STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555308	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trabuco Hills Post Acute	25652 Old Trabuco Road Lake Forest, CA 92630

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the menu was followed for 16 residents who received pureed food. * [NAME] 1 failed followed the recipe when preparing pureed zucchini and yellow squash for the lunch meal on 2/26/26. This failure posed the risk for the residents who received food prepared in the kitchen to not have their nutritional needs met.Findings: Review of the facility's document titled Diet Count by Modification / Portion dated 2/26/26, showed 16 of 161 residents received pureed food preparation from the kitchen, with no restrictions to zucchini and yellow squash. Review of the facility's diet spreadsheet titled Daily Spreadsheet for 2/26/26, showed the lunch menu included pureed zucchini and yellow squash #10 (scoop size #10 is equivalent to 3/8 cup) for the Minced and Moist diet (MMS), Pureed diet (PU4), and CCHO Pureed diet (PU4). Review of the facility's pureed recipe titled Pureed Vegetables Recipe dated 2/26/26, showed for 20 servings, portions size per spreadsheet:* Ingredients:- Seasoned vegetables, cooked and drained (reserve liquid) - 2-quart and 2 cups; and- Food Thickener - 2 Tablespoons. * Directions:- Remove portions required from regular prepared recipe; Drain and reserve cooking liquid. Place in food processor or blender and process until smooth;- If necessary, add a small amount of reserved cooking liquid or hot water;- If needed gradually add thickener and process until smooth in consistency;- Scrape down sides with rubber spatula and reprocess for 30 seconds;- Ensure mixture achieves smooth, lump free and extremely thick consistency; and- Serve using appropriate scoop size. On 2/26/26 at 1020 hours, an observation of the puree preparation and concurrent interview was conducted with [NAME] 1, [NAME] 2, the RD, and DSS. The following was observed:- [NAME] 2 was observed straining the prepared vegetables. [NAME] 2 did not reserve the cooking liquid of the vegetables;- [NAME] 2 served as a Spanish translator for [NAME] 1;- [NAME] 1 began the puree preparation for 25 portions in two separate batches. [NAME] 1 referred to the English version of the puree vegetable recipe;- For the first batch of pureed vegetables, [NAME] 1 used a #10 scoop to measure 12 portions of the prepared vegetables into the robot coupe. [NAME] 1 pureed the vegetables and then added one quart of honey consistency thickened chicken broth. [NAME] 1 poured the pureed vegetable mixture into a steam pan;- [NAME] 1 was asked how he knew how much liquid to add to the vegetables. [NAME] 1 pointed to the recipe where it showed seasoned vegetables, cooked and drained (reserve liquid) 2-quart and 2-cup and stated that is how much liquid the recipe said to use;- For the second batch of pureed vegetables, [NAME] 1 used a #10 scoop to measure 13 portions of the prepared vegetables into the robot coupe. [NAME] 1 pureed the vegetables and then added one cup of the honey consistency thickened chicken broth. [NAME] 1 poured the second batch of pureed vegetables into the steam pan with the first batch and mixed them together. [NAME] 1 stated the mixture was too runny. [NAME] 1 stirred in two teaspoons of thickener to the pureed vegetable mixture. [NAME] 1 placed the steam pan into the oven and stated he would wait to see if the pureed vegetable mixture thickens up over time, if not he would need to add more thickener; and- [NAME] 1 was asked how he read and followed the recipes if he did not speak English. [NAME] 1 stated he could ask for help with translation from [NAME] 2 or asked for the Spanish version of the recipe. On 3/2/26 at 1113 hours, an interview was conducted (continued on next page)

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

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with the DSS. The DSS stated there were Spanish versions of the recipes if the staff need them and he was always there to help if they did not understand the recipe. The DSS stated the pureed food should be similar to the regular foods without altering it too much. The DSS verified [NAME] 1 was preparing his own version of the puree vegetable recipe and the recipe for pureed zucchini and yellow squash was not followed when an excess of liquid was added to the puree zucchini.

