days. The report will be acted upon, and nursing personnel will provide a written response. Review of the Consultant Pharmacist's Medication Regimen Review for December 2025, showed for Resident 118, agitation or restlessness is too subjective and should not be used as a diagnosis nor as a behavior. Please update the resident's PRN Ativan order with a specific and quantifiable behavior based on the resident's words or action such as striking out, resisting care, continuous yelling/screaming. Under the follow-through column for facility follow-up notes, a ? was handwritten. Medical record review for Resident 118 was initiated on 2/11/26. Resident 118 was admitted to the facility on [DATE]. Review of Resident 118's Order Listing Report showed the following physician's orders for Ativan:- dated 12/3/25, for Ativan 1 mg every six hours PRN for increased agitation. The order was discontinued on 12/7/25;- dated 12/8/25, for Ativan 1 mg every six hours PRN for 14 days, for anxiety manifested by increased agitation;- dated 1/1/26, for Ativan 1 mg every six hours PRN for 14 days, for increased agitation; - dated 1/20/26, for Ativan 1 mg every six hours PRN for 14 days, for anxiety manifested by increased agitation; and- dated 2/4/26, for Ativan 1 mg every six hours PRN for 14 days, for anxiety manifested by increased agitation. Review of Resident 118's medical record failed to show the facility followed up on the consultant pharmacist's recommendations and notified the physician to update the order with a specific and quantifiable behavior for anxiety. On 2/17/26 at 1317 hours, an interview and concurrent medical record review for Resident 118 was conducted with the DON. The DON verified the facility failed to follow up on the consultant pharmacist's recommendations to update the behaviors for the PRN Ativan use.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and facility P&P review, the facility failed to ensure proper storage and disposal of medications for one of two medication storage rooms and three of five medication and treatment carts inspected for medication storage and labeling. * The facility failed to ensure medication storage room and carts were in a clean and sanitary condition. * The facility failed to ensure orally administered medications were stored separate from externally used medications. * The facility failed to ensure all medications and biologicals were not expired. These failures had the potential to negatively impact the residents well- being, the potential for the medications to lose stability and effectiveness, and unsafe administration of the medications and treatment. Findings: Review of the facility's P&P titled Medication Storage and Labeling (undated) showed the following:- all drugs will be labeled and stored in a manner consistent with manufacturer's published specifications, federal and state regulations, and to enhance accurate and safe medication administration by the facility staff,- external used drugs in liquid, tablet, capsule, or powder form shall be stored separately from drugs for internal use,- drugs shall not be kept in stock after the expiration date on the label and no contaminated or deteriorated drugs shall be available for use. 1.a. On [DATE] at 1035 hours, an inspection of Medication Storage Room A and concurrent interview was conducted with RN 2. The following was observed:- the front handles of the IV supplies storage drawers were dusty. Additionally, the bottom of the IV cabinet had light brownish sticky stains;- the over the counter cabinets were dusty with light brownish stains on the bottom of the cabinet;- an expired covid 19 testing kit dated [DATE];- oral medications were stored with non-oral medications: loperamide HCL (medication to treat diarrhea) tablets stored between fleet enema (medication to treat constipation) and Bisacodyl suppositories (medication to treat constipation), - yellowish stained label of vitamin C bottle and Naloxone spray (medication used to reverse opioid overdoses) package,- the cabinet door of the e-kit storage cabinet had dusty, sticky grayish stains;- the medication refrigerator exterior handle had dusty, sticky grayish stains; and- the treatment supplies storage closet had dark stains. RN 2 verified the above findings and stated the nurses and housekeeping staff clean this room. RN 2 stated the housekeeping staff could not come in unless a nurse stayed during the cleaning. b. Review of the [NAME] Metrix Pro System (glucometer) Comprehensive Resource Guide (undated) under System Storage instructions of the facility's glucometer in use, showed to store the meter, control solution, test strips in carrying case to protect from liquid, dust and dirt. On [DATE] at 1500 hours, an inspection of Medication Cart A and concurrent interview was conducted with LVN 17. The following was observed:- brownish blackish stains on bin inside the left top drawer used to store glucometer strips and lancets and on bin used to store syringes, and- used plastic-like oral syringes stored in a bin with unused syringes. LVN 17 verified the above findings and stated the medication cart storage bins should have been cleaned by the nurses from all shifts. On [DATE] at 1044 hours, an inspection of Medication Cart A and concurrent interview was conducted with the IP. The IP verified the above findings and stated the bin storing the glucometer, lancets and syringes should have been clean. The IP further stated the used syringes could not be stored with the unused syringes. The IP stated the ADON oversaw the medication storage. 