STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555328	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountain Valley Post Acute	11680 Warner Avenue Fountain Valley, CA 92708

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 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. **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 ensure the food safety guidelines were followed for the protection of 130 residents who received food prepared in the kitchen. 1. Cleaning cloths were not stored properly in the sanitizing solution. 2. The thawing process for meat was not followed. 3. Hair restraints were not worn properly. 4. The manual dishwashing procedure was not followed. 5. Frozen food was not stored properly. 6. Dry food was stored properly. 7. Two of two ice/water dispensers did not have an air gap. These failures posed the risk for food borne illnesses in 130 residents who received food prepared in the kitchen. Findings: Review of the facility's document titled Diet Order Tally Report dated 1/6/26, showed 130 residents received food prepared in the kitchen. 1. According to the USDA Food Code 2022 Section 3-304.14 Wiping Cloths, Use Limitation (B) (1) showed, Cloths in-use for wiping counter and other equipment surfaces shall be: (1) Held between uses in a chemical sanitizer. On 1/5/26 at 0830 hours, during the initial kitchen tour with the DSS, an observation of the sanitizing solution used to store the cleaning cloths was conducted. One of the cleaning cloths stored inside the sanitizing bucket was not fully submerged in the sanitizing solution. The DSS verified the cleaning cloths should be fully submerged in the sanitizing solution. On 1/6/26 at 1144 hours, an additional observation was conducted of the sanitizing bucket containing cleaning cloths. One of the cleaning cloths were not fully submerged in the sanitizing solution. 2. Review of the facility's P&P titled Thawing of Meats dated 2023 showed defrosting meats must be dated when removed from the freezer. On 1/5/26 at 0815 hours, during the initial kitchen tour with the DSS, an observation of the walk-in refrigerator was conducted. Four, ten-pound portions of partially thawed ground beef were observed in a black plastic bin. The ground beef did not have a date when it was removed from the freezer to start the thawing process. In addition, four, five-pound ham [NAME] were observed in a black plastic bin. The ham did not have a date when it was removed from the freezer to start the thawing process. The DSS verified the meats should be dated when removed from the freezer. 3. Review of the facility's P&P titled Dress Code dated 2023 showed if applicable, beards and mustaches (any facial hair) must be covered with a beard restraint. On 1/5/26 at 0910 hours, an observation of the dish room and concurrent interview was conducted with the DSS. Dietary Aide 1 was observed with facial hair wearing a face mask. Dietary Aide 1's facial hair was not covered by the face mask. The DSS was asked if the kitchen staff were allowed to wear a face mask in placed of a beard restraint. The DSS stated they had beard restraints, but it was the employees' choice to wear either a beard restraint or a face mask. On 1/5/26 at 0925 hours, an observation of the kitchen food preparation area and concurrent interview was conducted with the DSS. Dietary Aide 2 was observed with uncovered facial hair. The DSS confirmed Dietary Aide 2 should wear a beard restraint. On 1/7/26 at 1345 hours, an additional observation of the kitchen was conducted. Dietary Aide 1 was observed with facial hair wearing a face mask. Dietary Aide 1's facial hair was not covered by the face mask. 4. Review of the facility's P&P titled 3-Compartment Procedure for Manual Dishwashing dated 2023 showed the first compartment of the sink is meant for washing, and it should be filled with detergent and hot water. (continued on next page)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The second compartment is for rinsing and should be filled with clean, clear hot water. The third compartment is for sanitizing and should be filled clean hot water, and sanitizer. On 1/5/26 at 0855 hours, during the initial kitchen tour with the DSS, an observation of manual ware washing was conducted. During the observation there were soiled pans in the rinse and wash sink compartments with no water. In addition, the third sink compartment had dishes not fully submerged in the dish sanitizing solution. Dietary Aide 3 was asked what the process was for washing dishes manually, Dietary Aide 3 stated he was using soap with a scrubbing sponge and then rinses the dishes. When Dietary Aide 3 was asked what the sticker on the outside of the sink labeled water line meant, he stated it was where the water should be. Dietary Aide 3 stated he had drained the water in both the wash and rinse compartments when he started washing the dishes. The DSS confirmed the manual ware washing sink wash and rinse compartments should be filled with water to the indicator line on the outside of the sink. The DSS also stated the dishes in the sanitizing solution in the third compartment of the ware washing sink should be fully submerged in the sanitizing solution for one minute. 5. Review of facility's P&P titled Freezer Storage dated 2023 showed the frozen foods should be stored in an airtight moisture resistant wrapping such as a plastic bag or freezer paper to prevent freezer burn. On 1/5/26 at 0820 hours, during the initial kitchen tour with the DSS, an observation of the walk-in freezer was conducted. One box of Simply wheat dough rolls was left open, and the plastic bag was not sealed. In addition, one box of ground beef hamburger patties was left open, and the plastic bag was not sealed. The DSS confirmed the food items in the freezer should be sealed. 