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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 food safety and sanitation guidelines were followed. * The dish machine sanitizer ppm was less than the required concentration. * Dietary Aide 2 failed to wash his hands and change his gloves between the handling of dirty dishes and clean dishes. * The food preparation equipment was not air dried. * The food preparation equipment was not properly cleaned. * The wall in the kitchen behind the refrigerator was not clean. * Two meal carts were repaired with methods that were not smooth, cleanable surfaces. These failures had the potential to cause foodborne illnesses to the medically vulnerable residents population who consumed food prepared in the kitchen.Findings: Review of the facility's document titled Diet Count by Modification/Portion dated 2/26/26, showed 161 residents (including 16 residents on puree diet) who resided in the facility consumed food prepared in the kitchen. 1. Review of the facility's document titled Dishwashing Procedure dated 11/19/19, showed the concentration of the sanitary solution during the rinse cycle is 50-100 ppm with chlorine sanitizer on low temperature dish machines. On 2/25/26 at 0900 hours, during the initial tour of the kitchen, an observation and concurrent interview was conducted with the DSS. Dietary Aides 1 and 2 were washing the breakfast dishes. Dietary Aide 2 was asked to test the concentration of the sanitizing solution during the rinse cycle. Dietary Aide 2 placed a test strip in the water of the rinse cycle. The test strip resulted in a very light purple color. When the test strip was compared to the legend on the test strip bottle, it showed the sanitizer concentration was below 50 ppm. The DSS verified the result and found the tubing that connects the sanitizer to the dishwashing machine was twisted and stated they would rewash all the breakfast dishes. 2. Review of the facility's document titled Dishwashing Procedure dated 11/19/19, showed either two people are in the dish room, one on the dirty side, one on the clean side. If one person does both they must wash their hands between dirty and clean areas. Review of the facility's P&P titled Handwashing Guidelines for Dietary Employees dated 12/19/22, showed under Frequency of Handwashing, the dietary employees shall clean their hands and expose portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single service and single use articles and in the following situations: After hands have touched anything unsanitary i.e., garbage, soiled utensils/equipment, dirty dishes, etc. On 2/26/26 at 0915 hours, an observation of the dishwashing station and concurrent interview was conducted with the DSS. Dietary Aide 2 was observed loading dirty dishes into the dish machine. Dietary Aide 2 proceeded to unload clean dishes from the dish machine without washing his hands and changing his gloves The DSS verified Dietary Aide 2 was required to wash his hands and change his gloves when he moved from the dirty side to the clean side of the dish machine. 3. 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. Review of the facility's P&P titled Air Drying - Dishes and Utensils dated 12/19/22, showed dishes must be stored to promote air drying. Review of the facility's P&P titled Dish and Utensil Procedure dated 3/3/20, showed dishes, trays, and utensils shall be air dried before storage. On 2/25/26 at 0900 hours, during the initial tour of the kitchen, an observation and concurrent interview was conducted with the DSS. The following was observed:- One heavy-duty blender stored with the lid on with water inside the blender; and- One robot coupe stored with water inside. The DSS acknowledged the above findings and stated the blender and robot coupe would be washed again. 4. 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 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of dust, dirt, food residue, and other debris. Review of the facility's P&P titled Dish and Utensil Procedure dated 3/3/20, showed any dish, tray, or utensil with debris should not be used. Send back to the dish room to be properly washed and sanitized. On 2/25/26 at 0900 hours, during the initial tour of the kitchen, an observation and concurrent interview was conducted with the DSS. There was one robot coupe stored with food particles inside. The DSS acknowledged the above findings and stated the robot coupe would be washed again. 5. Review of the facility's P&P titled Sanitation Inspection dated 12/19/22 showed the following:- It is the policy of this facility, as part of the Departments sanitation program, to conduct inspections to ensure food service areas are clean, sanitary and in compliance with applicable state and federal regulations; and- Inspections will be conducted but not limited to the following areas: Dry storage, freezer, refrigerator, dish room, compartment sink area, main production area, and food preparation area. On 2/26/26 at 1135 hours, an observation and concurrent interview was conducted with the DSS. The wall above the reach-in refrigerator in the main production area was covered with a brown fuzzy residue. The DSS stated the walls are cleaned by kitchen staff at the end of every shift but verified the wall was not clean and would call maintenance to clean it. 6. According to the USDA Food Code 2022, 4-101.11 Characteristics, materials that are used in the construction of utensils and food-contact surfaces of equipment may not allow migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be (D) finished to have a smooth, easily cleanable surface; and (E) resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 2/26/26 at 0900 hours, an observation and concurrent interview was conducted with the Director of Maintenance. The following was observed:- Meal Cart A with duct tape to secure the door latch; and- Meal Cart B with the upper and lower corners repaired with a blue, plaster-like material. The Director of Maintenance stated he was not aware Meal Carts A and B needed to be repaired. The Director of Maintenance stated tape should never be used for repairs, and it appeared Bondo (a filler consisting of resin and a hardener used to repair, fill, and reshape dents, holes, and scratches) was used to repair Meal Cart B and it should have been sanded, and a primer should have been applied over the Bondo to complete the repair. On 2/26/26 at 0924 hours, an interview was conducted with the DSS. The DSS verified the duct tape on Meal Cart A and stated the weekend maintenance staff placed the duct tape to cover a sharp edge on the latch, but did not notify the Director of Maintenance to correctly repair Meal Cart A. The DSS verified Meal Cart B was not correctly repaired to have a smooth, cleanable surface.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary care and services for three of three residents (Residents 9, 16, and 22) reviewed for hospice services. * The facility failed to ensure Resident 9's facility plan of care included the frequency of visits by each hospice staff. * The facility failed to ensure Resident 16's medical record contained the visit notes by the hospice aide for February 2026, failed to ensure the hospice visitation calendar showed the scheduled hospice staff visits for February 2026 and failed to ensure the hospice plan of care was incorporated into the facility's care plan to include the frequency of visits for each hospice staff. * The facility failed to ensure future hospice visits were available in Resident 22's medical records. In addition, the facility failed to ensure schedule for the hospice staff visit was included in the facility plan of care. * The facility failed to ensure the physician's order was accurately reconciled for Resident 22. * The facility failed to ensure hospice staff were included in Resident 22's interdisciplinary team meeting. These failures posed the risk for delay in communication and/or uncoordinated medical care between the facility and hospice providers which may affect Residents 9, 16, and 22's care.Findings: Review of the facility's P&P titled Coordination of Hospice Services revised 11/1/23, showed the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physician, mental, and psychosocial well-being. A coordinated plan of care between the facility, hospice agency and resident/representative will be developed and shall include but not limited to the resident's rights, directives for managing pain and other uncomfortable symptoms and respite care program. The care plan and any related forms shall be revised and updated as necessary to reflect the resident's current status. 1. Review of the facility's contract with Hospice Provider B dated 7/25/24, showed Hospice will determine the appropriate course of hospice care, including the determination to change the level of services provided. Hospice will provide Hospice Services at the same level and to the same extent as those services would be provided if the facility resident were in his/her own home according to the frequency specified in the Hospice Plan of Care, including the following: a. Facility visits by hospice nurses. b. Facility visits by hospice social workers. c. Facility visits by hospice counselor. Medical record review for Resident 9 was initiated on 2/26/26. Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 9's Order Summary Report showed a physician's order dated 6/5/25, to admit Resident 9 under Hospice Provider B. Further review of the Order Summary Report failed to show the frequency of the hospice staff visits. Review of Resident 9's plan of care showed a care plan problem dated 8/8/25, addressing Resident 9's terminal prognosis and admission under Hospice Provider B. However, the plan of care failed to include the frequency of the visits by each hospice staff member. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reviews of Resident 9's MDS assessment dated [DATE], showed Resident 9 had severely impaired cognitive skills for daily decision making. Review of Hospice Provider B's plan of care for Resident 9 dated 1/8/26, showed the following information: - skilled nurse planned visit frequency: two times per week; - social worker planned visit frequency: as needed; and - hospice aide planned visit frequency: one time per week. On 3/4/26 at 0858 hours, an interview and concurrent medical record review for Resident 9 was conducted with the DON. The DON stated the residents who were receiving hospice services should have a schedule of when each hospice staff member would come to the facility to provide the care to the residents. The DON stated there should be a hospice plan of care as well as the facility's own plan of care and the hospice plan of care should be incorporated into the facility's care plan. The DON further stated the facility's care plan for the resident should include the frequency of visits for each hospice staff member. The DON reviewed Resident 9's medical records and verified the above findings. 2. Review of the facility's contract with Hospice Provider C dated 4/18/25, showed the following: - Hospice and the facility will establish a method of communication to ensure that the needs of the hospice patient are addressed and met twenty-four (24) hours a day including, regularly scheduled meeting in in person; and - The facility and hospice shall prepare and maintain complete and detailed clinical records concerning each hospice patient receiving facility services and hospice services under this agreement in accordance with prudent recordkeeping procedures as required by applicable federal and state laws and regulations. Each clinical record shall completely, promptly, and accurately document all services provided and event concerning each hospice patient. Medical record review for Resident 16 was initiated on 2/25/26. Resident 16 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 16's care plan for terminal prognosis related to Alzheimer's disease and admission to Hospice Provider C dated 10/3/23, failed to show the frequency of visit by each hospice staff member. Review of Resident 16's Order Summary Report showed a physician's order dated 4/18/25, to contact Hospice Provider C for any questions or concerns. The Order Summary Report failed to show the frequency of the hospice staff visits. Review of Resident 16's hospice records showed the Visit Note Report by the Hospice RN on 2/12 and 2/19/26. Further review of Resident 16's hospice records failed to show any hospice aide progress notes for February 2026. Review of Resident 16's hospice visitation calendar for February 2026 failed to show the scheduled (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	weekly visits by the skilled nurse or the hospice aide for the month. On 3/4/26 at 0832 hours, an interview was conducted with CNA 10. CNA 10 stated he was familiar with Resident 16's care. CNA 10 stated Resident 16 was receiving hospice services and the hospice aide came once a week to shower the resident. On 3/4/26 at 0841 hours, an interview and concurrent medical record review for Resident 16 was conducted with the MRD. The MRD stated the medical records team was responsible for printing the hospice information/records and placing them into the hospice binder and uploading the documents into the resident's electronic health records. The MRD stated the hospice notes should be sent to the facility weekly and placed into the resident's medical records as soon as possible. The MRD verified she did not receive any hospice aide notes for Resident 16 for the month of February. On 3/4/26 at 0858 hours, an interview and concurrent medical record review for Resident 16 was conducted with the DON. The DON stated for the residents who were receiving hospice services there should be a calendar to show the days the hospice aide and hospice nurses would be at the facility to see the resident. The DON stated the purpose of the calendar was so the facility could coordinate and plan care for the hospice residents. The DON stated the hospice plan of care should be incorporated into the resident's care plan and should include the frequency of visits for each hospice staff member. The DON was asked about the frequency and days of the hospice aide visits for Resident 16 in February. The DON reviewed Resident 16's medical record and verified the above findings. The DON stated the hospice visitation calendar for February was incomplete, the hospice aide visit notes were not uploaded in the resident's medical records or available in the resident's hospice binder, and the facility's plan of care did not include the frequency of hospice staff visits. On 3/4/26 at 1358 hours, a follow-up interview was conducted with the DON. The DON stated Resident 16 was seen by the hospice aide on 2/2, 2/5, 2/9, 2/12, 2/16, 2/19, 2/23, and 2/26/26. The DON stated the February hospice visitation calendar should have included those visits and the visit notes should have been sent to the facility and uploaded in the resident's medical records. The DON was informed and acknowledge the above findings. 3. Review of the facility's P&P titled Hospice Services Facility Agreement dated 12/19/22, showed it is the policy of this facility to provide and arrange for hospice services in order to protect residents right to a dignified existence, self-determination, and communication with, and access to, persons and service inside and outside of the facility. Review of the facility's Agreement with Hospice A dated 5/10/24, showed under the section hospice services a registered nurse will be assigned to coordinate and supervise care and services for patients and families. Registered nurses' responsibilities include: - coordination and implementation of each hospice patient's plan of care with facility staff. - provision of care as specified in each hospice patient's plan of care. - participation in interdisciplinary team, utilization review, and discharge planning meetings. Medical record review for Resident 22 was initiated on 2/25/26. Resident 22 was admitted to the facility on [DATE]. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 22's Hospice A medication list showed a physician's order dated 9/2/25, for morphine concentrate 20 mg/ml oral, to administer 5 mg every one hour as needed for shortness of breath or pain. Review of Resident 22's Order Summary Report showed following orders: - dated 9/2/25, to administer morphine sulphate (pain medication) oral solution 20 mg per 5 ml to give 0.25 ml (i.e.1 mg) by mouth every two hours as needed for severe pain; and - dated 2/15/26, to admit Resident 22 to Hospice A with terminal diagnosis of sarcoma (a rare, complex cancer arising from connective tissues like bone, fat, muscle, nerves, and blood vessels). Review of Hospice A's Interdisciplinary Group (IDG) Meeting dated 2/4/26, showed the following visit frequencies for hospice staff: - Chaplain: One visit per month for two months, scheduled from 2/1/26 through 3/31/26. - Nursing: One visit per week for six weeks, scheduled from 2/2/26 through 3/14/26. - Nursing (PRN): Up to three as needed visits, authorized from 1/10/26 through 3/10/26. - Social Worker: One visit per month for two months, scheduled from 2/1/26 through 3/31/26. - Social Worker (PRN): Up to three as needed visits, authorized from 1/10/26 through 3/10/26. Review of Resident 22's IDT Care Conference note dated 2/20/26, for behavioral and psychotropic medication management showed the IDT met with the psychiatric nurse practitioner for the resident's monthly behavior assessment and gradual dose reduction (GDR) review. The resident's current medication regimen has stabilized their behavior. A dose reduction or GDR was not recommended at that time because the resident was receiving hospice care, and the dosage is necessary to maintain emotional and physical comfort during the end^of^life process. Further review of IDT Care Conference document did not show if the Hospice A staff were the part of the IDT meeting. Review of Resident 22's Hospice A Monthly Calendar for March 2026 showed Resident 22 was visited by Hospice A Chaplin on 3/2/26; however, the calendar did not show the schedule of the Hospice staff visits for the rest of March 2026. Further review of Resident 22's medical record did not show if the frequency of Hospice A staff visits were included in the facility plan of care to provide coordinated patient care. On 3/3/26 at 0838 hours, an interview was conducted with LVN 5. LVN 5 stated Resident 22 was receiving hospice services. LVN 5 stated he was not sure when and how often the hospice staff were visiting Resident 22. LVN 5 stated he was not sure who was the hospice coordinator for the facility. On 3/3/26 at 0930 hours, an interview and concurrent medical record review for Resident 22 was conducted with RN 2. RN 2 verified Resident 22 was receiving hospice services through Hospice A. RN 2 stated he was unable to locate any future schedule indicating when Hospice A staff were expected (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **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 ensure the infection control practices were followed. * The facility failed to ensure the water management program was established and implemented to include the implementation of measures to prevent the growth of Legionella and other opportunistic pathogens; and a way to monitor the measures they had in place. * The facility failed to ensure there were no soiled, stained towels on top of a drawer in the clean linen area and the washing machine had no dust accumulation. * Housekeeping staff's personal water bottle and a cup of vitamins for personal use were stored in the cart with cleaning supplies, paper towels and tissue papers for resident rooms. * The facility failed to ensure LVN 5 performed hand hygiene after disconnecting Resident 46's feeding tube and before touching the medication cart and keys. * The facility failed to ensure the urinals were not stored hanging on the trash bins for two final sampled residents (Residents 194 and 195). * The facility failed to ensure Resident 68 was placed in isolation precaution for suspected C. diff. infection when the resident had four loose stools in less than 24 hours. In addition, the facility failed to ensure Resident 68's visitor was educated and followed the contact isolation precautions for suspected C. diff and the clinical staff performed hand washing upon leaving the room of Resident 68, who was in contact isolation for suspected C. diff. infection. * The facility failed to ensure Medication Cart E compartment where the pill cutter and label stickers were stored did not have the orange and brown-colored residues, the pill cutter was cleaned after every use, the glucometer did not have the brownish-orange stain and did not have the staff personal keys inside. * The facility failed to ensure CNA reported Resident 200's documented loose stools resulting in no further follow up and change to the residents' isolation precautions. These failures posed the risk for transmission of disease-causing microorganisms and infections to the resident, staff, and visitors.Findings: 1. According to the CDC's guidelines for Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings dated 9/30/25, under the section elements of a water management program showed the following steps: - to establish a water management program team, - to describe water system using text and flow diagrams, - to identify areas where legionella could grow and spread. - decide where control measure should be applied and how to monitor them - establishing the ways to intervene control limits are not met. - make sure program is running as designed and is effective. - document and communicate all the activities. Further review of the CDC guideline showed control measures and limits should be established for each control point. You will need to monitor to ensure your control measures are performing as designed. Control limits, in which a chemical or physical parameter must be maintained, should include a minimum and a maximum value. Examples of chemical and physical control measures and limits to reduce the risk of Legionella growth: Water quality should be measured throughout the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	system to ensure that changes that may lead to Legionella growth (such as a drop in chlorine levels) are not occurring, Water heaters should be maintained at appropriate temperatures, Decorative fountains should be kept free of debris and visible biofilm, Disinfectant and other chemical levels in cooling towers and hot tubs should be continuously maintained and regularly monitored. Surfaces with any visible biofilm (i.e., slime) should be cleaned. Under section Your program team should establish procedures to confirm, both initially and on an ongoing basis, that the water management program is being implemented as designed. This step is called verification. Your program team should establish procedures to confirm, both initially and on an ongoing basis, that the water management program effectively controls the hazardous conditions throughout the building water systems. This step is called validation. Review of the facility's P&P tiled Water Management Program dated 12/19/22, showed it is the policy of the facility to establish water management plans for reducing the risk of legionellosis and other opportunistic pathogens in the facility's water system based on nationally accepted standards. Further review of the P&P showed a risk assessment will be conducted by the water management team annually to identify where legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water system. Review of the facility's P&P titled Legionella Surveillance dated 12/19/22, under the section principles of legionella transmission showed legionella grows best in water temperature of 77-108 degrees Fahrenheit, particularly in water that I not moving or that does not have enough disinfectant to kill germs. Primary prevention strategies under temperature controls showed hot water shall be stored above 140-degree Fahrenheit and circulated at a minimum return temperature of 124-degree Fahrenheit. Review of the facility's Water Safety Program (legionella) dated 1/31/24, showed facility to describe facility water system using diagram and identify areas where legionella can grow and spread. On 2/26/26 at 1001 hours, an observation and concurrent interview was conducted with the Director of Maintenance. The water heater that supplies water to the resident care area was observed to be set at temperature of 119 degrees Fahrenheit. The Director of Maintenance verified the above observation. When asked what temperature the facility stored the cold temperature at, the Director of Maintenance was not able to answer. On 2/26/26 at 1553 hours, an interview and concurrent facility document review was conducted with the IP. The IP was not able to show if the risk assessment for the legionella prevention was conducted in the facility water system. In addition, the IP was not able to show the facility water system using a diagram and areas in the water system where the legionella could grow. When asked what control measures was being used to prevent legionella growth in the facility water system, the IP stated the facility used temperature control and visual inspection; however, the IP was not able to show specific control measures that was being applied in each control area in the facility water system. 2. Review of the facility's P&P titled Handling Clean Linen dated 12/19/22, showed it was the policy of the facility to handle, store, process and transport clean linen in a safe and sanitary method to prevent contamination of linen which can lead to infection. a. On 02/26/26 at 0942 hours, an observation of the laundry area and concurrent interview was conducted with the Housekeeping Supervisor. Two soiled, stained towels were observed on top of a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	drawer in the clean linen area. The Housekeeping Supervisor verified the observation and stated the soiled towels should not be stored in the clean linen area. The Housekeeping Supervisor was then observed removing the soiled towels and transporting them to the designated soiled laundry area. b. The resident's personalˆclothing washing machine was observed with dust accumulated around the top of the unit. The Housekeeping Supervisor verified the observation and stated the washing machine should have been cleaned. On 3/4/26 at 0957 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. On 2/27/26 at 0949 hours, an observation and concurrent interview was conducted with Housekeeping Staff 1. Housekeeping Staff 1 was observed standing in the doorway of a resident room with a housekeeping cart in front of her in the hallway. Housekeeping Staff 1 was observed drinking from a reusable water bottle, then placed the bottle inside of the housekeeping cart and then closed the cart door. When asked what was stored inside the cart, Housekeeping Staff 1 opened the door and the water bottle, a clear cup with orange tinted water, paper towels, and toilet paper, and a spray bottle were observed on a shelf. Housekeeping Staff 1 stated it was her water bottle and the cup had her vitamins. Housekeeping Staff 1 grabbed the clear cup with orange tinted water and drank it. Housekeeping Staff 1 stated there were also cleaning chemicals, paper towels and toilet paper for restocking resident rooms. Housekeeping Staff 1 verified she should not have drinks or personal items in the cart. On 2/27/26 at 0954 hours, an interview was conducted with the Housekeeping Supervisor. The Housekeeping Supervisor stated the housekeeping carts contain cleaning chemicals as well as supplies to stock the resident rooms including paper towels, toilet paper and hand sanitizer, and no drinks or personal belongings should be in the housekeeping carts. 4. On 2/25/26 at 1020 hours, an observation of the room for Residents 194 and 195 was conducted. Resident 194 was observed with two urinals hanging on the side of the trash bin and Resident 195 had a urinal hanging on the edge of Resident 195's trash bin. Resident 194 stated his urinals had been stored there since he had been using them. The Resident 194 stated the trash bin was not an ideal place to store the urinals, but he did not want the urinals on his bedside tray table and didn't have anywhere else to place them and would still be within his reach. a. Medical record review for Residents 194 was initiated on 2/25/26. Resident 194 was admitted to the facility on [DATE]. b. Medical record review for Residents 195 was initiated on 2/25/26. Resident 195 was admitted to the facility on [DATE]. On 2/25/26 at 1029 hours, an observation and interview was conducted with the DSD. The DSD verified the urinals were stored on the residents trash bins and stated the urinals should not be store hanging on the trash bin due to infection control concerns. 5. Medical record review for Resident 68 was initiated on 2/2/5/26. Resident 68 was readmitted to the facility on [DATE]. Review of the CDC's C. diff Facts for Clinicians dated 3/5/24, showed C. diff is a spore-forming (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bacteria that is shed in feces, and any surface, device or material that becomes contaminated with feces could serve as a reservoir for the C. diff spores, and can be transferred to other residents. If a resident has three or more stools in a 24 hour period, the resident should be places in isolation for possible and wear gloves and a gown when treating resident's with potential infectious diarrhea. Review of the CDC's C. diff Facts for Clinicians dated 3/5/24, showed C. diff is a spore-forming bacteria that is shed in feces, and any surface, device or material that becomes contaminated with feces could serve as a reservoir for the C. diff spores, and can be transferred to other residents. The guidance also showed hand sanitizer does not kill C. diff. a. Review of Resident 68's Nurse Progress Note dated 2/26/26 at 2236 hours, showed the resident had two loose stools. Review of Resident 68's eINTERACT SBAR Summary for Providers note dated 2/26/26 at 1057 hours, showed the resident had one loose stool yesterday and one this morning. An order was obtained to get a stool specimen and test for C. diff. On 2/26/26 at 1213 hours, an observation and concurrent interview was conducted with Resident 68 at bedside. The resident was on EBP; however, did not have contact isolation precautions implemented. Resident 68 stated he did not feel well and had been having loose stools all night and was still having them. On 2/26/26 at 1254 hours, an interview was conducted with CNA 2. CNA 2 stated Resident 68 had two loose stools so far for her shift. On 2/26/26 at 1255 hours, an interview was conducted with the IP. The IP stated for a resident with three loose stools, they should be placed on isolation for suspected C. diff. When asked why Resident 68 was not in isolation after having four loose stools in less than 24 hours, the IP stated she would double check. The IP verified Resident 68 was not on contact isolation precautions. On 2/26/26 at 1256 hours, an interview and record review was conducted with LVN 1. LVN 1 stated Resident 68 had one loose stool yesterday per the shift report and two today. LVN 1 reviewed Resident 68's medical record and verified the record showed Resident 68 had two loose stools last night and there were four loose stools in 24 hours. LVN 1 stated he obtained a physician's order to obtain a stool specimen to test for C. diff. When asked at what point the resident would be placed on contact isolation, LVN 1 replied when the stool specimen results comes back as positive for C. diff. On 2/26/26 at 1301 hours, an interview was conducted with the IP Lead. The IP Lead stated Resident 68 should have been placed on contact isolation precautions for suspected C. diff since he had four loose stools in 24 hours. b. On 2/26/26 at 1502 hours, an interview was conducted with the DON. The DON stated Resident 68 was now on contact isolation precautions for suspected C. diff. On 2/27/26 at 1051 hours, an observation and concurrent interview was conducted with Family Member 2 in Resident 68's room. Family Member 2 was observed inside Resident 68's room. A Contact Isolation signage was posted outside the room next to Resident 68's doorway. The signage showed to wear an isolation gown and gloves. Family Member 2 was observed not wearing any PPE. Family Member 2 stated no one had told her she needed to wear PPE. Family Member 2 also stated no (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	one told her she had to wash her hands instead of using ABHR. Family Member 2 stated the staff told her Resident 68 was on isolation for his stool. Family Member 2 stated she asked the facility if she could still visit and the facility informed her she could. Family Member 2 further stated the facility never mentioned about needing to wear anything in Resident 68's room. Family Member 2 stated she was at the facility yesterday too and no one had said anything. On 2/27/26 at 1502 hours, an observation and concurrent interview was conducted with NP 1. NP 1 was observed inside Resident 68's room and a contact isolation signage was posted outside the doorway. NP 1 was observed taking off an isolation gown and gloves, used ABHR located outside the doorway, picked up papers on top of the PPE cart, walked to the nurses' station, wrote on a paper, and handed the paper to LVN 1. NP 1 stated she was keeping the resident on isolation pending the test results, since he was recently in the acute care hospital and who knows what he was exposed to in acute hospital. When asked if she washed her hands after leaving the resident's room, NP 1 replied that was why she came to the nurses' station. NP 1 was then observed entering the station and washed her hands. On 2/27/26 at 1534 hours, an interview was conducted with the IP. The IP stated when leaving a room with contact isolation for C. diff., the clinical staff should use ABHR when leaving the room and then go directly to the nurses' station to wash their hands without handling or touching anything else. On 2/27/26 at 1134 hours, an interview was conducted with LVN 1. LVN 1 stated they notified Family Member 2 of the resident being on isolation for suspected C. diff and believed he spoke to her about PPE and hand washing but could not recall specifically. LVN 1 also stated he saw Family Member 2 earlier but could not recall if the family member was in the hallway or the resident's room. 6. On 2/26/26 at 0943 hours, a medication administration observation for Resident 46 was conducted with LVN 5. LVN 5 was observed donning the gown and gloves and entering Resident 46's room. LVN 5 then placed Resident 46's enteral feeding on hold and disconnected the enteral feeding tubing from Resident 46. LVN 5 stated he forgot his stethoscope and was observed retrieving the keys to the medication cart from his pockets. LVN 5 then unlocked the medication cart and removed the stethoscope. LVN 5 was not observed doffing the gloves and performing hand hygiene prior to retrieving the keys and unlocking the medication cart. On 2/26/26 at 1008 hours, an interview was conducted with LVN 5. LVN 5 verified he did not remove the gloves after disconnecting Resident 46's enteral feeding tubing and before touching the medication cart. LVN 5 stated his gloves were contaminated after he touched the resident's GT and he should have removed the gloves, and performed hand hygiene before touching his medication cart, for infection control purposes. 7. On 2/26/26 at 1158 hours, an inspection of Medication Cart E and concurrent interview was conducted with LVN 5. The following were observed: - the compartment storing the pill cutter and label stickers was observed with orange-colored and brown-colored residue, - one pill cutter was observed with significant white powder residue, - the glucometer was observed with multiple brown-orange colored stains, and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- one set of personal keys observed in the bottom drawer of the medication cart. LVN 5 verified the above findings. LVN 5 stated the glucometer and pill cutter should be cleaned and disinfected after every use. On 3/4/26 at 0919 hours, an interview was conducted with the DON. The DON stated the licensed nurses were responsible for cleaning the medication carts at the end of every shift. The DON stated the mediation carts should be kept clean at all times and the equipment should be cleaned after every use for infection control purposes and to prevent cross contamination. The DON stated the personal items should not be stored inside the medication carts. On 3/4/26 at 1105 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 8. On 2/25/26 at 0957 hours, during an initial tour of the facility, an observation was conducted for Resident 200. Resident 200 was observed with a signage indicating the resident was on Enhanced Barrier Precautions. On 3/3/26 at 0830 hours, an interview was conducted with Resident 200. Resident 200 verbalized he had a total of four loose stools on 3/2/26. Per Resident 200 the poop ran through me like sift. Per Resident 200 he was wearing diapers. On 3/3/26 at 0847 hours, an interview was conducted with CNA 6. When asked about Resident 200's bowel movements, CNA 6 stated she received a report from the previous shift Resident 200 had two loose stools. Per CNA 6 she was to monitor Resident 200's bowel movements. On 3/3/26 at 0851 hours, an observation, medical record review and concurrent interview was conducted with LVN 7. LVN 7 stated he did not receive any report about Resident 200 having loose bowel movements. LVN 7 was observed asking Resident 200 about his bowel movements and Resident 200 stated he had diarrhea on 3/2/26. Resident 200 was observed with signage indicating Resident 200 was on Enhanced Barrier Precautions. LVN 7 stated Resident 200 wore diapers because he was incontinent. Review of Resident 200's progress notes with LVN 7 showed there were no progress notes mentioning any episodes of diarrhea for Resident 200 on 3/2 or 3/3/26. LVN 7 looked for any change in condition notes and there were no changes in condition documentation related to Resident 200's bowel movements in Resident 200's medical record. Medical record review for Resident 200 was initiated on 3/3/26. Resident 200 was admitted to the facility on [DATE]. Review of his H&P examination dated 2/18/26, showed Resident 200's diagnoses included diabetes and seizure disorder. Review of Resident 200's Documentation Summary Report dated 3/3/26, Resident 200's bowel movements were documented as loose/diarrhea consistency, a total of three times during the day shift. On 3/3/26 at 1515 hours, a concurrent interview and medical record review was conducted with LVN 7 with the DON also present. LVN 7 verified the above findings on 3/3/26, and stated the information were not reported to him. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/3/26 at 1540 hours, a follow-up observation was conducted for Resident 200. Resident 200 had signage indicating he was still on Enhanced Barrier Precautions. On 3/4/26 at 0942 hours, a follow up interview was conducted with LVN 7. LVN 7 stated he obtained a stool sample from Resident 200 to rule out C diff. Per LVN 7 the stool sample was more putty-like but it did have a distinct smell to it. On 3/4/26 at 0955 hours, an interview was conducted with CNA 6. When asked about Resident 200's bowel movements documentation on 3/3/26, as having loose consistency, CNA 6 verbalized Resident 200 had no diarrhea but Resident 200 complained he was having diarrhea. CNA 6 stated she changed Resident 200's diaper four to five times at 0730, 1030, and 1200 hours. Per CNA 6 Resident 200's bowel movements were like baby food texture. CNA 6 further stated Resident 200's bowel movements were not watery or loose but they were not formed; therefore, CNA 6 stated she did not know how to document. CNA 6 stated Resident 200 said he felt okay. CNA 6 stated she did not report Resident 200's bowel movements to the nurse because it was not really like diarrhea. CNA 6 stated there was not a good option in the electronic health record system to describe Resident 200's bowel movements.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and facility document review, the facility failed to maintain the cleanliness and sanitation of the essential equipment for two of two ice machines (Ice Machines A and B). * The facility failed to ensure Ice Machine A was cleaned and sanitized using the recommended solution as per the manufacturer's guidelines. * The facility failed to ensure Ice Machine B was cleaned and sanitized as per the manufacturer's guidelines. In addition, the facility failed to ensure the correct solution ratio was used to clean Ice Machine B as per the cleaning agent instruction for use label. These failures had the potential for the essential equipment to be not cleaned and sanitized properly and could cause food contamination and food-borne illnesses to the residents.Findings: Review of the facility's document titled Diet Count by Modification/Portion dated 2/26/26, showed 161 residents who resided in the facility consumed an oral diet. a. Review of the Ice Machine A's manufacturer's guidelines titled Descaling/Sanitizing Procedure (undated) showed the following:- The ice machine and bin or dispenser requires disassembly, descaling and sanitizing every six months. Ice machine descaler is used to remove lime scale and mineral deposits. Ice machine sanitizer disinfects and removes algae and slime.- Only use Manitowoc approved ice machine descaler and sanitizer for this application:Manitowoc Descaler Part Number: 94-0546-3Manitowoc Sanitizer Part Number: 94-0565-3 b. Review of Ice Machine B's manufacturer's guidelines titled User Manual - Modular Ice Machines (undated) showed the Monthly Cleaning Process. The Note showed to empty the bin of ice in advance; clean and sanitize the bin and do a complete rinsing; and clean and sanitize the ice sliding board, water distribution line, water supply line, and water pump, then do a complete rinsing. The process included to put in the proper amount of sanitizing solution manually into the water trough followed by the clean and sanitizing process instruction.Refer to your cleaner and sanitizer for proper mixing and code instructions. On 2/25/26 at 1125 hours, an interview and concurrent observation of Ice Machines A and B was conducted with the Director of Maintenance. The Director of Maintenance stated he would clean Ice Machines A and B. The Director of Maintenance stated he would follow the procedure recommended by the manufacturer to clean and sanitize Ice Machines A and B. The Director of Maintenance presented two bottles of solution he would use to clean and sanitize Ice Machines A and B. The first bottle was labeled Essential Values Ice Machine Cleaner & Descaler and the second bottle was labeled HydroBalance H.B. 30 Ice Machine Cleaner. The Director of Maintenance verified he was using two cleaning solutions instead of having one cleaning solution and one sanitizing solution. The Director of Maintenance further stated he did not have the Manitowoc cleaner in stock and was using the HydroBalance and Essential Value brand cleaners to clean and sanitize Ice Machine A. The Director of Maintenance verified he should have followed the manufacturer's guidelines using Manitowoc brand to clean and sanitize Ice Machine A. Furthermore, the Director of Maintenance also verified he was using HydroBalance and Essential Value brand cleaners to clean and sanitize Ice Machine B. The Director of Maintenance stated he would follow the instructions on the cleaning solution bottle. The Director of Maintenance stated when cleaning Ice Machine B, he would use 6 to 7 ounces of cleaning solution per gallon of water. On 2/25/26 at 1456 hours, an observation and concurrent interview was conducted with the Director of Maintenance. An observation of the Essential Values Ice Machine Cleaner and Descaler bottle was conducted. The back label of the cleaning solution showed Instructions for Use: Remove all ice prior to cleaning. Mix 4 ounces of ice machine cleaner with one gallon of water. Do not mix with any other cleaner or chemicals prior to use. Follow the manufacturer's recommended cleaning instructions. For severe scale buildup repeated cleaning cycles may be required with fresh cleaning solution. The Director of Maintenance verified he was not using the correct ratio of the cleaning solution to water when cleaning Ice Machine B.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and facility P&P review, the facility failed to ensure an effective pest management program was in place. * The facility failed to ensure there were no small flies in the residents dining room. This failure posed the risk of pest contamination during residents mealtimes.Findings: Review of the P&P titled Control of Pests dated 6/2024 showed the community must have a pest control program in place. The section for Procedure - 11. Pest control operators should conduct additional treatments if pests are observed in the community. On 2/25/26 at 0930 hours, an observation of the resident dining was conducted, six small flies resembling fruit flies (a tiny common household pest that can carry bacteria that can contaminate food) were observed. The wall in the resident dining room had a dark pinprick-sized specks residue which resembled fruit fly excrement. On 2/26/26 at 0900 hours, an interview was conducted with the Director of Maintenance. The Director of Maintenance stated the facility had an outside pest control company that would service the facility monthly. When asked about the small flies and dark pinprick-sized residue on the walls in the dining room, the Director of Maintenance stated he was not aware of the flies and did not know what the dark pinprick-sized residue were. The Director of Maintenance stated he would call the pest control company. Review of the pest control reports dated 11/19 and 12/16/25, and 1/6 and 2/3/26, did not show the treatment for flies. On 2/26/26 at 0924 hours, an interview was conducted with the DSS. The DSS confirmed he was responsible for the dining room and kitchen areas. The DSS stated if he saw any type of pest he would report it. The DSS stated he was not aware of the small flies or the dark pinpricked-sized residue in the resident dining room. On 2/26/26 at 1020 hours, a follow-up observation of the resident dining room and concurrent interview was conducted with the Director of Maintenance. The facility staff were observed cleaning the walls of the resident dining room. The Director of Maintenance stated he took a picture of the dark pinprick-sized residue on the walls of the dining room and would show it to the pest control company. On 3/2/26 at 1056 hours, a telephone interview was conducted with the Pest Control Vendor 1. Pest Control Vendor 1 stated he treated the dining room for flies on 2/26/26. When asked about the dark pinprick-sized residue on the walls of the dining room, the pest control technician stated the dark pinprick-sized residue could be fruit fly excrement, but he would not confirm if it was fruit fly excrement.