2.a. On [DATE] at 1000 hours, an inspection of Treatment Cart A was conducted with LVN 4. The following was observed:- an opened, single use suture removal tray;- opened package of gauze; and- an culture set with an expiration date of [DATE]. LVN 4 verified the findings. LVN 4 stated the wound culture set was expired and should not be used. LVN 4 further stated the suture removal tray was used yesterday and should have been discarded. On [DATE] at 1030 hours, during an interview with RN 2, RN 2 verified the above findings. RN 2 stated culture sets should not be kept if expired, the suture removal tray should have been (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discarded once opened and the gauze should not have been opened until ready for the resident's use. b. On [DATE] at 1139 hours, an inspection of Treatment Cart B was conducted with RN 1. A covid 19 reagent was expired on [DATE]. RN 1 stated it should have been discarded. On [DATE] at 1342 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the above findings.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and facility document review, the facility failed to ensure food served was palatable, attractive, and at a safe and appetizing temperature for 88 of 88 residents who received food prepared in the kitchen. * The cole slaw for residents on regular and puree diets was observed with ice in it. This failure had the potential for decreased meal intake which could result in weight loss, decreased nutritive value, and negatively impact the residents' quality of life for all 88 residents who received food prepared in the kitchen. Findings: Review of the facility's Order Listing Report for February 2026 showed a total of 88 residents received meals prepared in the facility's kitchen. On 2/12/26 at 1028 hours, a resident council meeting was conducted with multiple residents. During this meeting, Residents 1 and 2 verbalized the food was served cold and did not taste good. On 2/12/26 at 1135 hours, an observation of the meal tray service was conducted with the Dietary Supervisor. The kitchen staff were preparing beef stew and corn cole slaw. On 2/12/26 at 1244 hours, two test trays (a regular diet and a pureed texture diet) were requested and observed with the Dietary Supervisor and the RD. The regular diet test tray containing the cole slaw had small pieces of ice in it. The pureed diet test tray containing the cole slaw had clumps of ice formation in it. The above findings were verified with the Dietary Supervisor and the RD.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility document review, the facility failed to maintain an effective pest control program to prevent the presence of an insect in Resident 132's room. * An insect was found crawling near Resident 132's bed. This failure had the potential for pests to multiply, and the presence of pest associated germs.Findings: Medical record review for Resident 132 was initiated on 2/11/26. Resident 132 was admitted to the facility on [DATE]. Review of Resident 132's MDS assessment dated [DATE], showed Resident 132 was severely impaired and never/rarely made decisions. On 2/11/26 at 1107 hours, during the initial tour of the facility, an observation was conducted with LVN 15 and Consultant 3 inside Resident 132's room. An insect was observed crawling near Resident 132's bed. The insect crawled under Resident 132's bed and LVN 15 and Consultant 1 were able to secure the insect and remove it from Resident 132's room. On 2/11/26 at 1233 hours, an interview was conducted with the Maintenance Director. The Maintenance Director stated there was a pest control company that came to the facility every two weeks, but the pest company did not spray inside the resident rooms due to the risks of the chemicals being used. The Maintenance Director added the pest control company sprayed the inside and outside perimeter of the facility. On 2/17/26 at 1130 hours, an interview was conducted with the DON. The DON verified Resident 132 was part of a vulnerable population and the facility should not have pests that could potentially jump into the residents' beds and possibly get into their mouths. On 2/17/26 at 1335 hours, an interview was conducted with the Administrator. The Administrator acknowledged Resident 132 was part of a vulnerable population and the facility should not have pests in the facility that could jump on the residents' who were not able to verbalize their needs. *Cross reference F584.