6. Review of the facility's P&P titled Storage of Food and Supplies dated 2023 showed the dry food items which have been opened will be tightly closed, labeled and dated. On 1/5/26 at 0905 hours, an observation of the kitchen preparation area and concurrent interview was conducted with the DSS. A small bin of instant mashed potatoes was observed on a food preparation table with no label, or date when it was placed in the bin. The DSS confirmed the bin of instant mashed potatoes should have been labeled and dated. 7. According to the USDA Food Code 2022 Section 5-202.13 Backflow Prevention, Air Gap showed, an air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch). On 1/5/26 at 1115 hours, an observation of the ice/water dispensers located in the resident's nourishment room located on the second and third floors and concurrent interview was conducted with the Maintenance Director. The ice/water dispensers had no air gap between the ice machine drain and the flood line of the floor sink. The Maintenance Director verified the two ice/water dispensers did not have an air gap.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **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 one final sampled resident (Resident 17) reviewed for physical restraint was informed of the use of the restraint. * The facility failed to ensure the informed consent was obtained prior to the use of the bed and chair alarms for Resident 17. This failure had the potential for Resident 17 not to be informed of the potential risks and benefits of the restraints.Findings: Review of the facility's P&P titled Use of Restraints revised 1/2025 showed under the Policy Interpretation and Implementation section, restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative. The order shall include the following: the specific reason for the restraint (as it relates to the resident's medical symptom), how the restraint will be used to benefit the resident's medical symptom, and the type of restraint, and period of time for the use of the restraint. Residents and/or surrogate/sponsor shall be informed about the potential risks and benefits of all options under consideration, including the use of restraints, not using restraints, and the alternatives to restraint use. On 1/5/26 at 1119 hours, during the initial tour of the facility, Resident 17 was observed in the activity room, up on his wheelchair and working with the activity staff. There was a chair alarm machine at the back of Resident 17's wheelchair and attached to the resident. The activity staff stated Resident 17 had episodes of getting up from the wheelchair unassisted. Medical record review for Resident 17 was initiated on 1/16/26. Resident 17 was readmitted to the facility on [DATE]. Review of Resident 17's H&P examination dated 9/24/25, showed Resident 17 could make needs known but had no capacity to make medical decisions. Review of Resident 17's MDS assessment dated [DATE], showed Resident 17 was dependent with mobility. Review of Resident 17's Order Summary Report showed a physician's order dated 12/29/25, for the use of the bed pressure pad alarm and wheelchair alarm to alert the staff of the resident's attempts to rise unassisted. However, further review of Resident 17's medical record failed to show an informed consent with the risks and benefits of the use of the bed and wheelchair alarm was provided to the resident or responsible party. On 1/7/26 at 0815 hours, an observation and concurrent interview was conducted with Resident 17. Resident 17 was awake and sitting in the wheelchair with the red chair alarm attached to the resident. Resident 17 just smiled when asked with questions but did not respond. On 1/7/26 at 1016 hours, an observation of Resident 17 and concurrent interview was conducted with CNA 2. CNA 2 was observed with Resident 17. Resident 17 was observed awake and sitting in the wheelchair with the chair alarm attached to the resident. CNA 2 stated Resident 17 could express simple needs in English language like water or help. CNA 2 stated Resident 17 used the bed and chair alarm because the resident would try to get out of the bed or wheelchair and the resident was unsteady and high risk for fall. On 1/7/26 at 1049 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 stated prior to the use of the physical restraints, after obtaining the order from the physician, an informed consent explaining the risks and benefits of the restraint should be provided to the resident or responsible party. RN 1 stated the facility used the bed pressure pad alarm and chair alarm for those residents who were impulsive, with poor safety awareness, who tried to get out of the bed or chair without calling for assistance and for those who had multiple history of falls. RN 1 further stated they did not consider the bed or chair alarm as physical restraint, but it was only a safety device. RN 1 verified there was no informed consent for the bed and chair alarm prior to its used. On 1/7/26 at 1140 hours, an interview and concurrent medical record review was conducted with the DON. The DON showed the Nursing - Safety Device Observation/assessment dated [DATE], under Section J. Acknowledgement/Consent, the boxes yes for Acknowledgement and Consent were highlighted, however, the SA (State Agency) informed the DON even if the nurse electronically signed the document, there was no name of the resident/family/resident representative, signature and date. The DON acknowledged it was left blank. Cross reference to F604.