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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 of 32 final sampled residents (Resident 187) and one nonsampled resident (Resident 162) was assessed, had a care plan and a physician's order to self-administer the medications. * The facility failed to ensure safe self- administration of a medication for Resident 162. * Resident 187's bedside table had an eye drop medications (artificial tears and refresh plus lubricant). There were no self-administration assessment, care plan or physician's order to self-administer the medications and physician's order for the eye drop medications. These failures had the potential for the residents to administer the medications inaccurately and negatively impact the residents' physiological well-being.Findings: 1. Review of the facility's P&P titled Resident Self- Administration of Medication dated 12/19/22, showed a resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. A self-administration assessment was conducted by the interdisciplinary team and the assessment are recorded on the medical records. Medications at bedside are with physician's order in the same manner as other medications. On 2/25/26 at 0928 hours, during the initial tour of the facility, Resident 187 was observed in bed. There were eye drop medications (artificial tears and refresh plus lubricant) on the top of the bedside drawer. On 2/26/26 at 1121 hours, an observation and concurrent interview with LVN 10 was conducted at Resident 187's bedside. LVN 10 verified two eye drops medications were on top of Resident 187's bedside drawer. LVN 10 stated the eye drop medication did not belong to Resident 187 and was uncertain to whom they belonged. Medical record review for Resident 187 was initiated on 2/26/26. Resident 187 was admitted to the facility on [DATE]. Review of Resident 187's H&P examination dated 2/14/26, showed Resident 187 had the capacity to make decisions. Review of Resident 187's Order Summary Report dated 2/26/26, failed to show a physician's order for the artificial tears and refresh plus lubricant eye drops medication. In addition, there was no physician's order to self- administer medication was obtained for Resident 187. Further review of Resident 187's medical record failed to show documented evidence a self-administration of medication assessment was conducted. On 2/26/26 at 1316 hours, a telephone interview was conducted with Family Member 1. Family Member 1 stated Resident 187 used her eye drops medication at home and used to administering by herself the eye drop medication. Family Member 1 stated she was not sure if the nurses evaluated and assessed Resident 187 on self-administering the eye drop medications. On 2/26/2026 at 1545 hours, an interview and concurrent medical record review for Resident 187 was conducted with RN 2. RN 2 stated they need to have a physician's order for the medication and the resident should be assessed for self-administration of medication. RN 2 verified there was no (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician's order for artificial tears and refresh eye lubricant for Resident 187. RN 2 verified there was no assessment, physician's order, or care plan for self-administering medications for Resident 187. On 3/4/26 at 1056 hours, an interview and concurrent medical record review for Resident 187 was conducted with the DON. The DON was informed and verified the above findings. 2. Review of the facility's P&P titled Resident Self- Administration of Medication dated 12/19/22, showed a resident may only self-administer medication after the facility's interdisciplinary team has determined which medication may be self-administered safely. All nurses and aids are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage. Unauthorized medications are given to the charge nurse for return to the family or responsible party. Families or responsible parties are reminded of policy and procedures regarding resident self-administration when necessary. On 2/25/26 at 0938 hours, an observation and concurrent interview with Resident 162 was conducted at Resident 162's bedside. There was an eye drop medication at the bedside. Resident 162 stated her eye doctor prescribed the medication for her cataracts (a common age-related clouding of the eye's natural lens, causing blurry vision, glare, and faded colors) and she has been administering the medication by herself at the facility. Resident 162 stated she has been storing the eyedrop medication at the bedside and the facility staff were aware that she had the eyedrop at the bedside. Medical record review for Resident 162 was initiated on 2/25/26. Resident 162 was admitted to the facility on [DATE]. Review of Resident 162's H&P examination dated 5/29/25, showed Resident 162 had the capacity to understand and make decisions. Review of Resident 162's Self-Administration of Medication dated 8/18/25, showed Resident 162 was capable of self-administration of the medication. However, the above assessment did not show if Resident 162 could safely administer the eye drops stored at the bedside. Further review of Resident 162's medical record failed to show a physician's order for the eye drop medication. On 2/25/26 at 0941 hours, an observation and concurrent interview was conducted with LVN 5. LVN 5 verified the observation. LVN 5 stated the eye drop medication should not have been stored unlocked at the bedside. LVN 5 further stated there was potential for unauthorized access to other residents and visitors. LVN 5 verified there was no physician's order for the eye drop medication and verified the above findings. LVN 5 stated the eye drop medication should be stored in a locked container. On 3/4/26 at 0957 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **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 obtain and maintain a copy of the Advanced Directive for one of six final sampled residents (Resident 107) investigated for Advanced Directives. * Resident 107's Advanced Directive was not in the medical record. This failure had the potential for the resident's wishes related to the provision of medical treatment and services to not be followed if the resident was unable to make medical decisions for themselves.Findings: Review of the facility's P&P titled Residents' Rights Regarding Treatment and Advance Directives dated 12/19/22, showed on admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident, if cognitively able to, would like to formulate an advance directive. In the event the resident is unable to formulate an advanced directive due to cognitive impairment or deemed by the medical doctor that the resident is incapable of making decisions on his or her own, the facility will provide information and education to the resident representative. The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advanced directive. Upon admission, should the resident have an advanced directive, copies will be made and placed on the chart as well as communicated to the staff. Medical record review for Resident 107 was initiated on 3/3/26. Resident 107 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 107's Physician Orders for Life Sustaining Treatment (POLST) dated 1/20/26, showed Resident 107 had the capacity and the advance directive not available. Review of Resident 107's Internal Medicine History & Physical / Progress Note dated 1/21/26, showed Resident 107 had the capacity to make decisions. Review of the Advance Directive Acknowledgement form dated 1/21/26, showed Resident 107 have executed an advance directive and signed by the resident. Review of Resident 107's Social Service assessment dated [DATE], failed to show whether Resident 107 had an advance directive. Further review of Resident 107's medical record failed to show a copy of the advance directive was obtained and maintained in the medical record. In addition, the medical records failed to show documented evidence the facility staff followed up with the resident or their family representative. On 3/3/26 at 1445 hours, an interview was conducted with Resident 107. Resident 107 verified and acknowledged he had an advance directive and provided a copy to facility staff when he was admitted to the facility. Resident 107 stated he formulated his advance directive a few months ago. On 3/3/26 at 1451 hours, an interview and concurrent medical record review for Resident 107 was conducted with SSD 1. SSD 1 stated if the resident had an advance directive, they would request a copy and keep it in the medical records. SSD 1 reviewed Resident 107's medical record and verified Resident 107 had an advance directive based on the acknowledgement form. SSD 1 stated he was not able to locate a copy of Resident 107's advance directive and verified the findings. On 3/4/26 at 1033 hours, an interview and concurrent medical record review for Resident 107 was conducted with the DON. The DON was informed and verified 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, medical record review, and facility P&P review, the facility failed to ensure resident privacy for one of four final sampled residents (Resident 68) investigated for tube feeding. * Resident 68 was not provided privacy during a GT feeding administration. This failure had the potential for the resident to experience a negative outcome and feel exposed.Findings: Review of the facility's P&P titled Promoting/Maintaining Resident Dignity dated 9/2/22, showed the staff will maintain resident privacy. Review of the facility's P&P titled Flushing A Feeding Tube dated 12/19/22, showed to provide privacy by pulling the privacy curtain. Medical record review for Resident 68 was initiated on 2/25/26. Resident 68 was readmitted to the facility on [DATE]. Review of Resident 68's Order Summary Report showed the following physician's orders:- dated 2/24/26, for Jevity 1.5 (enteral feeding formula) to be administered via GT at 65 ml/hr for 20 hours; and- dated 2/24/26, to flush the GT with water at 65 ml/hr for 20 hours. On 2/25/26 at 1221 hours, an observation of RN 1 starting Resident 68's GT feeding and water flush was observed in Resident 68's room. The resident's privacy curtain was pulled between the resident and the doorway to the hallway, however there was no privacy curtain pulled between Resident 68 and their roommate. Both residents were sitting in their wheelchairs approximately two feet from each other. RN 1 lifted Resident 68's hospital gown exposing the resident's abdomen and incontinence brief, placed a stethoscope on the resident's abdomen to check tube placement, and then aspirated gastric contents with a 60 ml syringe. RN 1 then connected the tubing for the Jevity 1.5 and water flushes, and put the resident's gown back down. RN 1 verified he did not pull the privacy curtain between Resident 68 and his roommate before exposing the resident's abdomen and incontinent brief. On 2/27/26 at 0817 hours, during an interview with the DON, the DON stated the privacy curtain should have been pulled between Resident 68 and his roommate for GT care to ensure privacy.

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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 three of 32 final sampled residents (Residents 3, 13, and 16) were free from the unnecessary psychotropic medications. * The facility failed to ensure the nonpharmacological interventions were provided to Resident 3 when Resident 3 had behavior episodes related to the use of quetiapine (antipsychotic medication) and lorazepam (antianxiety medication). * The facility failed to ensure the behaviors were monitored related to the use of quetiapine for Resident 13. In addition, orthostatic blood pressure was not monitored related to the use of the quetiapine medication for Resident 13. * The facility failed to ensure Resident 16's orthostatic blood pressure was accurately monitored as ordered by the physician for the use of the quetiapine medication. These failures had the potential for adverse effects from the psychotropic medications and the potential for not providing the correct data to the prescriber to adjust the dosage of the psychotropic medications.Findings: Review of facility's P&P titled Use of Psychotropic Medication Use dated 12/19/22, showed resident do not receive psychotropic medications unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident response to the medications. Resident who use psychotropic drugs shall receive non-pharmacological interventions to facilitate reduction or discontinuation of the psychotropic drugs. Further of the P&P showed the resident's response to the medication (s), including progress towards goal and presence /absence of adverse consequences, shall be documented in the resident medical records. The effects of the psychotropic medication on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as but not limited to: - upon physician evaluation routine and as needed, - during the pharmacist monthly medication regimen review, - during significant change, and - in accordance with nurse assessment and medication monitoring parameters consistent with clinical standards of practice, manufacturer specification, and residents comprehensive plan of care. 1. Medical record review for Resident 3 was initiated on 2/25/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 9/24/25, showed Resident 3 had no capacity to understand and make decisions. Review of Resident 3's Order Summary Report showed the following physician's orders: - dated 5/22/24, lorazepam tablet 0.5 mg to give one tablet by mouth in the afternoon for anxiety as manifested by inability to relax as evidenced by persistent screaming; - dated 5/26/25, for quetiapine fumarate oral tablet 25 mg, to give one tablet by mouth two times a day for schizoaffective disorder as manifested by sudden angry outburst; (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 5/26/25, for quetiapine fumarate oral tablet 50 mg, to give one tablet by mouth at bedtime for schizoaffective disorder as manifested by sudden angry outburst; - dated 9/23/24, to monitor behavior related to use of antipsychotic medication for schizoaffective disorder as manifested by sudden angry outburst. To monitor number of episodes of behavior observed. Nonpharmacological interventions include relaxation, adjust room temperature/lighting, reposition, toileting, music/television, and snacks; and - dated 11/5/24, to monitor behavior related to use of antianxiety medication Ativan for anxiety as manifested by inability to relax as evidenced by persistent screaming. To monitor number of episodes of behavior observed. Nonpharmacological interventions include relaxation, to adjust room temperature/lightening, repositioning, toileting, music/television, and snacks. Review of Resident 3's MAR dated for February 2026 showed the following: * For episodes of sudden angry outbursts related to the use of quetiapine: - dated 2/3/26, during the evening shift (1900–0700 hours), Resident 3 had two episodes of the behavior; - dated 2/10/26, during the evening shift, Resident 3 had one episode of the behavior; and - dated 2/28/26, during the morning shift (0700–1900 hours), Resident 3 had one episode of the behavior. * For episodes of persistent screaming related to the use of lorazepam: - dated 2/3/26, during the evening shift, Resident 3 had two episodes of the behavior; and - dated 2/28/26, during morning shift, Resident 3 had one episode of the behavior. Further review of the MAR did not show if nonpharmacological interventions were provided when Resident 3 had the above episodes of the behavior related to the use of quetiapine and lorazepam medications. On 3/3/26 at 0953 hours, an interview and concurrent medical record review for Resident 3 was conducted with RN 2. RN 2 verified the physician's orders for quetiapine and lorazepam included monitoring behaviors of sudden angry outburst related to the use of quetiapine, and persistent screaming related to the use of lorazepam and providing the nonpharmacological interventions as needed. RN 2 verified Resident 3 had the above behavior episodes related to the use of quetiapine and lorazepam medications. RN 2 also verified there was no documented evidence to show the nonpharmacological interventions were provided during these episodes. 2. Medical record review for Resident 13 was initiated on 2/25/26. Resident 13 was admitted to the facility on [DATE]. Review Resident 13's H&P examination dated 12/18/25, showed Resident 13 had no capacity to understand and make medical decisions. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Review of Resident 13's Order Summary Report showed an order dated 12/17/25, for quetiapine fumarate oral tablet 25 mg, to give one tablet by mouth two times a day for psychosis as manifested by disorganized thinking. Review of Resident 13's MAR for January 2026 showed an order dated 12/17/25, to monitor the resident for psychosis manifested by disorganized thinking. There was no documented evidence the resident was monitored for their behaviors after 1/4/26. Review of Resident 13's medical record failed to show documented evidence Resident 13's behaviors related to the use of quetiapine were being monitored since 1/4/26. b. Review of Resident 13's MAR for January 2026 showed an order dated 12/21/25, to monitor the resident's orthostatic blood pressure due to antipsychotic every day shift every Sunday sitting, standing and lying down positions. There was no documented evidence the resident's BP was being monitored in either sitting, standing or lying down positions. Review of Resident 13's Change in Condition Notes dated 2/2, 2/20, and 3/2/26, showed Resident 13 had fall incidents on 2/2, 2/20, and 3/2/26. Further review of Resident 13's medical record failed to show documented evidence the resident's orthostatic blood pressure was monitored related to the use of antipsychotic medication. On 3/3/26 at 1352 hours, an interview and concurrent medical record review for Resident 13 was conducted with RN 2. RN 2 verified the physician's order for the quetiapine medication for Resident 13 was due to psychosis manifested by disorganized thinking. RN 2 confirmed the behavior of disorganized thinking had not been monitored since 1/4/26. RN 2 also verified the orthostatic blood pressure monitoring, which was required for residents receiving antipsychotic medications, was not being completed. RN 2 stated that antipsychotic medications can cause orthostatic hypotension, which increases the risk of falls for residents receiving these medications. RN 2 further verified Resident 13 had experienced three fall incidents since February 2026. On 3/4/26 at 0957 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. Medical record review for Resident 16 was initiated on 2/25/26. Resident 16 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 16's Order Summary Report dated 2/26/26, showed the following physician's orders: - dated 10/30/24, for the use of the quetiapine antipsychotic medication, to monitor Resident 16's orthostatic blood pressure in the lying position every Sunday during the day shift; - dated 10/30/24, for the use of the quetiapine antipsychotic medication, to monitor Resident 16's orthostatic blood pressure in the sitting position every Sunday during the day shift; - dated 10/30/24, for the use of the quetiapine antipsychotic medication, to monitor Resident 16's orthostatic blood pressure in the standing (if able) position every Sunday during the day shift; and (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 9/10/25, to administer quetiapine 50 mg by mouth two times a day for schizophrenia manifested by extreme paranoia as evidenced by visual/auditory hallucinations. Review of Resident 16's MAR for February 2026 showed the following documentation of Resident 16's blood pressure readings: - dated 2/1/26, the BP readings were 122/73 mmHg for the lying, sitting, and standing positions; - dated 2/8/26, the BP readings were 130/64 mmHg for the lying, sitting, and standing positions; - dated 2/15/26, the BP readings were 127/68 mmHg for the lying and sitting positions; and - dated 2/22/26, the BP readings were 121/65 mmHg for the lying and sitting positions. On 3/3/26 at 1534 hours, an interview and concurrent medical record review for Resident 16 was conducted with the DON. The DON stated for the resident on an antipsychotic medication, residents were monitored for behavior every shift as well as monitoring for side effects. The DON further stated the residents on the antipsychotic medications were monitored for orthostatic hypotension weekly. The DON reviewed Resident 16's medical record and verified the above findings. The DON stated the monitoring for orthostatic hypotension was done inaccurately for Resident 16. On 3/4/26 at 1105 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **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 one of two final sampled residents (Resident 68) investigated for hospitalization was readmitted to their prior room upon return to the facility. * Resident 68 was not readmitted to the same room after returning from the acute care hospital after two days. This failure resulted in the resident being upset having to switch his room once readmitted to the facility. Findings: Medical record review for Resident 68 was initiated on 2/25/26. Resident 68 was initially admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 68's Order Summary Report showed a physician's order dated 2/22/26, for a bed-hold for seven days. Review of Resident 68's Nurse Progress Note dated 2/22/26 at 1920 hours, showed the resident was transferred to an acute care hospital. Review of Resident 68's N ADV Clinical admission Assessment Note dated 2/24/26 at 2057 hours, showed the resident arrived back at the facility by ambulance. Review of Resident 68's Census List (undated) showed the resident was admitted to Room A on 2/6/26, and was readmitted to Room B on 2/24/26. Review of the facility's facility midnight census reports dated 2/22 to 2/24/26, showed Room A was empty. On 2/26/26 at 1213 hours, an interview was conducted with Resident 68. Resident 68 stated he was readmitted to the facility into a new room and was expecting and wanting to be in his original Room A. On 2/27/26 at 1051 hours, a follow-up interview was conducted with Resident 68 and Family Member 2. Family Member 2 stated she was surprised when Resident 68 was readmitted to a different room because they had a bed-hold and assumed Resident 68 would return to his original Room A. On 2/27/26 at 1333 hours, an interview and concurrent medical record review for Resident 68 was conducted with the DON. The DON verified Resident 68 had a physician's order for a bed-hold and the resident was not readmitted to his previous room even though it was available. (Cross reference with 628).

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary transfer/discharge services for one of two final sampled residents (Resident 68) investigated for hospitalization. * Resident 68 was not provided a bed-hold notice when he was discharged from the facility to the acute care hospital on 2/22/26. This failure resulted in the resident being upset having to switch his room once readmitted to the facility. Findings: Review of the facility's P&P titled Bed Hold Notice Upon Transfer dated 12/19/22, showed before a resident is transferred to the hospital, the facility will provide to the resident or the responsible party written information about the duration of the bed-hold policy and the reserve bed payment, if any. Medical record review for Resident 68 was initiated on 2/25/26. Resident 68 was initially admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 68's Bed Hold Notification Informed Consent form dated 2/16/26, showed the resident was notified of his right to a bed-hold. The form was only completed on the top section which showed On Admission, and was blank for the Confirmation of Transfer & Bed-hold Provision and 24 Hour Notification sections. The form failed to show the estimated daily rate and whether a bed hold was offered to the resident on 2/22/26. Review of Resident 68's Order Summary Report showed a physician's order dated 2/22/26, for a bed-hold for seven days. Review of Resident 68's Nurse Progress Note dated 2/22/26 at 1920 hours, showed the resident was transferred to an acute care hospital. Review of Resident 68's N ADV Clinical admission Assessment Note dated 2/24/26 at 2057 hours, showed the resident arrived back at the facility via ambulance. Review of Resident 68's Census List (undated) showed the resident was admitted to Room A on 2/6/26 with an active status, stop billing status on 2/22/26, and was readmitted to Room B on 2/24/26 with an active status. Review of Resident 68's medical record failed to show a bed-hold was offered and/or accepted when the resident was transferred to an acute care hospital on 2/22/26. On 2/26/26 at 1537 hours, an interview and concurrent medical record review for Resident 68 was conducted with the DON. The DON stated on admission, the resident or their responsible party will sign information regarding a bed-hold. The DON stated if the resident leaves the facility for a hospitalization, staff will ask the resident if they would like a bed-hold and if accepted, sign the bed-hold consent. The DON stated the facility would then get a physician's order for a bed-hold. The DON stated if the resident's insurance would not cover the bed-hold payment, the business office would follow up on it. The DON stated Resident 68 had a physician's order for a seven day bed-hold dated 2/22/26. The DON further stated since the facility had an order, she would expect consent was obtained for a bed-hold. The DON reviewed Resident 68's census list and stated on 2/22/26, it showed to stop billing, which was done by the business office staff to discharge the resident. The DON stated the business office staff must have discharged the resident because his insurance did not cover the bed-hold rate. On 2/27/26 at 1048 hours, an interview was conducted with the MRD. The MRD stated there was no closed chart for Resident 68's 2/6/26 admission. The MRD stated it was part of the resident's active chart because the resident was out on a bed-hold and not discharged from the facility. The MRD stated she was unable to find a signed bed-hold consent in the resident's medical records for 2/22/26. On 2/27/26 at 1051 hours, a follow-up interview was conducted with Resident 68 and Family Member 2. Family Member 2 stated she was surprised when Resident 68 was readmitted to a different room because they had signed a bed-hold and assumed Resident 68 would return to his original Room A. Family Member 2 and Resident 68 stated no one from the facility told her if insurance would not cover the resident's bed-hold, or what the daily rate would be. On 2/27/26 at 1105 hours, an interview and concurrent medical record review for Resident 68 was conducted with the BOM. The BOM stated the residents can have a bed-hold if they have MediCal. The BOM stated the facility would then get a physician's order for a seven day bed-hold. The BOM stated if the resident did not have MediCal, the (continued on next page)

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Trabuco Hills Post Acute	25652 Old Trabuco Road Lake Forest, CA 92630

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	business office would contact the family about the daily $750 bed-hold rate. The BOM stated Resident 68 did not have MediCal for his bed-hold and was discharged . The BOM stated she believed she spoke to the resident's wife but could not recall. The BOM stated she did not have access to the resident's clinical record to document, and did not have any notes to show she discussed a bed-hold rate with the resident or Family Member 2. The BOM stated maybe she heard Family Member 2 did not want a bed-hold from the admissions department. The BOM reviewed Resident 68's file and stated the resident was self-responsible. On 2/27/26 at 1113 hours, an interview was conducted with the Admissions Director and Admissions Staff. The Admissions Director and Admissions Staff both stated they were not part of the bed-hold process and were not aware of any specific information regarding Resident 68's bed-hold. (Cross reference with 627).