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F 0686 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure one of 27 final sampled residents (Resident 1) received services to prevent pressure ulcers. * Resident 1's LAL mattress settings were not set according to Resident 1's weight. This failure posed the risk of Resident 1's pressure ulcers not receiving full treatment to prevent further decline.Findings: On 2/11/26 at 1239 hours, Resident 1 was observed in bed on a LAL mattress. The mattress settings showed the weight setting was set to 15 pounds. Resident 1 appeared to weigh more than 15 pounds. Medical record review for Resident 1 was initiated on 2/11/26. Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's Order Summary Report showed an order dated 2/10/26, to use LAL mattress for wound management. Check placement and settings every shift. Review of Resident 1's Skin Check Progress Notes dated 2/11/26, showed Resident 1 had an arterial wound to her right foot, stage 2 pressure injury to her left buttock area and a state 2 pressure injury to her left gluteal fold. On 2/17/26 at 1047 hours, Resident 1 was observed in bed on her back. The mattress settings showed it was set to 150 pounds. Resident 1 did not appear to weigh 150 pounds. On 2/17/26 at 1619 hours, an observation, interview, and concurrent medical record review for Resident 1 was conducted with LVN 14. LVN 14 stated Resident 1 weighed 104 pounds. LVN 14 verified Resident 1's LAL mattress settings were set at 150 pounds. LVN 14 acknowledged the mattress should have been set to the correct settings according to Resident 1's weight.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and facility record review, the facility failed to ensure annual performance evaluations were completed for two of three CNA employee files reviewed (CNAs 4 and 5). * CNAs 4 and 5 did not have annual performance evaluations completed since 2024. This failure had the potential to delay identifying areas requiring additional staff training, leading to the residents to not receiving the proper and safe care. Findings: On 2/12/26 at 0928 hours, an employee file review and concurrent interview was conducted with the DSD. The following was noted:- CNA 4 was hired on 7/2/24. There was no annual performance evaluation completed for the CNA based on job performance and competency. - CNA 5 was hired on 8/13/24. There was no annual performance evaluation completed for the CNA based on job performance and competency.The DSD verified the above findings and stated he was behind on completing employee evaluations.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medical records were complete and accurate for one of three closed record sampled residents (Resident 12). * Resident 12's medical record showed a respiratory therapy note for care provided on 2/3/26 when the resident was transferred to a GACH on 2/2/26. This failure resulted in an inaccurate medical record for Resident 12. Findings: Review of the facility's P&P titled Documentation revised 5/2007 showed the resident's medical record is a concise and accurate account of treatment, care, response to care, signs, symptoms and progress of the resident's condition. Medical record review for Resident 12 was initiated on 2/11/26. Resident 12 was re-admitted to the facility on [DATE]. Review of Resident 12's Order Summary Report showed a physician's order dated 2/2/26, to transfer the resident to the ED. Review of Resident 12's Progress Notes showed the following:- dated 2/2/26 at 1405 hours, showed the resident was transferred to the ED;- dated 2/2/26 at 1956 hours, showed the resident was admitted to the GACH; and- dated 2/3/26 at 1837 hours (more than 24 hours after the resident was transferred out of the facility), showed the resident was on humified oxygen, treatments were administered per the physician's orders, routine tracheal tube suctioning and care were provided, and the tracheal tube site was assessed. The note also showed Resident 12 had no signs of respiratory distress or increased respiratory effort. On 2/12/26 at 1554 hours, an interview and concurrent medical record review for Resident 12 was conducted with the Medical Records Director. The Medical Records Director stated late entries made in the medical records should be documented to show it is a late entry. The Medical Records Director reviewed Resident 12's medical record and verified the resident was transferred out on 2/2/26, and did not return to the facility. The Medical Records Director reviewed the respiratory note and verified the note incorrectly showed Resident 12's respiratory care and assessments were performed the day after the resident left the facility.