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, and facility P&P review, the facility failed to ensure the PASARR recommendations were followed up and incorporated into the resident care for one of three final sampled residents (Resident 3) reviewed for PASARR. * Resident 3's PASARR - level II determination recommendations were not followed up and incorporated into the resident's care. This failure had the potential for Resident 3 not receiving the adequate care that was recommended by PASARR level II determination and evaluation report assessed by an appropriate state-designated authority.Findings: Review of the facility P&P titled Resident Assessment-Coordination with PASARR Program dated 12/19/22, showed recommendations such as any specialized services, from a PASARR level II determination and PASARR evaluation report will be incorporated into the resident's assessment, care planning, and transitions of care. Review of the facility's P&P titled Comprehensive Care Plans dated 12/19/22, showed the comprehensive care plan will describe any specialized services or specialized rehabilitation services the nursing facility will provide as a result of PASARR recommendations. Medical record review for Resident 3 is initiated on 2/25/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 9/24/25, showed Resident 3 had no capacity to understand and make decisions. Review of the Department of Health Care Services' letter sent to Resident 3 dated 10/27/25, showed the PASARR level II evaluation was conducted on 10/27/25. The letter further showed the facility staff would receive the copy of the determination report and discuss the result with Resident 3 and would incorporate the recommendations into Resident 3's care plan. Review of Resident 3's PASARR Individualized Determination Report dated 10/27/25, showed Resident 3 required nursing facility services due to a medical and/or mental health condition. The PASARR Individualized Determination Report further showed special services were recommended. Further review of Resident 3's medical record did not show the recommendations from the PASARR Individualized Determination Report was followed up. Review of Resident 3's care plans failed to show a care plan was developed for addressing the recommendations from the PASARR Individualized Determination Report. On 2/27/26 at 1017 hours, an interview and a concurrent medical record review for Resident 3 was conducted with MDS Coordinator 3. MDS Coordinator 3 verified the above findings and stated he could not find documented evidence showing the recommendations from the PASARR level II determination was followed up. MDS Coordinator 3 reviewed the care plan and stated he could not find the care plan problem addressing the recommendation for specialized services as per the PASARR Individualized Determination Report. MDS Coordinator 3 stated Resident 3 was receiving services recommended from PASARR level II determination even before PASARR level II evaluation was conducted and were already part of Resident 3's care plan. However, MDS Coordinator 3 stated the care plan did not address the PASSAR level II evaluation and its result. The MDS Coordinator acknowledged there was a possibility the recommendation from the PASSAR level II evaluation could have been missed. On 3/4/26 at 0957 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **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 develop a care plan for two of 32 final sampled residents (Residents 7 and 90). * The facility failed to develop a care plan to address Resident 7's preference to lower his head of the bed during GT feeding. Additionally, there was no care plan developed to address Resident 7's use of hearing devices. * The facility failed to develop a care plan to address Resident 90's weight loss of 11.5% in one month. These failures had the potential for the resident's needs not being communicated to the IDT and placed the resident at risk of not being provided appropriate, consistent, and individualized care. Findings: Review of the facility's P&P titled Comprehensive Care Plans revised 12/19/22, showed the care planning process will include an assessment of the resident's strength's and needs, and will incorporate the resident's personal preferences. The care plan will describe any services that would otherwise be furnished, but are not provided due to the resident's exercises of his right to refuse treatment. The P&P further showed the following: - The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change; - The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change; and - Procedure for reviewing and revising the care plan when a resident experiences a status change: The care plan will be updated with the new or modified interventions. 1. Medical record review for Resident 7 was initiated on 2/25/26. Resident 7 was readmitted to the facility on [DATE]. a. Review of Resident 7's Order Summary Report showed the following orders:- dated 1/6/26, to elevate the head of the bed 30-45 degrees while tube feeding is infusing; and - dated 1/26/26, for Jevity 1.5 to be administered at 65 ml/hr for 20 hours a day. Review of Resident 7's care plan for swallowing with the goal of not having an injury related to due aspiration dated 1/23/26, showed interventions including to keep the head of the bed elevated at least 30-45 degrees during tube feeding. On 2/25/26 at 1251 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 stated for the residents with a tube feeding infusing, the head of the bed should be elevated to 30-45 degrees as an aspiration precaution. LVN 1 went to Resident 7's bedside and verified the resident's tube feeding was infusing and the head of the bed was elevated 16 degrees using an electronic level, not the required 30-45 degrees. LVN 1 stated the resident puts the head of the bed down himself, elevated the head of the bed and reminded the resident to keep it elevated. Resident 7 confirmed he put it down himself. On 2/26/26 at 1600 hours, Resident 7 was observed sleeping in bed with the tube feeding infusing, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the head of the bed elevated 17 degrees using an electronic level. On 2/27/26 at 0750 hours, Resident 7 was observed sleeping in bed with the tube feeding infusing, the head of the bed elevated 15 degrees using an electronic level. On 2/27/26 at 0822 hours, an interview and concurrent medical record review for Resident 7 was conducted with the DON. The DON stated Resident 7's head of bed should be elevated 30-45 degrees. The DON stated LVN 1 told her earlier the resident preferred to keep it lower. The DON verified Resident 7's care plan failed to address the resident preference to keep his head of the bed lowered. b. Review of Resident 7's Resident's Clothing and Possessions form dated 10/14/25, showed the resident's left and right hearing aids and charger were brought to the facility. Review of Resident 7's N Adv – Clinical admission – V 29 assessment dated [DATE], showed the resident had right and left hearing aids, which were worn on admission. Review of Resident 7's Activity Assessment – V4 dated 1/9/26, showed the resident used hearing aids in both ears. Review of Resident 7's care plan for impaired hearing initiated 1/23/26, failed to mention Resident 7 used hearing devices. On 2/25/26 at 1250 hours, Resident 7 was observed in bed. When attempting to talk to Resident 7, he replied I can't hear well. When asked if he had hearing aids while pointing to ears, Resident 7 stated they forgot to charge them last night. After writer attempted in a louder voice closer to the resident, the resident still could not understand and started to get frustrated. On 2/27/26 at 1019 hours, during an observation, Resident 7 was in bed. Resident 7 stated he charged his hearing aids himself last night, but only wanted to wear the left one right now. Resident 7 stated he keeps his hearing aids at his bedside and charges. On 2/27/26 at 1137 hours, an interview and concurrent medical record review for Resident 7 was conducted with LVN 1. LVN 1 stated residents with hearing aids should have a physician's order for hearing aids. LVN 1 stated Resident 7 did not have hearing aids. LVN 1 reviewed the above records and verified Resident 7 did in fact have the hearing aids. LVN 1 verified the resident's care plan showed the resident was hard of hearing, but failed to address use of the hearing aids. On 3/4/26 at 0939 hours, the DON stated resident care plans should address the use of the hearing aids. (Cross reference with F693 example 2, and F685) 2. Medical record review for Resident 90 was initiated on 3/2/26. Resident 90 was admitted to the facility on [DATE]. Review of Resident 90's Weights from December 2025 to February 2026 showed the following: - dated 12/28/25, a weight of 154.0 lbs.; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 1/7/26, a weight of 156.0 lbs.; - dated 1/29/26, a weight of 156.0 lbs.; and - dated 2/4/26, a weight of 138.0 lbs. Review of Resident 90's IDT Care Conference Note dated 2/4/26, showed Resident 90 had a weight loss of 11.5% in one month. The RD's recommendations included for the resident to have large entree portions TID. Review of Resident 90's H&P examination 2/19/26, showed Resident 90 had the capacity to make medical decisions. Review of Resident 90's care plans failed to show a care plan was developed for the resident's weight loss of 11.5% in one month. Additionally, there was no indication the RD's recommendation to have large entrée portions TID was implemented by the facility per the IDT meeting on 2/4/26. On 3/2/26 at 1429 hours, an interview and concurrent medical record review for Resident 90 was conducted with the RD. The RD verified there was no care plan developed for the resident's weight loss of 11.5%. The RD verified the above finding.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **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 quality care and services were provided for one of three final sampled residents (Resident 174) reviewed for accidents. * The facility failed to ensure Resident 174 was accurately assessed for the neurological evaluations after a fall incident on 2/9/26. The facility documented the same vitals signs from the previous neurological evaluations. In addition, the facility failed to ensure Resident 174's blood pressure readings for the sitting, lying, and standing positions were obtained, as per the care plan intervention for Resident 174's fall. These failures had the potential for Resident 174 to not receive the necessary care and services to maintain the resident's highest physical well-being.Findings: Review of the facility's P&P titled Fall Prevention Program revised 12/28/23, showed when any resident experiences a fall, the facility will:- assess the resident.- complete a post-fall assessment.- complete an incident report.- notify the physician and family.- review the residents care plan and update as indicated.- document all assessments and actions.- obtain witness statements in the case of injury. Review of the facility's P&P titled Comprehensive Care Plan revised 12/19/22, showed the comprehensive care plan will describe, at a minimum, the following: the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Medical record review for Resident 174 was initiated on 2/25/26. Resident 174 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 174's H&P examination dated 12/1/25, showed Resident 174 had the capacity to make medical decisions. Reviewed of Resident 174's Progress Notes dated 2/9/26 at 1700 hours, showed a note titled einteract SBAR Summary for Providers for Resident 174's change in condition related to a fall. Under Primary Care Provider Feedback-Recommendations, showed the NP was present in the building and ordered the neurological check for 72 hours. Review of Resident 174's care plan for unwitnessed fall dated 2/9/26, showed the following interventions:- to conduct neurological checks for 72 hours; and- to obtain vital signs as ordered. Take the blood pressure for the lying, sitting, and standing, one time in the first 24 hours. Review of Resident 174's Neurological Flowsheet initiated 2/9/26 at 1700 hours, showed the following documentation for the neurological assessments/evaluations:- 2/9/26 at 1900 hours, the most recent BP was 138/80 mmHg, the most recent pulse was 70 beats per minute, the most recent respiration was 18 breaths per minute. The documentation showed the above vital signed were obtained on 2/9/26 at 1911 hours;- 2/9/26 at 2000 hours, the most recent BP was 134/78 mmHg and the most recent pulse was 72 bpm (both were obtained on 2/9/26 at 2043 hours); and the most recent respiration was documented as 18 breaths per minute (however, the documentation showed the respirations were obtained on 2/9/26 at 1911 hours);- 2/9/26 at 2100 hours, the most recent BP was 134/78 mmHg and the most recent pulse was 72 bpm (both were obtained on 2/9/26 at 2043 hours); the most recent respiration was documented as 18 breaths per minute (however, the documentation showed the respirations were obtained on 2/9/26 at 1911 hours); the most recent pain level was documented as 0 (out of 10, however, the documentation showed the pain level was obtained on 2/9/26 at 1912 hours);- 2/9/26 at 2300 hours, the most recent pulse was 72 beats per minute (however, the documentation showed the pulse was obtained on 2/9/26 at 2043 hours); the most recent respiration was 18 breaths per minute (however, the documentation showed the respiration were obtained on 2/9/26 at 1911 hours); and- 2/11/26 at 0100 hours, the most recent BP was 108/60 mmHg (obtained on 2/10/26 at 2304 hours), the most recent pulse was 87 beats per minute (obtained on 2/10/26 at 2022 hours), the most recent respirations was 18 breaths per minute and most recent pain level was 0 (both obtained on 2/1026 at 2221 hours). Further review of Resident 174's medical record failed to show the documented evidence Resident 174's BP was obtained in the sitting, lying, and standing positions within the first 24 hours of Resident 174's fall, as per the care plan interventions for Resident 174's fall on 2/9/26. On 3/3/26 at 0825 hours, an interview and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concurrent medical record review for Resident 174 was conducted with RN 2. RN 2 stated for the unwitnessed falls at the facility, the residents would be assessed for injuries and if the resident remained at the facility following the fall incident, the neurological evaluations would be completed per the facility protocol. RN 2 stated the purpose of the 72- hour neurological evaluations was to determine if the resident had any neurological complications related to the fall, which may occur over time. RN 2 stated the neurological evaluations assessed the resident for pupillary size and response, speech and motor responses, and level of consciousness. RN 2 stated new sets of vital signs should be obtained for every neurological evaluation, including the assessment for pain. RN 2 stated following each neurological evaluation, the licensed nurse should compare the assessment findings to the previous and baseline findings, to determine if there were any significant changes. RN 2 reviewed Resident 174's medical records and verified the above findings. RN 2 reviewed Resident 174's care plan addressing the resident's fall on 2/9/26. When asked to show the documentation Resident 174's BP was obtained as per the care plan interventions, RN 2 verified there was no documented evidence Resident 174's BP readings were obtained in the sitting, lying, and standing positions. On 3/4/26 at 0919 hours, an interview was conducted with the DON. The DON stated following an unwitnessed fall at the facility, the licensed nurses should conduct the 72-hour neurological evaluations as per the facility protocol. The DON stated new vital signs should be obtained for every neurological evaluation and the assessment findings of each evaluation should be compared to determine if there were any changes in the resident's condition. On 3/4/26 at 1105 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **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 one final sampled resident (Resident 7) investigated for hearing received proper assistance with devices to maintain hearing abilities. * Resident 7 had no physician's order for hearing aid use, and the facility did not charge or assist him with his devices. This failure resulted for the resident having difficulty communicating with others. Findings: Medical record review for Resident 7 was initiated on 2/25/26. Resident 7 was readmitted to the facility on [DATE]. Review of Resident 7's Resident's Clothing and Possessions form dated 10/14/25, showed the resident's left and right hearing aids and charger were brought to the facility. Review of Resident 7's N Adv - Clinical admission - V 29 assessment dated [DATE], showed the resident had right and left hearing aids, which were worn on admission. Review of Resident 7's Activity Assessment - V4 dated 1/9/26, showed the resident used hearing aids in both ears. On 2/25/26 at 1250 hours, Resident 7 was observed in bed. When attempting to talk to Resident 7, he replied I can't hear well. When asked if he had hearing aids while pointing to ears, Resident 7 stated they forgot to charge them last night. After writer attempted in a louder voice closer to the resident, the resident still could not understand and started to get frustrated. On 2/27/26 at 1019 hours, during an observation, Resident 7 was in bed. Resident 7 stated he charged his hearing aids himself last night, but only wanted to wear the left one right now. Resident 7 stated he kept his hearing aids at his bedside and charges. On 2/27/26 at 1137 hours, an interview and concurrent medical record review for Resident 7 was conducted with LVN 1. LVN 1 stated the residents with hearing aids should have a physician's order for hearing aids. LVN 1 stated Resident 7 did not have hearing aids. LVN 1 reviewed the above records and verified Resident 7 did in fact have hearing aids. LVN 1 verified the resident's care plan showed the resident was hard of hearing, but failed to address use of the hearing aids. On 3/4/26 at 0939 hours, the DON stated the residents should use the hearing aids, and the nurses were responsible to insert the hearing aids every morning, to store when not in use, and to charge or change the hearing aid batteries. (Cross reference with F656 example b).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility document review, the facility failed to ensure the necessary care and services were provided to prevent the development of new pressure ulcers (areas of damaged skin caused by staying in one position for a long time which reduces blood flow to the area and causes the skin to die and develop a sore) for one of four final sampled residents (Resident 9) reviewed for pressure ulcers. * The facility failed to ensure the LAL (Low Air Loss) mattress setting was consistent with Resident 9's weight. Resident 9's current weight was 102 lbs., whereas the LAL mattress setting was set at 150 lbs. This failure posed the risk for Resident 9 to not benefit from the therapy provided by the LAL mattress.Findings: Review of the manual titled DynaRest Airfloat 100 Air Mattress with Pump (undated), showed the DynaRest AirFloat 100 Air Mattress is designed for bed sore and wound care therapy treatment and prevention, which may occur during an extended hospital stay and nursing home/long term care environment. Under the section Pressure Adjust Knob (adjustable by patient's weight) showed to turn the pressure adjust knob to set a comfortable pressure level by using the weight scale as a guide. On 2/26/26 at 1030 hours, Resident 9 was observed lying in bed and the LAL mattress was observed on and set at 150 lbs. Medical record review for Resident 9 was initiated on 2/25/26. Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 9's MDS assessment dated [DATE], showed Resident 9 had severely impaired cognitive skills for daily decision making. Further review of the MDS showed Resident 9 was at risk for developing pressure ulcers/injuries and Resident 9 required substantial to maximal assistance (where the helper does more than half the effort) for rolling from left and right in bed. Review of Resident 9's Weights and Vitals Summary dated 2/26/26, showed on 2/10/26, Resident 9 weighed 102 lbs. On 2/26/26 at 1239 hours, Resident 9 was observed lying in bed and the LAL mattress was observed on and set at 150 lbs. On 2/26/26 at 1255 hours, an observation, interview, and concurrent medical record review for Resident 9 was conducted with LVN 8. LVN 8 stated the LAL mattress was used for the residents who were at risk for developing pressure ulcers or who currently had pressure ulcers. LVN 8 stated the LAL mattress provided alternating therapy to relieve pressure while the residents were lying on the mattress. LVN 8 stated the LAL mattress device should be set based on the resident's current weight and the treatment nurses were responsible for changing the weight settings. LVN 8 reviewed Resident 9's medical record and verified the residents current weight was 102 lbs. LVN 8 verified Resident 9's LAL mattress setting did not match the resident's weight and verified the above findings. On 2/26/26 a 1303 hours, an interview was conducted with LVN 3. LVN 3 stated the LAL mattress was used as a preventative measure and to help heal existing pressure wounds. LVN 3 stated the LAL mattress setting was checked every shift by the treatment nurses during the day shift and by the charge nurses in the evening shift. LVN 3 stated when checking the LAL mattress, the licensed nurses should review the resident's medical records for the most recent weight and adjust the LAL mattress setting appropriately. When asked about the settings on the LAL mattress, LVN 3 stated the LAL mattress setting should be set based on the resident's weight. LVN 3 further stated if the LAL mattress was set too firm, it would not provide adequate offloading and pressure relief, and if the LAL mattress was set too soft, it could make the wound worse by not providing the adequate support. On 2/26/26 at 1541 hours, Resident 9 was observed lying in bed and the LAL mattress was observed on and set at 150 pounds. On 3/4/26 at 919 hours, an interview was conducted with the DON. The DON stated for the resident's with a LAL mattress, the licensed nurses were responsible for ensuring the LAL mattress setting was appropriately set to the resident's weight On 3/4/26 at 1105 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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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, and medical record review, the facility failed to ensure the physician's order was followed for one of three final sampled residents (Resident 107) reviewed for urinary catheter/UTI. * Resident 107 had an indwelling urinary catheter. The facility failed to conduct the voiding trial as per the physician's order for Resident 107. This failure had the potential for the resident to develop indwelling urinary catheter related infection and/or complications.Findings: On 2/25/26 at 0848 hours, an observation and concurrent interview was conducted with Resident 107. Resident 107 had an indwelling urinary catheter draining yellow colored urine. Resident 107 stated he had the indwelling urinary catheter because he was unable to urinate. Medical record review for Resident 107 was initiated on 2/25/26. Resident 107 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 107's Order Summary Report showed the following physician's orders:- dated 1/20/26, for the indwelling urinary catheter to straight drainage, size 16 French, 10 cc bulb for the diagnosis of obstructive uropathy. - dated 1/21/26, for voiding trials in one week. Review of Resident 107's H&P examination dated 1/21/26, showed Resident 107 had the capacity to make decisions. Review of Resident 107's medical record failed to show documented evidence the voiding trials were conducted after 1/21/26. On 3/3/26 at 1522 hours, an interview and concurrent medical record review for Resident 107 was conducted with the DON. The DON stated the results of the voiding trials, if conducted, should be documented in the MAR. The DON stated for the voiding trials, the licensed nurses were responsible for removing the indwelling urinary catheter and monitoring for the urine residual in the ladder using the bladder scanner. The DON reviewed Resident 107's medical records and verified the above findings. The DON stated following the physician's order, the licensed nurse should have followed up with the physician to determine how often to conduct the bladder scan and the parameters for residual volume in the bladder. On 3/4/26 at 0819 hours, a follow-up interview was conducted with the DON. The DON stated the purpose of the voiding trials were to attempt for the removal of the indwelling urinary catheter, if it was no longer needed. The DON stated she spoke with the licensed nurse who entered the original physician's order for the voiding trials. The DON stated the licensed nurse informed her she spoke with the resident and he stated he would think about it. The DON stated there was no follow-up following that discussion with the resident and no documentation of the voiding trials the following week, or if the physician was informed the voiding trials were not conducted. On 3/4/26 at 1105 hours, an interview was conducted with the DON. The DON was informed and acknowledged 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 P&P review, the facility failed to ensure the appropriate care and services for the use of a GT for one of four final sampled residents (Resident 7) and one nonsampled resident (Resident 69) reviewed for tube feedings. * The facility failed to ensure LVN 6 checked for gastric residual prior to flushing the GT. Additionally, LVN 6 failed to administered Resident 69's medications via the GT by gravity. * Resident 7's physician was not notified of the resident's preference to lower their head during GT feed infusion. In addition, the resident's medical record failed to show the facility discussed the risks of lowering their head of bed during tube feeding. These failures posed the risk of Residents 7 and 69 to experience gastric complications and/or discomfort.Findings: Review of the facility's P&P titled Appropriate Use of Feeding Tubes revised 12/19/22, showed a resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Feeding tubes will be utilized in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. Review of the facility's P&P titled Verifying Placement of Feeding Tube revised 12/19/22, showed to flush the feeding tube with 30 ml of water after residual measurements to maintain tube patency. 1. Medical record review for Resident 69 was initiated on 3/2/26. Resident 69 was admitted to the facility on [DATE], and readmitted on [DATE]. On 3/2/26 at 0547 hours, a medication administration observation for Resident 69 was conducted with LVN 6. LVN 6 prepared and crushed Resident 69's medications and placed them into individual plastic cups. LVN 6 stated Resident 69 had six medications to be administered via the GT and was observed adding 10 ml of water to the cups with the crushed medications. During the medication administration, LVN 6 was observed checking for the GT placement. LVN 6 was then observed aspirating 30 ml of water to flush the GT. LVN 6 was not observed checking for gastric residual. LVN 6 was then observed aspirating the contents of each plastic cup with the irrigation syringe and pushing the medications through the GT. LVN 6 repeated this for all six medications and was not observed allowing the medications to flow down the syringe via gravity. On 3/2/26 at 0650 hours, an interview and concurrent medical record review for Resident 69 was conducted with LVN 6. LVN 6 stated prior to the administration of the medication via the GT, the GT placement should be checked as well as checking for gastric residual. LVN 6 verified she did not check for the residual prior to attempting to flush the GT with water. LVN 6 stated the administration of medications via the GT should be by gravity unless there was a physician's order that it was ok to push the medication through the GT. LVN 6 reviewed Resident 69's physician's orders and verified there was no physician's order to push the medications though the GT. On 3/2/25 at 0654 hours, an interview was conducted with the DON. The DON stated prior to the administration of the medication via the GT, the licensed nurse should check for GT placement and gastric residual. The DON further stated the medications should be administered via gravity unless there was a physician's order to push the medication through the GT. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/26 at 1105 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Review of the facility's P&P titled Flushing A Feeding Tube dated 12/19/22, showed to place the resident in Fowler's position (30-45 degrees). Review of the facility's P&P titled Verifying Placement of Feeding Tube dated 12/19/22, showed the resident's head of the bed should be kept elevated at a minimum of 30 degrees at all times during the administration of feedings to prevent aspiration and pneumonia. Medical record review for Resident 7 was initiated on 2/25/26. Resident 7 was readmitted to the facility on [DATE]. Review of Resident 7's Order Summary Report showed the following orders:- dated 1/26/26, for Jevity 1.5 (enteral feeding formula) to be administered at 65 ml/hr for 20 hours a day.- dated 1/6/26, to elevate the head of the bed 30-45 degrees while tube feeding is infusing. On 2/25/26 at 1251 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 stated for the residents with a tube feeding infusing, the head of the bed should be elevated to 30-45 degrees as an aspiration precaution. LVN 1 went to Resident 7's bedside and verified the resident's tube feeding was infusing and the head of the bed was elevated 16 degrees using an electronic level, not the required 30-45 degrees. LVN 1 stated the resident puts the head of the bed down himself, elevated the head of the bed and reminded the resident to keep it elevated. Resident 7 confirmed he put it down himself. On 2/26/26 at 1600 hours, Resident 7 was observed sleeping in bed with the tube feeding infusing, the head of the bed elevated 17 degrees using an electronic level. On 2/27/26 at 0750 hours, Resident 7 was observed sleeping in bed with the tube feeding infusing, the head of the bed elevated 15 degrees using an electronic level. On 2/27/26 at 0822 hours, an interview and concurrent medical record review for Resident 7 was conducted with the DON. The DON stated Resident 7's head of bed should be elevated 30-45 degrees. The DON stated LVN 1 told her earlier the resident preferred to keep it lower. The DON stated facility staff should have notified the physician regarding the resident not wanting to keep the head of the bed elevated 30-45 degrees while the tube feeding was infusing. The DON verified Resident 7's medical record failed to show the facility discussed the risks of lowering the head of the bed with the resident. (Cross reference with F656, example a)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **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 proper IV care was provided for one of one final sampled resident (Resident 66) receiving an IV fluids. * Resident 66's IV Sodium Chloride 0.45 % (is a sterile, medical-grade mixture of salt and water used primarily as an intravenous (IV) fluid. It is used to hydrate the body, replace fluid loss and electrolytes) bag, IV tubing, and IV site was not labeled and dated. This failure had the potential to place Resident 66 at risk of infection and IV therapy complications.Findings: Review of the facility P&P titled Intravenous Therapy dated 12/19/22, showed the facility will adhere to accepted standards of practice regarding infusion practices. All IV tubing is to be labeled with date, time and initials. IV sites are changed every seventy-two hours unless otherwise ordered by the physician . On 2/25/26 at 0825 hours, Resident 66 was observed lying in bed. A bag of 0.45 % Sodium Chloride solution was noted hanging on the IV stand and connected to Resident 66 through IV tubing attached to the peripheral IV site on his right arm. The sodium chloride solution bag, the IV tubing, and the IV site were not labeled with the date, time, or staff initials. Medical record review for Resident 66 was initiated on 2/25/26. Resident 66 was admitted to the facility on [DATE]. Review of Resident 66's H&P examination dated 9/5/25, showed Resident 66 had the capacity to understand and make decisions. Review of Resident 66's Order Summary Report showed an order dated 2/24/26, for 0.45% Sodium Chloride intravenous solution, to administer at 75 ml per hour, intravenously one time for IV hydration for one day, for a total volume of 1 (one) liter. On 2/25/26 at 0832 hours, an observation and concurrent interview was conducted with RN 2. RN 2 verified the above findings and stated the Sodium Chloride solution bag, IV tubing, and IV site should have been labeled with the date, time, or staff initials when he started the IV fluid for Resident 66. On 3/4/26 at 0957 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **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 necessary respiratory care services for one of 32 final sampled residents (Resident 187) and two nonsampled residents (Residents 49 and 54) reviewed for respiratory care. * The facility failed to ensure Resident 187's nasal cannula, nebulizer mask and tubing were stored in a sanitary condition when not in use. *The facility failed to ensure Resident 49's CPAP machine was cleaned and maintained per manufacturers recommendation for cleaning and maintenance. * The facility failed to ensure Resident 54 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: 1. On 2/25/26 at 0928 hours, during the initial tour of the facility, an observation was conducted in Resident 187's bedroom. Resident 187 was working with staff. The oxygen machine was stored at the bedside and was turned off. The nasal cannula was observed on top of the bed. The nebulizer mask and tubing were placed on top of the bedside drawer. Medical record review for Resident 187 was initiated on 2/25/26. Resident 187 was admitted to the facility on [DATE]. Review of Resident 187's Order Summary Report showed the following physician's orders:- dated 2/13/26, to administer oxygen therapy via nasal cannula at two LPM to maintain oxygen saturation to 92%; and- dated 2/15/26, to administer Ipratropium-Albuterol (breathing treatment medication) 0.5-2.5 mg per ml one vial inhalation orally every four hours as needed for shortness of breath. On 2/25/26 at 1121 hours, an observation and concurrent interview was conducted with LVN 10 at Resident 187's bedside. LVN 10 verified the nebulizer tubing and mask were placed on top of the bedside drawer. LVN 10 stated the nebulizer tubing and mask should have been placed inside the clear plastic bag with label. 2. Review of the facility's P&P titled CPAP/BiPAP Cleaning dated 12/19/22, showed the facility should clean the mask frame daily after use with CPAP cleaning wipe or soap and water, dry well, cover with plastic bag or completely enclosed in machine storage when not in use. Follow manufacturer instructions for the frequency of cleaning/replacing filters and servicing the machine. Review of the CPAP User manual (undated) showed to hand wash the tubing and mask adaptor daily in a solution of warm water and a liquid dish soap, rinse thoroughly, air dry and inspect the tubing and mask adaptor for damage and wear. On 2/26/2026 at 1043 hours, an observation and concurrent interview was conducted with Resident 49 at the resident's bedside. There was a CPAP machine on top of the bedside drawer. Resident 49 stated he used it himself. Resident 49 stated he puts on the mask at night, turns on the machine, and he turns it off and removes the mask when he wakes up in the morning. Resident 49 stated he keeps asking the nurses to clean it for him because it needed to be cleaned after use, however no one was cleaning the machine. Resident 49 stated the nurses should clean the tubing and rinse it with water but no one was doing it. Resident 49 stated he uses facial wet wipes to clean the mask before putting it on at night before he goes to bed. Medical record review for Resident 49 was initiated on 2/26/26. Resident 49 was admitted to the facility on [DATE]. Review of Resident 49's MDS assessment dated [DATE], showed Resident 49 was cognitively intact. On 2/26/26 at 1218 hours, an observation and concurrent interview was conducted with CNA 7 at Resident 49's bedside. CNA 7 verified Resident 49's CPAP machine was at the bedside. CNA 7 stated he did not see the resident wearing the mask when he came in the morning. CNA 7 stated he did not see the nurses cleaning the CPAP machine. On 3/2/26 at 0730 hours, an interview and concurrent medical record review for Resident 49 was conducted with LVN 12. LVN 12 stated the resident was independent and could turn the CPAP machine on and off, and put and remove the mask. LVN 12 stated the licensed nurses were responsible for the CPAP machine settings and turning it on and off, even if the resident was independent. LVN 12 verified and acknowledged he did not place the CPAP mask on the resident and did not check if the resident had turned on the machine. LVN 12 stated the licensed nurses were responsible for cleaning the CPAP (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	machine. LVN 12 stated the machine needed to be cleaned one a week, and the tubing and mask were as needed. LVN 12 was uncertain if there was a copy of the CPAP machine user's manual, stated he would ask his supervisor. LVN 12 verified and acknowledged the CPAP machine was not cleaned and maintained per manufacturer's manual. On 3/2/26 at 0745 hours, an interview and concurrent medical record review for Resident 49 was conducted with RN 3. RN 3 stated the licensed nurses were responsible for cleaning the CPAP machine. RN 3 verified Resident 49 used the CPAP machine. RN 3 stated she was uncertain when the CPAP machine was last cleaned. RN 3 verified there was no copy of the CPAP manual. RN 3 stated the licensed nurses were responsible for following the physician's order for the application of the CPAP machine of the resident. RN 3 was informed Resident 49 was observed not wearing the CPAP machine while sleeping at night. RN 3 verified and acknowledged the findings. RN 3 stated the resident should have been wearing the CPAP machine while sleeping per physician's order. 3. Review of facility's P&P titled Hand Held Nebulizer Administration dated 8/2014 showed the resident should assessed and record the respiratory status, pulse rate and other significant respiratory functions when receiving a nebulizer treatments. Assess deep breathing throughout the treatment to allow the medication time to deposit in the airway. On 2/26/26 at 0937 hours, during an observation, Resident 54 was on his wheelchair at the side of the bed and receiving a nebulizer treatment. There was no licensed nurse observed in the room with Resident 54. Medical record review for Resident 54 was initiated on 2/26/26. Resident 54 was readmitted to the facility on [DATE]. Review of Resident 54's Order Summary Report showed a physician's order dated 2/12/26, to administer Budesonide Inhalation Suspension (breathing treatment) 0.5 mg 2 ml inhale orally via nebulizer two times a day for shortness of breath/cough for seven days. On 2/26/26 at 1247 hours, an interview and concurrent medical record review for Resident 54 was conducted with LVN 1. LVN 1 verified the order and verified he administered the breathing treatment to Resident 54. LVN 1 verified he did not stay with Resident 54 when he administered the breathing treatment. LVN 1 stated he came afterwards, checked on Resident 54 and turned off the machine. LVN 1 acknowledged he needed to stay with the resident while providing the medication to make sure he get all the medication and to monitor the resident because the medication might raise heart rate of the resident. On 3/4/26 at 1042 hours, an interview and concurrent medical record review for Residents 49, 54 ,and 187 was conducted with the DON. The DON was informed and verified the above findings.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **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 provide adequate and appropriate pain management for one of one final sampled resident (Resident 68) investigated for pain. * The facility failed to provide Tramadol (a controlled opioid pain medication) as ordered by the physician for Resident 68. This failure resulted in the resident experiencing pain due to PRN controlled pain medication not being administered. Findings: Review of the facility's P&P titled Pain Management dated 12/19/22, showed the facility must ensure pain management is provided to residents. On 2/25/26 at 1119 hours, an interview was conducted with Resident 68. Resident 68 stated he was readmitted the prior on 2/24/26 at around 1830 hours. Resident 68 stated he took Tramadol for pain, but it was still being ordered from the pharmacy. Resident 68 stated the facility was giving him acetaminophen (a medication for mild pain) for now, which helped the pain a little bit. Resident 68 stated if the Tramadol was available to be administered when he returned to the facility, he would have wanted it to be administered. Medical record review for Resident 68 was initiated on 2/25/26. Resident 68 was initially admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 68's Progress Notes showed the following:- dated 2/22/26 at 1713 hours, during GT water flush after Tramadol administration, the resident's GT leaked. The physician was notified and an order to transfer the resident to the acute care hospital was obtained; and- dated 2/22/26 at 1920 hours, showed the resident was transferred to an acute care hospital.Review of Resident 68's N ADV Clinical admission assessment note dated 2/24/26 at 2057 hours, showed the resident arrived at the facility via ambulance. Review of Resident 68's MAR for February 2026 showed the following physician's orders:- dated 2/6/26 for Tramadol 50 mg, via GT every four hours PRN for moderate to severe pain. The order was discontinued on 2/24/26; - dated 2/24/26 for Tramadol 50 mg, via GT every six hours PRN for severe pain. The MAR further showed Resident 68 received Tramadol from 2/7 to 2/22/26. There was no documented evidence Tramadol was administered to the resident on 2/24/26. The resident then received Tramadol on 2/25 and 2/26/26. On 2/26/26 at 1537 hours, an interview and concurrent medical record review for Resident 68 was conducted with the DON. The DON stated when a resident goes to the acute care hospital and was expected to return, their controlled medications were kept locked up in the medication cart until they were given to the DON to destruct with the pharmacist. The DON stated she did not receive Resident 68's Tramadol from the nursing staff, so the medication should still be locked up in the medication cart. On 2/26/26 at 1600 hours, a follow-up interview was conducted with the DON. The DON stated Resident 68 was initially in a room upstairs before he was transferred to the acute care hospital. When Resident 68 was readmitted , he was placed in a room downstairs, and his Tramadol was still locked up in a medication cart upstairs, until staff brought it down yesterday. The DON verified the resident's Tramadol was in the facility on 2/24/26, and available to administer to the resident as needed.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the dialysis care and services were provided for one of three final sampled residents (Resident 174) reviewed for dialysis care. * The facility failed to ensure Resident 174's Hemodialysis Communication Records contained accurate documentation for the monitoring of Resident 174's hemodialysis access. * The facility failed to ensure Dialysis Center A was informed of Resident 174's change of condition for an unwitnessed fall on 2/9/26. * The facility failed to ensure the physician was informed of the dialysis center recommendation to hold Resident 174's hypertension medications on the days Resident 174 had hemodialysis treatments and failed to hold the blood pressure medications on the days Resident 174 had the hemodialysis treatments. * The facility failed to ensure Resident 174 was assessed and monitored following the placement of a new hemodialysis access in the right arm. These failures had the potential to delay identifying and responding to dialysis access site issues, and delay of care and treatment for Resident 174.Findings: Review of the facility's P&P titled Hemodialysis revised 6/5/23, showed the facility will assure that each resident receives care and services for the provision of hemodialysis and/or peritoneal dialysis consistent with professional standards of practice. This will include:- the ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received a certified dialysis facility;- ongoing assessment and oversight of the resident before, during, and after dialysis treatments, including monitoring of the resident's condition during treatments, monitoring for complications, implementation of appropriate interventions, and using appropriate infection control practices; and- ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. Further review of the P&P showed the licensed nurse will communicate to the dialysis facility via telephone communication or written format, such as a dialysis communication form or other form, that will include, but not limited itself to:a. Timely medication administration (initiated, held or discontinued) by the nursing home and/or dialysis facility;b. Physician/treatment orders, laboratory values, and vital signs;e. Dialysis treatment provided and resident's response, including declines in functional status, falls, and the identification of symptoms that may interfere with treatments;f. Dialysis adverse reactions/complications and/or recommendations for follow-up observations and monitoring, and/or concerns related to the vascular access site;g. Changes and/or declines in condition unrelated to dialysis; andh. The occurrence or risk of falls and any concerns related to transportation to and from the dialysis facility. Medical record review for Resident 174 was initiated on 2/25/26. Resident 174 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 174 had diagnoses including End Stage Renal Disease and dependence on renal dialysis. Review of Resident 174's Order Summary Report showed a physician's order dated 10/27/25, for hemodialysis treatments on Tuesdays, Thursdays, and Saturdays at Dialysis Center A. Chair time at 0935 hours. Review of Resident 174's H&P examination dated 12/1/25, showed Resident 174 had the capacity to make medical decisions. a. Review of Resident 174's Order Summary Report showed a physician's order dated 8/12/25, to monitor Resident 174's hemodialysis access site in the right upper chest, Perma catheter (a flexible tube that's inserted into a blood vessel in the neck or upper chest and used for dialysis or other medical procedures), every shift for signs and symptoms of infections. Dressing changes at the dialysis center and as needed. Review of Resident 174's Dialysis Communication Forms showed the following incomplete or inaccurate documentation for the following dates:- dated 1/27/26, the post-dialysis weight was not documented and the post- dialysis assessment showed Resident 174's catheter location in the right upper chest. Yes was marked for the assessment of bruit and thrill;- dated 1/29, 1/31, 2/3 and 2/5/26, the post- dialysis assessment showed Resident 174's catheter location in the right upper chest. Yes was marked for the assessment of bruit and thrill; and- dated 2/7, 2/10, and 2/12/26, the dialysis center assessment documented no signs or symptoms of (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infection, however the catheter location was not documented. Additionally, the post- dialysis assessment showed Resident 174's catheter location in the right upper chest. Yes was marked for the assessment of bruit and thrill. On 2/26/26 at 1554 hours, an interview and concurrent medical record review for Resident 174 was conducted with LVN 8. LVN 8 verified the above findings and stated bruit and thrill were assessed for the residents with a dialysis shunt in the arm. LVN 8 further stated the dialysis communication forms should be complete and accurate. On 3/2/26 at 0530 hours, an interview was conducted with the DON. The DON stated Resident 174 had two hemodialysis sites, one in the right upper chest and a new access that was recently placed on 2/23/26 in the right arm. b. Reviewed of Resident 174's SBAR Summary for Providers dated 2/9/26 at 1700 hours, showed a change in condition related to a fall. Under Primary Care Provider Feedback-Recommendations showed the NP was present in the building and ordered the neurological check for 72 hours. Review of Resident 174's plan of care showed a care plan dated 2/9/26, addressing Resident 174's unwitnessed fall with no injuries on 2/9/26. Review of Resident 174's Dialysis Communication Form dated 2/10/26, failed to show documentation the facility informed Dialysis Center A of Resident 174's unwitnessed fall on 2/9/26. Review of Resident 174's medical record failed to show documented evidence Dialysis Center A was informed of Resident 174's unwitnessed fall on 2/9/26. On 3/3/26 at 0825 hours, an interview and concurrent medical record review for Resident 174 was conducted with RN 2. RN 2 stated if a resident had a fall at the facility, the fall incident was considered a change in condition. RN 2 further stated when the resident was sent for hemodialysis treatment, the hemodialysis center should be informed of the resident's fall and the notification documented in the resident's medical record. RN 2 reviewed Resident 174's medical record and verified the above findings. c. Review of Resident 174' Order Summary Report showed the following physician's orders:- dated 8/22/25, to give all medications at 0730 hours on hemodialysis days Tuesday, Thursday and Saturday. Okay by the physician; and- dated 10/17/25, may hold blood pressure medications on dialysis days, dialysis center's request or physician approval. Review of Resident 174's Dialysis Communication Forms dated 1/27/26 and 1/31/26, showed the dialysis center's recommendation to please hold Resident 174's hypertension medications in the mornings every hemodialysis treatment day. Review of Resident 174's MAR for February 2026 showed the following:- for the furosemide (diuretic medication) 40 mg one tablet by mouth one time a day every Tuesday, Thursday, and Saturday for hypertension. Resident 174 was administered the medication at 0800 hours on 2/3, 2/5, 2/7, 2/20, 2/12, 2/14, 2/17, and 2/24/26.- for the metoprolol (blood pressure medication) 25 mg one tablet by mouth every 12 hours every Tuesday, Thursday, and Saturday for hypertension. Resident 174 was administered the medication at 0700 hours on 2/3, 2/10, 2/17, and 2/24/26. Review of Resident 174's Dialysis Communication Form dated 2/24/26, showed the hemodialysis center's documentation Dialysis Center A was unable to remove more fluids due to hypotension during the hemodialysis treatment. Review of Resident 174's Progress Notes failed to show documented evidence the physician was informed (1/27 and 1/31/26) of the dialysis center's recommendations to hold Resident 174's hypertension medications on the mornings she was scheduled for hemodialysis treatments. On 3/3/26 at 0905 hours, an interview and concurrent medical record review for Resident 174 was conducted with RN 2. RN 2 stated the Dialysis Communication Form was used as a communication tool between the facility and the dialysis center. Upon the resident's return to the facility after the hemodialysis treatment, the licensed nurse should review the dialysis center information on the Dialysis Communication Form for any new orders, recommendations, or additional information. RN 2 stated for any additional information documented, or any recommendations by the dialysis center, the licensed nurse should inform the physician and document the notification in the progress notes. RN 2 reviewed Resident 174's medical record and verified the above findings. d. Review of Resident 174's Order Summary Report showed a physician's order dated 2/18/26, nothing by mouth after midnight for surgery on 2/23/26. Review of Resident 174's Progress Notes showed the following entries:- dated 2/23/26 at 1230 hours, the Nurse's Progress Note showed the (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation Resident 174 returned from her surgery appointment in stable condition. Vital signs were within normal limits, and no complaints of pain and discomfort. No new orders from the hospital;- dated 2/23/26 at 1455 hours, the note titled N Adv- Skin Check, showed the documentation no new skin issues were identified. The current skin issues documented were the left thigh surgical wound (present on admission) and the right upper chest, dialysis catheter;- dated 2/26/26 at 0850 hours, the Nurse's Progress Note showed the documentation Resident 174's right arm AV shunt was intact with no signs or symptoms of bleeding and her right chest permcath was also noted with no signs or symptoms of bleeding; and- dated 2/26/26 at 1612 hours, the Nurses Progress Notes showed the documentation Resident 174 was back from dialysis. Her right upper chest and right hand were observed with no signs or symptoms of bleeding noted. The entry showed the licensed nurse spoke with the dialysis personnel about Resident 174's right arm fistula, placed on Monday. Further review of Resident 174's medical record failed to show Resident 174 was assessed for the new hemodialysis access or a change in condition monitoring was initiated to monitor Resident 174 following her surgical procedure on Monday 2/23/26. Review of Resident 174's Written Discharge Instructions dated 2/23/26, for the operative site, showed to refer to the surgeon's after-care instructions for specific details. Further review of the Written Discharge Instructions failed to show any after-care instructions were included for Resident 174's operative site. On 3/3/26 at 0215 hours, an interview and concurrent medical record review for Resident 174 was conducted with RN 2. RN 2 stated Resident 174 had a new hemodialysis access placed in the right arm by the vascular surgeon on 2/23/26. RN 2 stated when the resident leaves the facility for a surgical procedure, upon the resident's return to the facility, the resident should be assessed and the licensed nurse should review and carry out the post-operative instructions/orders. RN 2 reviewed Resident 174's medical record and verified the above findings. When asked about the surgeon's after-care instructions for Resident 174's new right arm AV shunt, RN 2 stated he was unable to locate the instructions. RN 2 stated the licensed nurse should have follow-up for clarifications and documented in the progress notes. RN 2 further stated a change in condition evaluation should have been initiated following Resident 174's return from the facility, to monitor the resident for any complications related to her procedure. On 3/4/26 at 0919 hours, an interview was conducted with the DON. The DON stated the facility utilized the Dialysis Communication Form as a form a communication between the facility and the dialysis center. The DON stated the resident should be assessed before, during, and after the hemodialysis treatments and any changes to the resident should be communicated on the form. The DON stated the assessments should be documented on the form and the documentation should be accurate and complete. The DON further stated, upon the resident's return to the facility, the licensed nurse was expected to inform the physician of the recommendations from the dialysis center and document in the progress notes. On 3/4/26 at 1105 hours, a follow-up interview was conducted with The DON. The DON was informed and acknowledged the above findings.

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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 review, facility document review, and facility P&P review, the facility failed to provide the necessary pharmaceutical services. * The facility failed to ensure eight lidocaine 4% patches were disposed of and destructed properly in one of two medication rooms (Medication room [ROOM NUMBER]). * The facility failed to ensure the narcotic sheets had the nurses' initials and signatures for one of five medication carts (Medication Cart A). * Resident 68's alprazolam (an anxiety medication) was not administered as ordered by the physician. * LVN 7 failed to check the CNA's documentation for Resident 200 who had loose bowel movement prior to administering a stool softener to the resident. These failures had the potential for the medications to be administered in error and opportunities for drug diversion or drug misuse.Findings: Review of the facility's P&P titled Destruction of Unused Drug revised 3/3/23, showed drugs will be destroyed in a manner that renders the drug unfit for human consumption and disposed of in compliance with all current and applicable state and federal requirements. Review of the facility's P&P titled Controlled Substance Administration & Accountability revised 6/5/23, showed two licensed nurses account for all controlled substances and access keys at the end of the shift. 1. On 2/25/26 at 1533 hours, an observation and concurrent interview with RN 1 was conducted in Medication room [ROOM NUMBER]. There were eight packs of lidocaine 4% patch inside, unopened and still intact inside a white bin with blue top label for incineration in Medication room [ROOM NUMBER]. RN 1 verified the lidocaine patches were unopened and still intact. RN 1 further stated the lidocaine patches should be destructed and cut up before disposed in the white bin for incineration. On 2/25/26 at 1550 hours, the DON was summoned to Medication room [ROOM NUMBER]. The DON verified and acknowledged there were eight packs of lidocaine 4% were unopened and intact in the white bin with blue top labeled for incineration. The DON stated the lidocaine patches should be removed from the original packet, and fold in half then placed in the white bin for disposal. The DON verified and acknowledged the above findings. 2. Review of Medication Cart A's Controlled Substances Shift Count Log for February 2026 showed multiple entries were missing nurses' initials when the oncoming and off going nurses counted the narcotic medication on the following dates and times: - 2/8/26 at 0700-1900 hours, for the off going nurse; - 2/23/26 at 1900 -0700 hours, for the oncoming nurse; and -2/24/26 at 0700-1900 hours, for the off going nurse. On 2/26/26 at 0748 hours, an interview and concurrent facility document review was conducted with LVN 1. LVN 1 reviewed Medication Cart A's Controlled Substances Shift Count Log and verified there were no signatures and initials from the nurses for the above dates and times. On 2/26/26 at 1150 hours, an interview was conducted with the DON. The DON was informed and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	verified all the above findings. The DON further stated the licensed nurses are required to count the controlled drugs and initial on the Controlled Substances Shift Count Log at shift change. 3. Medical record review for Resident 68 was initiated on 2/25/26. Resident 68 was initially admitted to the facility on [DATE], re-admitted on [DATE]. Review of Resident 68's MAR for February 2026, showed the following:- a physician's order dated 2/5/26, for alprazolam 0.25 mg via GT at bedtime for anxiety. The order was discontinued on 2/24/26; - a physician's order dated 2/24/26, for alprazolam 0.25 mg via GT at bedtime for anxiety; and- on 2/24/26 at 2100 hours, the alprazolam showed a 6 for the scheduled administration. The MAR's Chart Coded legend, showed 6 was for other/see progress notes. Review of Resident 68's Progress Notes dated 2/22/26 at 1920 hours, showed the resident was transferred to an acute care hospital. Review of Resident 68's N ADV Clinical admission Assessment Note dated 2/24/26 at 2057 hours, showed the resident arrived back at the facility by ambulance. Review of Resident 68's Orders - Administration Note dated 2/24/26 at 2306 hours, showed alprazolam would be given when available. On 2/25/26 at 1119 hours, an interview was conducted with Resident 68. Resident 68 stated he was readmitted the prior evening around 1830 hours. Resident 68 stated he takes alprazolam but did not receive it last night because it was still being ordered from the pharmacy. On 2/26/26 at 1537 hours, an interview and concurrent medical record review for Resident 68 was conducted with the DON. The DON stated when a resident goes to the hospital and is expected to return, their controlled medications are kept locked up in the medication cart until they are given to the DON to destruct with the pharmacist. The DON stated she did not receive Resident 68's alprazolam from the nursing staff, so the medication should still be locked up in the medication cart. On 2/26/26 at 1600 hours, a follow-up interview was conducted with the DON. The DON stated Resident 68 was initially in a room upstairs before he was transferred to an acute care hospital. When Resident 68 was readmitted , he was placed in a room downstairs, and his alprazolam was still locked up in a medication cart upstairs, until staff brought it down yesterday. The DON verified the resident's alprazolam medication was in the facility on 2/24/26, and was available to administered as ordered. 4. Medical record review for Resident 200 was initiated on 3/3/26. Resident 200 was admitted to the facility on [DATE]. On 3/3/26 at 0830 hours, an interview was conducted with Resident 200. Resident 200 verbalized he had a total of four loose stools on 3/2/26. Resident 200 verified he was wearing diapers. On 3/3/26 at 0847 hours, an interview was conducted with CNA 6. CNA 6 stated she received report from the previous shift Resident 200 had two loose stools. CNA 6 stated she was to monitor Resident 200's bowel movements. On 3/3/26 at 0851 hours, an observation, interview and concurrent medical record review for Resident (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	200 was conducted with LVN 7. LVN 7 stated he did not receive any report about Resident 200 having loose bowel movements. LVN 7 was observed asking Resident 200 about his bowel movements and Resident 200 stated he (Resident 200) had diarrhea on 3/2/26. LVN 7 stated Resident 200 wore diapers because he was incontinent. LVN 7 verified there were no progress notes mentioning any episodes of diarrhea for Resident 200 on 3/2/26 or 3/3/26. LVN 7 looked for any change in condition notes and no changes in condition related to Resident 200's bowel movements was documented in Resident 200's medical record. Review of Resident 200's Documentation Summary Report dated 3/3/26, showed Resident 200's bowel movements were documented as loose/diarrhea consistency, a total of three times during the day shift. Review of Resident 200's MAR for March 2026 showed Resident 200 was administered 100 mg of docusate sodium (stool softener) on 3/3/26, during Resident 200's morning medication administration. Further review of this MAR showed the docusate sodium was to be held if the resident had loose stools. On 3/3/26 at 1515 hours, an interview and concurrent medical record review for Resident 200 was conducted with LVN 7 and the DON. LVN 7 verified the above findings and stated this information was not reported to him. On 3/3/26 at 1540 hours, a follow-up interview was conducted with LVN 7. LVN 7 verified the above findings. LVN 7 acknowledged he did not check Resident 200's Documentation Summary Report prior to administering Resident 200 with the docusate sodium medication.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 6.67%. Two of five licensed nurses (LVNs 5 and 6) were found to have made errors during the medication administration observation. * LVN 5 failed to administer the complete dose of Resident 46's medication when significant residual of the medication was observed in the medication cup after LVN 5 administered the vitamin B12 (supplement) via GT to Resident 46. * LVN 6 failed to administered the correct medication as ordered by the physician for Resident 69. LVN 6 administered the senna-plus (stimulant laxative with stool softener) medication instead of the sennosides (laxative) as per the physician's order. These failures had the potential to negatively affect the residents' health conditions and posed the risk for possible complications or delay in interventions. Findings: Review of the facility's P&P titled Medication Administration reviewed 9/2/22, showed medications are administered by the licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. To review the MAR to identify the medications be administered. To compare the medication source (bubble pack, vial, etc.) with the MAR to verify the resident name, medication name, form, dose, route, and time. 1. On 2/26/26 at 0943 hours, a medication administration observation for Resident 46 was conducted with LVN 5. LVN 5 prepared one tablet of vitamin B12 100 mcg and was observed administering the medication to Resident 46 via the GT. After administering the medication, the medication cup was observed with significant amount of whitish-pink colored medication residue at the bottom and surrounding walls of the medication cup. LVN 5 verified the above findings and stated he forgot to bring a spoon to mix the medication after adding the water to the medication cup. On 2/26/26 at 1008 hours, an interview was conducted with LVN 5. LVN 5 was asked about the protocol for the administration of medications via the GT. LVN 5 stated after the medications were individually crushed, water should be added to the medication cup and the solution mixed to ensure the crushed medication dissolved, to ensure the medication would be fully administered to the resident via the GT. LVN 5 stated during the medication administration, he forgot to bring in a spoon to mix the medication. 2. On 3/2/26 at 0547 hours, a medication administration observation for Resident 69 was conducted with LVN 6. LVN 6 prepared and administered Resident 69's medication which included the following:- one tablet of amlodipine (blood pressure medication) 2.5 mg;- one and a half (1.5) tablet of carbidopa-levodopa (for Parkinson's disease) 25-100 mg;- two tablets of vitamin D3 (supplement) 25 mcg;- two tablets of sennosides-docusate sodium (laxative with stool softener) 8.6-50 mg;- one tablet of simethicone (anti-gas medication) 80 mg; and- 17 g- polyethylene glycol 3350 (laxative). LVN 6 was observed administering the above medications to Resident 69 via the GT. Medical record review for Resident 69 was initiated on 3/2/26. Resident 69 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 69's Order Summary Report showed a physician's order dated 7/27/23, to administer sennosides 8.6 mg, two tablets via GT one time a day for bowel management. On 3/2/26 at 0650 hours, an interview and concurrent medical record review for Resident 69 was conducted with LVN 6. LVN 6 verified the physician's order showed to administer sennosides 8.6 mg. LVN 6 verified she administered the sennosides-docusate sodium 8.6-50 mg during the medication administration observation. LVN 6 stated the medication should be administered to the resident as per the physician's orders. On 3/2/26 at 0654 hours, an interview was conducted with the DON. The DON stated the medications should be administered to the residents as per the physician's orders and should be completely administered to the residents. The DON further stated during the administration of the medications to the residents via GT, if residual medication was observed in the medication cup, the licensed nurse should add water and mix the solution to ensure the full dose was administered to (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident. On 3/4/26 at 1105 hours, an interview was conducted with The DON. The DON was informed and acknowledged the above findings.

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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 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, facility document review, and facility P&P review, the facility failed to provide the necessary pharmacy services for three of 32 final sampled residents (Residents 13, 22, and 35) and two of five medication carts (Medication Carts A and E) to ensure proper storage and labeling of the medications. * The facility failed to ensure the orally administered medications were stored separate from the externally used medications for one of five Medication Carts (Medication Cart A) inspected. * The facility failed to ensure the orally administered medications were stored separate from the externally used medications for one of five Medication Carts (Medication Cart E) inspected. The suppository Bisacodyl (stimulant laxative) was stored with the oral loperamide (antidiarrheal) and Cepacol oral lozenges. * The facility failed to ensure Resident 13's discontinued lorazepam (antianxiety, controlled medication) was removed from one of five Medication Carts (Medication Cart E) inspected. * The facility failed to ensure Resident 22's opened ipratropium-albuterol (breathing treatment medication) was labeled with the opened date. * Resident 35's Refresh eye drops (lubricating eye drops) bottle was unlabeled, unattended, unsecured on the resident's overbed table. These failures had the potential to have negative impact on the residents' well-being, and the potential for the medications to be contaminated, losing the stability and effectiveness. Findings: 1. Review of the facility's P&P title Medication Storage revised 12/19/22, showed internal products: medications to be administered by mouth are stored separately from other formulations (i.e., eye drops, ear drops, injectables). On 2/26/26 at 0748 hours, a medication cart inspection for Medication Cart A was conducted with LVN 1. The following was observed: - one box of Lubricating Plus eye drops was stored with one bottle of aspirin 81 mg, one bottle of Calcium Carbonate and one box of Cepacol extra strength cough lozenges in a cube of the first drawer of the Medication Cart A. LVN 1 verified the above findings. LVN 1 further stated internal and external medications should not be stored in the same cube because the medications were administered via different routes and could cause medication errors and contamination. On 2/26/26 at 1150 hours, an interview was conducted with the DON. The DON was informed and acknowledged of the above findings. The DON further stated external and internal medications should be stored separately to prevent medication errors. 2. Review of the facility's P&P titled Labeling of Medications and Biologicals revised 12/19/22, showed all the medications and biologicals will be labeled in accordance with applicable federal and state requirements and current accepted pharmaceutical principles and practices. Review of the facility's P&P titled Medication Storage revised 12/19/22, showed internal products: medications to be administered by mouth are stored separately from other formulations (i.e., eye drops, ear drops, injectables). Review of the facility's P&P titled Controlled Substance Administration and Accountability revised (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/5/23, showed the facility will have safeguards in place in order to prevent loss, diversion or accidental exposure. Review of the facility's P&P titled Destruction of Unused Drugs revised 8/3/23, showed unused, unwanted, and non-returnable medications should be removed from their storage area and secured until destroyed. The facility utilized a waste disposal service or reverse distributor to destroy dangerous drugs and controlled substance. Upon verification of the dangerous drugs and controlled substance to be destroyed, the consultant pharmacist must seal the container or drugs . The sealed container must be maintained in a secure area in the pharmacy or in a locked cabinet in the medication room until transferred to the waste disposal service or the reverse distributor by the consultant pharmacist, an agent of the state board of pharmacy, the facility administrator, or the director of nursing services. On 2/26/26 at 1158 hours, an inspection of Medication Cart E, interview and concurrent medical record review for Resident 13 was conducted with LVN 5. The following were observed: - one box of bisacodyl 10 mg suppositories stored in the same compartment as the loperamide 2 mg oral tablets and Cepacol extra strength oral lozenges; - one opened box of ipratropium-albuterol 0.5-3 mg/3 ml inhalation solution for Resident 22. The box was not labeled with the opened date; and - a bubble pack containing lorazepam 0.5 mg for Resident 13. The label showed to administer one tablet by mouth every six hours as needed for anxiety for 14 days. The fill date showed 1/8/26. Review of Resident 13's medical record failed to show an active order for the lorazepam medication. LVN 5 verified the above findings. LVN 5 stated when the controlled medications were changed or discontinued, the bubble pack (in the medication cart) should be removed from the medication cart and given to the DON by the end of that shift. LVN 5 further stated the opened medications in the medication cart should be labeled with the opened date when first opened, and the other oral medications should not be stored together with external medications. On 3/4/26 at 0919 hours, an interview was conducted with the DON. The DON stated when the controlled medications were no longer in use or discontinued, the controlled medication should be given to the DON by the end of the shift. The DON further stated the medications for breathing treatments should be labeled with the opened date upon opening of the medication and the external and internal medications should not be stored together. On 3/4/26 at 1105 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. On 2/25/26 at 0910 hours, during an initial tour of the residents' rooms, a bottle of Refresh Tears was observed on Resident 35's overbed table, to the left side of Resident 35's bed. The bottle of Refresh Tears was observed unattended, unsecured, and unlabeled On 2/25/26, at 0913 hours, an observation and concurrent interview was conducted with LVN 7. LVN 7 verified the above finding. LVN 7 stated he thought the eye drops belonged to Resident 35. LVN 7 verbalized Resident 35 did not disclose this medication to LVN 7. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 35 was initiated on 2/25/26. Resident 35 was admitted to the facility on [DATE]. Review of Resident 35's H&P examination dated 2/11/26, showed Resident 35 could make her needs known. Further review of the H&P examination showed Resident 35's diagnoses included prediabetes, dementia, and lack of coordination. Review of Resident 35's MAR for February 2026 failed to show the Refresh eye drops was included as part of Resident 35's list of medications. On 3/4/26 at 1310 hours, an interview was conducted with the DON. The DON was informed of the above findings.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, facility document review, and P&P review, the facility failed to ensure one of 16 kitchen staff members (Dietary Aide 2) had the appropriate skill set necessary to safely perform automatic dishwashing. * Dietary Aide 2 was not competent in demonstrating the automatic dishwashing process. This failure had the potential for resident dishes not to be washed correctly which could lead to sanitation concerns.Findings: Review of the facility's P&P titled Dishwasher Temperature revised 12/19/2022, showed the following:1. All items cleaned in the dishwasher will be washed in water that is sufficient to sanitize any and all items.2. Manufacturer's instructions shall be followed for machine washing and sanitizing.3. Chemical solutions shall be maintained at the correct concentration, based on periodic testing, at least once per shift, and the effective contact time according to manufacturer's guidelines. Results of concentration checks shall be recorded.4. Water temperatures shall be measured and recorded at every shift and\or after the dishwasher has been emptied or re-filled for cleaning purposes. Review of the facility's P&P titled Handwashing Guidelines for Dietary Employees revised 12/19/22, showed Frequency of Handwashing: Dietary employees shall clean their hands and exposed portions of their arms immediately before engaging in .clean equipment and utensils.and also in the following situations: b. after hands have touched anything unsanitary i.e. soiled utensils, dirty dishes. Review of the facility's dish machine manufacturer operational requirements located on a plaque on the outside of the dish machine showed for chemical sanitizing: sanitizer required: minimum 50 PPM. Review of the facility's document titled Dish Machine Log dated 2/25/26, showed the breakfast section did not include an entry for the wash temperature, the rinse temperature and PPM of the sanitizing solution. Review of the facility's document titled Verification of Job Competency Demonstration - Dietary Aides and Dishwasher signed and dated 1/7/26, by Dietary Aide 2, the DSS and RD, showed Dietary Aide 2 was competent in sanitation method used in dish machine and proper PPM concentration and how to avoid cross contamination when working alone on the dish machine, PPE and proper glove usage. The section titled Employee Performance Appraisal showed Dietary Aide 2 needed improvement in knowledge and quality of work. The section titled Developmental Needs/Concerns showed Dietary Aide 2 tends to forget procedures, employee shows no interest in trying or following instructions. Review of the facility's document titled In-service Dishwashing Procedure dated 9/26/25 showed Dietary Aide 2 was in attendance. The dishwashing in-service showed if one person does both dirty and clean sides of the dishwashing, they must wash their hands between dirty and clean areas and change aprons between clean and dirty dish machine areas. 2. Recording of dish machine temperature and PPM: Dish machine Temperature Log - post in dish washing area. Wash, and rinse temperatures must be observed and logged during the dishwashing period three times a day. PPM noted on cold temperature dish machines three times a day. During an observation of the automatic dish machine on 2/26/26 at 0915 hours, Dietary Aide 2 was observed to load dirty dishes into the dish machine then without changing his gloves or washing his hands, pick up clean dishes from the clean side of the dish machine. An interview was conducted with Dietary Aide 2 with the DSS present. Dietary Aide 2 was asked to test the dish machine sanitizing solution. Dietary Aide 2 dipped the sanitizing test strip into the rinse water of the dish machine. The strip read less than 50 PPM. Dietary Aide 2 was asked what he should do if the sanitizing solution was not the correct PPM. Dietary Aide 2 stated he would tell his supervisor. The DSS confirmed he was not aware the dish machine sanitizing solution was not the correct PPM. The DSS stated the tubing that connected the sanitizing solution to the dish machine was twisted causing the sanitizing solution to not reach the dish machine. The DSS stated the dishes would all be rewashed. The dish machine log for the breakfast meal dated 2/25/26 was reviewed with the DSS. The DSS confirmed the dish machine log had not been filled out prior to washing the breakfast dishes. The DSS stated the dish machine water temperatures and sanitizing solution PPM (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	must be tested and recorded prior to washing dishes three times a day. The DSS also confirmed all employees must change gloves and wash their hands prior to touching clean dishes. On 3/2/26 at 1113 hours, an interview was conducted with the DSS. The DSS stated he did an annual competency evaluation of his employees. The DSS stated he evaluated the kitchen staff competency by demonstrating the task and if the employee wanted to do a return demonstration they could.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility documents review, the facility failed to ensure one of one final sampled residents (Resident 200) reviewed for food accommodations and one nonsampled resident (Resident 164) received food that accommodated the residents' preferences. * Resident 200 did not consistently receive his fruit cup with meals. * Resident 164 was not served the alternative entree for the broccoli. These failures posed the risk of the residents not enjoying their meals and their food preferences not being honored. Findings: 1. Review of the facility's P&P titled Standardized Menus revised 12/19/22, showed the facility shall provide nourishing, palatable meals to meet the nutritional needs of the residents based on the recommended daily Allowances of the Food and Nutrition Board of the National Research Council. Menus will be planned to meet basic nutritional needs by providing meals based on individual nutritional assessment and the individualized plan of care. Alternative menus will be available if the primary menu or immediate selections for a particular meal are not to the resident's liking. On 2/25/26 at 0957 hours, during an observation, Resident 200 was awake in bed. Resident 200 verbalized he was not provided fruit and his family brought fruit for him to the facility. Resident 200 stated he recently started getting fruit served to him at the facility. On 2/26/26 at 1335 hours, an observation and concurrent interview was conducted with Resident 200. Resident 200 was observed asking staff for a fruit cup. Resident 200 was visibly upset and stated he had to keep asking staff for a fruit cup daily. The DSS was summoned into Resident 200's room for further follow up. The DSS and RD verified Resident 200 was not served a fruit cup for lunch. The RD stated she would follow up on Resident 200's fruit cup. Medical record review for Resident 200 was initiated on 2/26/26. Resident 200 was admitted to the facility on [DATE]. Review of Resident 200's H&P examination dated 2/18/26, showed Resident 200's diagnoses included diabetes, high blood pressure, high cholesterol, and seizure disorder. On 3/3/26 at 0830 hours, an interview was conducted with Resident 200. Resident 200 stated he did not get a fruit cup today for breakfast. Resident 200 stated he asked staff for a fruit cup. On 3/3/26 at 0847 hours, during an observation, Resident 200 was observed asking CNA 6 for a fruit cup. On 3/3/26 at 0851 hours, during an observation, Resident 200 was observed asking LVN 7 for a fruit cup. LVN 7 stated he would follow up on getting Resident 200 his fruit cup. On 3/3/26 at 0900 hours, an observation and concurrent interview was conducted with the DSS. The DSS was informed Resident 200 was not served his fruit cup for breakfast. The DSS stated all residents should have received a fruit cup for breakfast. The DSS verified Resident 200 was not served his fruit cup for breakfast. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the facility's document titled Week at a Glance (undated), showed the lunch menu for Wednesday 2/25/26, was BBQ pork rib patty, roasted sweet potatoes, sauteed broccoli spears, bread or roll with butter or margarine, vanilla chocolate chip cake, and choice of beverage. On 2/25/26 at 1209 hours, during the meal observation in the dining room, Resident 164 was observed sitting at the table and being assisted with her meal. Resident 164's lunch tray was observed with a scoop of pureed BBQ pork rib patty, a scoop of pureed roasted sweet potatoes, a scoop of bread/roll and butter/margarine, and a scoop of pureed vanilla chocolate chip cake. Resident 164's meal tray was not observed with the pureed sautéed broccoli spears. Review of Resident 164's lunch meal ticket showed Resident 164 disliked broccoli. However, Resident 164 was not served an alternative item. Medical record review for Resident 164 was initiated on 2/25/26. Resident 164 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 164's H&P examination dated 3/11/25, showed Resident 164 had no capacity to make medical decisions. Review of Resident 164's Order Summary Report showed a physician's order dated 4/16/25, for Resident 164 to have a regular, pureed texture diet with thin consistency. To provide a sippy cup for meals. Review of the facility's document titled Daily Spreadsheet for 2/25/26, under pureed, showed the following items: pureed BBQ pork rib patty, pureed roasted sweet potatoes, pureed sauteed broccoli spears, pureed bread or roll and butter or margarine, and pureed vanilla chocolate chip cake. On 2/25/26 at 1242 hours, an observation and concurrent interview of Resident 164 was conducted with the Staffing Coordinator. The Staffing Coordinator stated if the resident disliked broccoli, then she should be provided with the alternative entrée. The staffing coordinator verified Resident 164 was missing an item on her lunch tray but was unable to identify which item was missing. On 2/25/26 at 1249 hours, an observation and concurrent interview of Resident 164's tray was conducted with the DSS. The DSS stated if the resident disliked an entrée, the resident should be served the alternative entrée to ensure the resident received their daily caloric intake for the meal. The DSS stated the alternative entrée for the broccoli was the pureed cauliflower, carrots, or corn. The DSS verified Resident 164 was missing the alternative entrée for the broccoli entree. On 3/4/26 at 1105 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on interview and facility P&P review, the facility failed to ensure perishable food brought to the facility from outside sources for resident consumption was allowed to be stored and heated. * The facility failed to ensure the residents were able to store food brought from outside sources in the facility. This failure posed the potential for poor food intake which could lead to weight loss in the 161 residents who consumed an oral diet. Findings: Review of the facility's P&P titled Outside Food Brought in by Family or Visitors revised 1/25/24, showed all food items that are already prepared by the family or visitor must be approved per Nursing to ensure it is in accordance with the diet order and eaten within two hours of receiving and all remaining food must be discarded. Review of the facility's document titled Diet County by Modification/Portion dated 2/26/26, showed 161 residents who resided in the facility consumed an oral diet. On 2/26/26 at 1000 hours, an interview was conducted with the ADON. When asked how perishable food brought to the facility from outside sources for the resident consumption was stored, the ADON stated the facility did not allow perishable food from outside sources to be stored. The ADON stated the residents must consume perishable food within two hours. The ADON further stated that food brought to the facility from outside sources could not be heated up.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **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 medical records for three of 32 final sampled residents (Residents 7, 68, and 198). * Resident 7's admission Social Service Assessment failed to show the resident had hearing devices. * Resident 68's pain monitoring for each shift failed to show the resident's highest level of pain for the shift.* Resident 198's skilled evaluation notes showed the resident was on room air, when the MAR showed the resident was on oxygen. In addition, the resident's MAR had multiple blank entries. These failures resulted in inaccurate and incomplete medical records, and the potential for inaccurate information being communicated to the residents' IDT. Findings: Review pf the facility's P&P titled Documentation in Medical Record dated 121/9/22, showed each resident's medical record will contain a representation of the experiences of the resident and will include enough information to provide a picture of the resident's progress. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. 1. Medical record review for Resident 198 was initiated on 2/25/26. Resident 198 was admitted to the facility on [DATE]. Review of Resident 198's N Adv Skilled Evaluation notes showed:-a note dated 2/11/25 at 1025 hours, showed the resident was on room air;-a note dated 2/13/25 at 1517 hours, showed the resident was on room air;-a note dated 2/13/25 at 1538 hours, showed the resident was on room air;-a note dated 2/13/25 at 2359 hours, showed the resident was on room air; and-a note dated 2/14/25 at 1350 hours, showed the resident was on room air. Review of Resident 198's MAR for February 2026 showed the resident was administered continuous oxygen from 2/8/26 through 2/14/26. In addition, the MAR for February 2026 was blank for the following dates and times:- on 2/17/26 for the 0700 to 1900 hour shift, for oxygen to be administered at 4 LPM;- on 2/17/26 for the 0700 to 1900 hour shift, for a fluid restriction of 1200 ml per day;- on 2/17/26 for the 0700 to 1900 hour shift, to monitor for signs or symptoms of hypogylcemia (low blood sugar) and hyperglycema (high blood sugar) every shift; and- on 2/17/26 for the 0700 to 1900 hour shift. On 3/3/26 at 1118 hours, an interview and concurrent medical record review for Resident 198 was conducted with LVN 1. LVN 1 reviewed the above N Adv Skilled Evaluation notes and MAR for February and verified the resident was on continuous oxygen at the time, and the N Adv Skilled Evaluation notes were incorrect. LVN 1 further stated the MAR should not have gaps, and nursing should document to show if something was done, or why it was not done. On 3/3/26 at 1124 hours, an interview and concurrent medical record review for Resident 198 was conducted with LVN 2. LVN 2 reviewed Resident 168's MAR for February 2026 and stated he was the nurse on 2/17/26 for the 0700 to 1900 hours shift. LVN 2 stated the resident was on continuous oxygen that day and he monitored the resident for hypo/hyperglycemia. LVN 2 stated he ensured the resident's fluid restriction was followed. LVN 2 stated he forgot to document them in the MAR. 2. Medical record review for Resident 68 was initiated on 2/25/26. Resident 68 was readmitted to the facility on [DATE]. Review of Resident 68's MAR for February 2026 showed the following the resident received Tramadol (a controlled opioid pain medication) 50 mg on the following dates:- on 2/7/26 at 1100 hours, for a pain level of 9 (out of a scale of 0-10, with zero being no pain, and 10 being the worst pain);- on 2/7 at 2124 hours, 2/9 at 2129 hours, 2/11 at 2306 hours, 2/12 at 2107 hours, 2/14 at 0126 hours, 2/14 at 2148 hours, 2/18 at 2125 hours, 2/19 at 2201 hours, 2/20 at 1641 hours, 2/20 at 2311 hours, 2/25 at 2157 hours, and 2/26/26 at 0501 hours, for a pain level of 7; and- on 2/8 at 2221 hours, 2/9 at 0538 hours, 2/10 at 2213 hours, 2/15 at 1708 hours, 2/21 at 1716 hours, and 2/22/26 at 1619 hours, for a pain level of 6.The MAR also showed to monitor the resident's pain level every shift, the following was shifts were documented with no pain, even though the resident received PRN Tramadol for pain:- on 2/7, 2/15, 2/20, 2/21, 2/22/26 for the 0700-1900 hour shift, (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had no pain; and- on 2/7, 2/8, 2/9, 2/10, 2/11, 2/12, 2/13, 2/14, 2/18, 2/19, 2/20, and 2/25/26 for the 1900-0700 hour shift, resident had no pain. On 2/27/26 at 0807 hours, an interview and concurrent medical record review for Resident 68 was conducted with the DON. The DON stated the monitoring for pain every shift; the nurse should document then highest level of pain for the shift. The DON verified Resident 68's pain level for the shift did not document the highest level of pain on the above dates. 3. Medical record review for Resident 7 was initiated on 2/25/26. Resident 7 was readmitted to the facility on [DATE]. Review of Resident 7's N Adv - Clinical admission - V 29 assessment dated [DATE], showed the resident had right and left hearing aids which were worn on admission. Review of Resident 7's Activity Assessment - V4 dated 1/9/26, showed the resident used the hearing aids in both ears. Review of Resident 7's Social Service Assessment - V5 dated 1/11/26, showed not applicable for hearing aid use. On 2/25/26 at 1250 hours, Resident 7 was observed in bed. When attempting to talk to Resident 7, he replied I can't hear well. When asked if he had hearing aids while pointing to ears, he replied they forgot to charge them last night. After writer attempted in a louder voice closer to the resident, Resident 7 still could not understand and started to get frustrated. On 2/27/26 at 1019 hours, Resident 7 was in bed, the resident stated he charged his hearing aids himself last night, but only wanted to wear the left one right now. The resident stated he keeps his hearing aids at his bedside and charges. On 2/27/26 at 1141 hours, an interview and concurrent medical record review for Resident 7 was conducted with SSD 2. SSD 2 reviewed Resident 7's Social Service Assessment - V5 dated 1/11/26, and stated not applicable for hearing aids use meant the resident did not use hearing aids. SSD 2 reviewed the resident's medical record and verified her assessment was incorrect and should show the resident used hearing aids.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and facility document review, the facility failed to implement the QAPI plan and the past Recertification Survey POC for F554, F578, F583, F693, F755, F761, F803, F812, F880, and F881. * The facility failed to ensure audits and/or observations for F578 and F803 were completed. Additionally, the facility failed to show the audits and observation findings for F554, F578, F583, F693, F755, F761, F803, F812, F880, and F881 were presented to the QA Committee for review, and continued monitoring. This failure had the potential for ongoing non-compliance and complete data being reviewed by the QAPI committee. Findings: Review of the facility's 2024 Recertification Survey POC accepted by the department on 12/11/24, included the following:- for F578, the POC showed the Medical Records staff will audit completion of the POLST and availability of the Advanced Directive in resident medical records withing 72 hours of admission. Findings will be reported to the SSD for further action;- for F803, the DSS, RD or trained dietary staff will conduct kitchen rounds five days a week for three months to ensure recipes are followed, and they will also conduct weekly tray line audits for three months, to ensure resident preferences are followed; and- for F554, F578, F583, F693, F755, F761, F803, F812, F880, and F881, the facility will present audit findings to the QA Committee for three months or until substantial compliance is achieved. On 3/4/26 at 1310 hours, a review of the facility's QA and QAPI program binders was conducted with the Administrator. Review of the facility's records failed to show the above audits and/or observations for F578 and F803 were completed. Review of the QA and QAPI binders failed to show the audits and observation findings for F554, F578, F583, F693, F755, F761, F803, F812, F880, and F881 were presented to the QA Committee for review, and continued monitoring. The Administrator verified these findings.

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Trabuco Hills Post Acute	25652 Old Trabuco Road Lake Forest, CA 92630

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to monitor and address the use of the antibiotics for one final sampled resident (Resident 22) and two nonsampled residents (Resident 18 and 95) reviewed for antibiotic stewardship. * The facility failed to ensure the infection screening evaluation was conducted when Resident 18 was prescribed an antibiotic for urinary tract infection. * The facility failed to ensure the infection screening evaluation was conducted when Resident 22 received an antibiotic for upper respiratory infection. * The facility failed to monitor and address the use of the antibiotics on admission when the resident's condition did not meet the McGeer's criteria (a set of specific definitions to identify true infections in long term nursing facilities) for Resident 95. These failures had the potential for the antibiotics to be used when it was not indicated and the development of antibiotic-resistant bacteria.Findings: Review of the facility's P&P titled Antibiotic Stewardship dated 12/19/22, showed the antibiotic stewardship program included antibiotic use protocols and a system to monitor antibiotic use. The nursing shall assess the residents who are suspected of having an infection and complete an SBAR from prior to notifying the physician. The facility uses the CDC's NHSN surveillance definitions, updated McGeer criteria, or other surveillance tool to define infection. Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness. 1. Medical record review for Resident 22 was initiated on 2/25/26. Resident 22 was admitted to the facility on [DATE]. Review of Resident 22's Order Summary Report showed a physician's order dated 2/12/26, to administer azithromycin (antibiotic) oral tablets 250 mg one tablet by mouth one time a day for upper respiratory infection for four days. Further review of the physician's orders showed the medication was discontinued on 2/17/26. However, further review of Resident 22's medical record did not show if the infection screening evaluation was done to identify if the symptoms experienced by Resident 22 met the criteria for a true infection. 2. Medical record review for Resident 18 was initiated on 2/25/26. Resident 18 was admitted to the facility on [DATE]. Review of Resident 18's Physician Order dated 12/18/28, showed to administer Macrobid (antibiotic) oral capsules 100 mg one capsule by mouth two times a day for urinary tract infection for five days. However, further review of Resident 18's medical record did not show if the infection screening evaluation was done to identify if the symptoms experienced by Resident 18 met the criteria for a true infection. 3. Medical record review for Resident 95 was initiated on 2/26/26. Resident 95 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 95's Order Summary Report showed a physician's order dated 2/23/26, to administer levofloxacin (antibiotic) oral tablet 750 mg one tablet by mouth one time a day for 10 days. Review of Resident 95's Infection Screening Evaluation dated 2/23/26, showed the resident had an active diagnosis of infection, the pulse was more than 100 beats per minute, a single temperature reading greater than 100 degrees Fahrenheit, and a pulse oximetry reading below 94% on room air. Further review of the Infection Screening Evaluation did not show documentation indicating whether the symptoms experienced by Resident 95 met McGeer's criteria for a true infection. Further review of Resident 95's medical record did not show evidence that the physician was notified when the resident's symptoms did not meet McGeer's criteria for a true infection and when the resident was prescribed the antibiotic. On 2/26/26 at 1009 hours, an interview and concurrent medical record review for Residents 18, 22, and 95 was conducted with the IP. The IP stated the Infection Screening Evaluation should be completed for all the residents receiving antibiotics to determine whether their symptoms met McGeer's criteria for a true infection. The IP further stated if the criteria for a true infection were not met, the physician should be notified. The IP verified Resident 22 received an antibiotic for an upper respiratory tract infection; however, an Infection Screening Evaluation was not conducted at the time the antibiotic was administered; therefore, she could not determine whether the resident's symptoms met McGeer's criteria for a true (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infection. The IP verified Resident 18 received a fiveˆday course of antibiotics for a UTI; however, an Infection Screening Evaluation was not completed for the resident. The IP stated an Infection Screening Evaluation should also be completed for the residents admitted to the facility with antibiotic prescription, and if the symptoms did not meet the criteria for a true infection, the physician should be notified. The IP stated Resident 95 was transferred to an acute care hospital and was prescribed an antibiotic for a UTI. However, the Infection Screening Evaluation did not indicate whether Resident 95's symptoms met McGeer's criteria for a true infection. The IP verified there was no documented evidence to show the physician was notified when the resident's symptoms did not meet criteria for a true infection. On 3/4/26 at 0957 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to offer and provide education for the influenza and pneumococcal immunizations for two of six final sampled residents (Residents 66 and 195) reviewed for the immunizations. * The facility failed to ensure Resident 66 was offered the influenza and pneumococcal vaccinations. * The facility failed to ensure Resident 195's consent for the pneumococcal vaccination specified the type of pneumococcal vaccine. These failures had the potential for the residents and/or their representatives not being informed of the influenza and pneumococcal vaccines, and the benefits and risks of the vaccines to make an informed decision. In addition, these failures had the potential for the residents to not be aware of the exact type of pneumococcal vaccine being offered by the facility.Findings: Review of the facility's P&P titled Influenza Vaccination dated 12/19/22, showed the facility to minimize the risk of acquiring, transmitting or experiencing complication from influenza by offering resident, staff members, and volunteer workers annual immunization against influenza. Influenza vaccination will be routinely offered annually from October 1st through March 31st unless such immunization is medically contraindicated, the individual has already been immunized during this time period or refuses to receive the vaccine. The medical record will include documentation that the resident and/or the resident's representative was provided education regarding the benefits and potential side effects of immunization, and that the resident received or did not receive the immunization due to medical contraindication or refusal. Review of facility's P&P titled Pneumococcal Vaccine (series) dated 12/19/20, showed each resident will be assessed for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented, including efforts to determine date of immunization or type of vaccine received. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized. Further review of the P&P showed prior to offering the pneumococcal immunization, each resident or the resident representative will receive education regarding benefits and potential side effects of the immunization. The individual receiving the immunization or the resident representative, will be provided with a copy of CDC's current vaccine information statement relative to that vaccine. 1. Medical record review for Resident 66 was initiated on 2/25/26. Resident 66 was admitted to the facility on [DATE]. Review of Resident 66's H&P examination dated 9/5/25, showed Resident 66 had the capacity to understand. Review of Resident 66's CAIR report (undated) did not show if Resident 66 received the seasonal influenza vaccine and/or pneumococcal vaccine. Further review of Resident 66's medical record did not show documented evidence if Resident 66 was offered the seasonal influenza vaccine and/or pneumococcal vaccine. 2. Medical record review for Resident 195 was initiated on 2/26/26. Resident 195 was admitted to the facility on [DATE]. Review of Resident 195's H&P examination dated 2/14/26, showed Resident 195 had the capacity to understand and make decisions. Review of Resident 195's Pneumococcal Vaccine Consent Form dated 2/13/26, showed Resident 195's signature and consented to receive the pneumococcal vaccine. Further review of the consent form showed I have read or had explained to me the vaccine information statement for the pneumococcal vaccine. I have been educated on and understand risk, benefits and potential side effects of the pneumococcal vaccine. Under the section to indicate kind of pneumococcal vaccine to be given did not show any entry. Review of Resident 195 Immunization Report dated 2/26/26, showed the resident received the Pneumovax 21 (type of pneumococcal vaccine) on 2/24/26. On 2/26/26 at 1009 hours, an interview and concurrent medical record review for Residents 66 and 195 was conducted with the IP. The IP stated she was not able to find the documented evidence to show if Resident 66 was offered the seasonal influenza and pneumococcal vaccine. The IP verified the informed consent for Resident 195 did not indicate the type of pneumococcal vaccine the resident received. The IP stated (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the informed consent for Resident 195 should have indicated the type of vaccine the resident received. On 3/4/26 at 0957 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **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 assessed for seasonal COVID-19 vaccination status or offered the COVID-19 vaccine for one of six final sampled residents (Resident 66) reviewed for the COVID-19 vaccination. * The facility failed to determine or offer the COVID-19 vaccine to Resident 66. This failure put the resident at risk for increased risk of infection and transmission of COVID-19. Findings: Review of the facility's P&P titled COVID-19 Vaccination dated12/19/22, showed it was the policy of the facility to minimize the risk of acquiring, transmitting or experiencing complications from COVID-19 by educating and offering our residents and staff the COVID-19 vaccine. Medical record review for Resident 66 was initiated on 2/25/26. Resident 66 was admitted to the facility on [DATE]. Review of Resident 66's H&P examination dated 9/5/25, showed Resident 66 had the capacity to understand. Review of Resident 66's CAIR report (undated) showed Resident 66 received two of the five series of the COVID-19 vaccine on 9/30 and 10/21/21. The CAIR report also showed the earliest date recommended for the COVID-Seasonal vaccine was on 8/22/25. However, further review of Resident 66's medical record did not show documented evidence if Resident 66 was offered or assessed for the seasonal COVID-19 vaccination. On 2/26/26 at 1009 hours, an interview and concurrent medical record review for Resident 66 was conducted with the IP. The IP verified she was not able to find documented evidence to show if Resident 66 was offered or assessed for the seasonal COVID-19 vaccination. On 3/4/26 at 0957 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the residents' call system was working properly and call buttons were place within the residents' reach for three of 32 sampled residents (Residents 196, 199, and 201). * The facility failed to ensure when Resident 196 would use her call light, the call light was audible and would light up outside Resident 196's room and at the nurses' station panel. * The facility failed to ensure Resident 199's call light button was placed within Resident 199's reach. * The facility failed to ensure Resident 201's call light was working and the silver bell provided to call assistance was placed within Resident 201's reach. These failures posed the risk for the delay in response when the residents would summon the staff for assistance.Findings: 1. On 2/25/26 at 0825 hours, a concurrent observation and interview was conducted with Resident 196. Resident 196 stated she had to wait over 15 minutes this past weekend for the staff to respond to her call light. Resident 196 stated she pressed her call button because she wanted pain medication. Resident 196 was then encouraged to press her call button to see if Resident 196's call light was working. Resident 196 pressed the call button; however, the call light located outside Resident 196's room did not light up and was not audible. On 2/25/26, at 0841 hours, an observation was conducted at the nurse's station. Resident 196's call light was observed not audible and did not light up at the nurse station call light system panel.On 2/25/26 at 0850 hours, a concurrent observation and interview was conducted with the Director of Maintenance. The Director of Maintenance verified the findings and verbalized the call light system for Station A did not have audio. The Director of Maintenance further stated the facility was pending for a company to come and work on the audible part of the call light system. The Director of Maintenance stated he was not aware or notified about Resident 196's call light not lighting up outside Resident 196's room or at the nurse's station call light system panel. Medical record review for Resident 196 was initiated on 2/25/26. Resident 196 was admitted to the facility on [DATE]. Review of Resident 196's H&P examination dated 2/19/26, showed Resident 196's diagnoses included post status multiple bone fractures, osteoporosis, chronic back pain, diabetes, and generalized weakness. 2. On 2/25/26 at 1356 hours, an observation and concurrent interview was conducted with Resident 201. Resident 201 was observed sitting on her wheelchair at an angle facing towards the foot of Resident 201's bed. Resident 201 requested for the call light button be provided to her. Resident 201's call light cord was observed on the upper right side rail and not within Resident 201 reach. Resident 201 was also observed to have a silver colored bell on her overbed table; however, the bell was not within Resident 201 reach. Resident 201 was observed trying to reach for the bell but unable to reach it. Resident 201 stated she had been sitting on her wheelchair for a while and wanted to get off her wheelchair. Resident 201 stated she had back pain and was observed not being able to bend at the waist. On 2/25/26, at 1358 hours, a staff member was asked to come in Resident 201's room. LVN 2 came in Resident 201's room. An observation and concurrent interview was conducted with Resident 201 and LVN 2. When asked where Resident 201's call light was, LVN 2 did not respond but was observed picking up Resident 201's call light from Resident 201's upper right side rail. Resident 201's call light was observed not working. LVN 2 was then observed showing Resident 201 the silver bell on Resident 201's overbed table. LVN 2 told Resident 201 she could use the silver bell to call for help. Resident 201 told LVN 2 she was unable to reach for the bell. Resident 201 was observed demonstrating to LVN 2, she was unable to bend at the waist to reach for the silver bell. Resident 201 stated she wanted to be taken off the wheelchair because she had been on her wheelchair for too long and had been waiting for staff to come to help her. LVN 2 verified Resident 201 call light was not working and the silver bell was provided; however, it was not within Resident 201's reach. Medical record review for Resident 201 was initiated on 2/25/26. Resident 201 was admitted to the facility on [DATE]. Review of Resident 201's H&P examination dated 2/19/26, showed Resident 201's diagnoses included recurrent falls, diabetes, (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	chronic low back pain, and generalized weakness. 3. On 2/25/26 at 0855 hours, an observation and concurrent interview was conducted with Resident 199. Resident 199 was observed in bed, awake. Resident 199 was asking for somebody to raise the head of his bed. Resident 199 was encouraged to press his call light button. Resident 199 stated he was unable to reach it and he did not know where his call light button was. Resident 199 verbalized he had carpal tunnel syndrome to both his hands. Resident 199's call light was observed dangling downwards the left side of Resident 199's bed with the red call light button towards the bottom of bed, not easily accessible to Resident 199. On 2/25/26 at 0857 hours, an observation and concurrent interview was conducted with OTA 1. Resident 199 was observed telling OTA 1 he wanted the head of his bed raised. OTA 1 verified Resident 199's call light button was dangling downward the left side of Resident 199's bed. Resident 199 was observed telling OTA 1 Resident 199 had carpal tunnel syndrome. On 2/26/26 at 1122 hours, an interview was conducted with CNA 9. When asked about Resident 199, CNA 9 verbalized Resident 199 would use his call light. Medical record review for Resident 199 was initiated on 2/25/26. Resident 199 was admitted to the facility on [DATE]. Review of Resident 199's H&P examination dated 2/24/26, showed Resident 199's diagnoses included polyneuropathy due to diabetes, degenerative spine disease with progressive weakness, and bilateral hand numbness.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the facility staff was trained on how to document the bowel movements for one of 32 final sampled resident (Resident 200). * The facility failed to ensure CNA 6 knew when to report and how to correctly document the bowel movements in the electronic health record. This failure had the potential for the delay in treatment and/or the resident not to receive the appropriate care. Findings: On 3/3/26 at 830 hours, an interview was conducted with Resident 200. Resident 200 verbalized he had a total of four loose stools on 3/2/26. Resident 200 stated the poop ran through me like sift. Per Resident 200 he was wearing diapers. On 3/3/26 at 0847 hours, an interview was conducted with CNA 6. When asked about Resident 200's bowel movements, CNA 6 stated she received report from the previous shift Resident 200 had two loose stools. Per CNA 6 she was to monitor Resident 200's bowel movements. Medical record review for Resident 200 was initiated on 3/3/26. Resident 200 was admitted to the facility on [DATE]. Review of Resident 200's H&P examination dated 2/18/26, showed Resident 200's diagnoses included diabetes and seizure disorder. Review of Resident 200's Documentation Summary Report for March 2026 , the section for B&B - Bowel Elimination showed the following:- dated 3/3/26 at 0722 hours, Resident 200 was described as 1 (incontinent), with size M (Medium) and consistency 2 (Loose /Diarrhea);- dated 3//3/26 at 0928 hours, Resident 200 was described as 1 (incontinent), with size M (Medium) and consistency 2 (Loose /Diarrhea); and- dated 3/3/26 at 1137 hours, Resident 200 was described as 1 (incontinent), with size S (Small) and consistency 2 (Loose /Diarrhea); Further review of the documentation summary report showed there were options to describe the resident's bowel movement consistency as formed/normal, loose/diarrhea, constipated/hard, or putty-like. On 3/3/26 at 1515 hours, a concurrent interview and medical record review was conducted with LVN 7 with the DON also present. LVN 7 verified the above findings on 3/3/26 and stated the information were not reported to him. On 3/4/26 at 0955 hours, an interview was conducted with CNA 6. When asked about Resident 200's bowel movements documentation on 3/3/26, as having loose consistency, CNA 6 verbalized Resident 200 did not have diarrhea but Resident 200 complained he was having diarrhea. CNA 6 stated she changed Resident 200's diaper four to five times at 0730, 1030, and 1200 hours. Per CNA 6 Resident 200's bowel movements were like baby food texture. CNA 6 further stated Resident 200's bowel movements were not watery or loose but they were not formed; therefore, CNA 6 stated she did not know how to document. CNA 6 stated Resident 200 said he felt okay. CNA 6 stated she did not report Resident 200's bowel movements to the nurse because it was not really like diarrhea. CNA 6 stated there was not a good option in the electronic health record system to describe Resident 200's bowel movements. When asked if CNA 6 had received an in-service about residents' bowel movements, CNA 6 verbalized they had in-service every two weeks; however, describing the bowel movements was not really discussed during the in-services. On 3/4/26 at 1007 hours, an interview was conducted with the DSD. The DSD stated ADL care and charting were topics covered during the CNA in-services. The DSD verbalized he did not show pictures, sizes, or descriptors for the bowel movements during the in-services. Review of the facility's lesson plan dated 12/22/25, titled ADL care and documentation showed the course content emphasized the importance of accurate and detailed bowel movements; however, the in-service failed to show how to document the bowel movements in the electronic health record system used by the facility.

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure an accurate MDS assessment was completed for two of 32 final sampled residents (Residents 198 and 200). * Resident 198's MDS assessment was not coded accurately to show she was administered oxygen while at the facility. * Res 200's MDS assessment was not coded accurately to show the resident's use of a hearing device.These failures posed the risk for the residents to not have an individualized plan of care based on the residents' specific needs. Findings: 1. Medical record review for Resident 198 was initiated on 2/25/26. Resident 198 was admitted to the facility on [DATE]. Review of Resident 198's MAR for February 2026 showed the resident was administered continuous oxygen from 2/8/26 through 2/14/16. Review of Resident 198's MDS assessment dated [DATE], failed to show the resident received oxygen therapy for the past seven days. On 3/3/26 at 0848 hours, an interview and concurrent medical record review for Resident 198 was conducted with MDS Coordinator 1. MDS Coordinator 1 stated when completing the MDS for the oxygen, the MDS staff should check the resident's MAR or nurses' progress notes for oxygen use. MDS Coordinator 1 reviewed Resident 198's MDS dated [DATE], and stated MDS Coordinator 2 completed that section of the MDS. MDS Coordinator 1 verified it showed the resident did not receive oxygen during the seven days look back period (2/8/26 through 2/14/26). MDS Coordinator 1 reviewed Resident 198's medical record and verified the resident was administered oxygen and the MDS was coded incorrectly. 2. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1, dated 10/2025 showed the steps for assessing a resident's hearing included to observe the resident when they interacted with others throughout the day and to consult the resident's family, caregivers, direct care staff, activities personnel, and speech or hearing specialists. On 2/25/26 at 0957 hours, an observation and concurrent interview was conducted with Resident 200. Resident 200 was observed awake in bed. Resident 200 stated he was hard of hearing to both ears. Resident 200 was observed with both his hearing aids in place. Resident 200 stated he had been at the facility about one and one half weeks. On 2/26/26 at 1335 hours, an observation was conducted in the hallway outside Resident 200's room. The RD was observed talking to Resident 200 inside his room. Resident 200 had bilateral hearing aids in place and the RD was observed talking into Resident 200's right ear. Medical record review for Resident 200 was initiated on 2/26/26. Resident 200 was admitted to the facility on [DATE] Review of Resident 200's H&P exam dated 2/19/26, showed Resident 200's diagnoses included diabetes and had the capacity to make decisions. Review of Resident 200's admission MDS dated [DATE], showed under Section B hearing (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555308	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trabuco Hills Post Acute	25652 Old Trabuco Road Lake Forest, CA 92630

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	assessment, Resident 200 had moderate difficulty for his ability to hear. Further review of Resident 200's hearing assessment showed Resident 200 was coded as not having hearing aids. On 3/3/26 at 1000 hours, an interview and concurrent medical record review for Resident 200 was conducted with MDS Coordinator 3. MDS Coordinator 3 verified the above findings. MDS Coordinator 3 showed Resident 200's Clothing and Possessions list dated 2/17/26, showed one pair of Resident 200's hearing aids was brought to the facility on 2/20/26. On 03/3/26 at 1029 hours, an interview and concurrent medical record review for Resident 200 was conducted with MDS Coordinator 1. MDS Coordinator 1 verified she had completed Resident 200's hearing assessment for his admission MDS. MDS Coordinator 1 verified she coded Resident 200's hearing ability as moderately difficult for hearing and no hearing aids. MDS Coordinator 1 stated the hearing aids were brought into the facility after MDS Coordinator 1 had completed Resident 200's hearing assessment. MDS Coordinator 1 stated she did not conduct any further observations as a follow up to Resident 200's moderate difficulty for hearing. MDS Coordinator 1 verified the hearing aids were not coded in the MDS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Potential for minimal harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and facility assessment review, the facility failed to ensure the Facility Assessment was complete. * The facility failed to ensure the Facility Assessment included the contracts specifying resources that would assist the facility in case of emergencies, resources needed to care for the residents competently during operations (including nights and weekends), input received from the residents, resident representatives, and family members, a plan to maximize recruitment and retention of the direct care staff and inform contingency planning for events that do not require activation of the facility's emergency plan. This failure posed the risk of the facility not having all needed planned resources in place to care for its residents.Findings: According to the CMS QSO-24-13-NH dated 6/18/24, with an implementation date of 8/8/24, CMS had issued a revised guidance for long-term care facility assessment requirement. The Facility Assessment should address and included the active involvement of the direct care staff in developing the Facility Assessment. Also included the staffing resources necessary to care for the residents, including the weekends; a plan to maximize recruitment and retention of direct care staff member, and a contingency plan for staffing needs for the events not to activate the facility's emergency plan. Review of the Facility assessment dated [DATE], failed to show input from the residents, resident representatives, and family members was obtained for the assessment. The assessment failed to include the facility's retention plan for events that did not require activation of the facility's emergency plan. The plan failed to specify with whom the facility had obtained contracts to refer to in case of emergencies. Additionally, the Facility Assessment failed to show resources needed to care for residents during nights and weekends in case regular staff was not available. On 2/27/26 at 1300 hours, an interview and concurrent facility document review was conducted with the Administrator. The Administrator reviewed the Facility Assessment and verified the above findings.