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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 28 final sampled residents (Resident 130) was assessed to self-administer medications. * Resident 130 had medications on the resident's bedside table. Resident 130 was not assessed to self-administer the medications. This failure had the potential to negatively impact on the resident physiological well-being and could administer the medication inaccurately.Findings: Review of the facility's P&P titled Self-Administration of Medications revised February 2021 showed the residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. The IDT assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. The policy also showed that any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. On 1/5/26 at 0927 hours, Resident 130 was observed with an Albuterol Sulfate inhaler (bronchodilator medication) on top of the bedside table. There was a bag containing multiple medication boxes and container inside the bag with the resident's name on it. Resident 130 stated it was his medication and took it by himself. Resident 130 stated the medications in the bag were his medications and his daughter brought them from home. Medical record review for Resident 130 was initiated on 1/5/26. Resident 130 was admitted to the facility on [DATE]. Review of Resident 130's H&P examination dated 12/11/25, showed Resident 130 had the capacity to make medical decisions. Further review of Resident 130's medical record failed to show documented evidence a physician's order was obtained for the resident to self-administer the Albuterol Sulfate inhaler and store it at the resident's bedside. In addition, there was no care plan initiated or developed to address the resident's self-administration of the Albuterol Sulfate inhaler medication. On 1/5/25 at 0937 hours, an observation and concurrent interview was conducted with LVN 5. LVN 5 verified Resident 130 had the Albuterol Sulfate inhaler at the bedside. LVN 5 stated Resident 130 could not have the medication at bedside. On 1/7/26 at 0939 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 was informed and verified Resident 130 did not have a physician's order for self-administration of the Albuterol Sulfate inhaler and did not have a care plan problem addressing the resident's self-administration of Albuterol Sulfate inhaler medication. On 1/12/26 at 1351 hours, an interview was conducted with the DON. The DON was informed and verified 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 provide information regarding the rights to formulate the advance directives to three of five final sampled residents (Residents 13, 83, and 130) reviewed for the advance directives. * The facility failed to ensure the advanced directive copy of Resident 13 was available in the resident's medical records. * The facility failed to ensure the formulation of the advance directive for Resident 83 was followed up. * The facility failed to ensure the advance directive copy for Resident 130 was available in the medical records. These failures had the potential for the residents' wishes related to the provision of medical treatment and services to not be followed if the residents were unable to make medical decisions for themselves.Findings: Review of the facility's P&P titled Advance Directives revised September 2022 showed prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/ or his or her legal representative, about the existence of any written directives. The resident or representative is provided a written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. If the resident or the resident's representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff. If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative. The interdisciplinary team conducts ongoing review of the residents decision-making capacity. Changes are documented in the care plan and medical record. 1. Medical record review for Resident 83 was initiated on 1/6/26. Resident 83 was admitted to the facility on [DATE]. Review of Resident 83's IDT Conference Summary dated 12/11/25, showed under the progress note section, Resident 83 stated he has an advanced directive in place, but would like to redo his advance directive, blank copy will be provided to resident to fill out. The SSA was made him aware. Review of Resident 83's Social History Review dated 12/10/25, showed under other notes, no AHCD (Advance Health Care Directive) completed. The SSA offered to complete AHCD, but the resident had declined. Per the resident, I don't like to talk about those things. Further review of Resident 83's medical record failed to show documented evidence a copy of the advance directive was placed. On 1/7/26 at 1013 hours, an interview and concurrent medical record review for Resident 83 was conducted with SSA 1. SSA 1 stated the resident was provided with a blank copy of the advance directive. SSA 1 verified there was no copy of advance directive in the resident's medical record. SSA 1 verified she followed up but did not document the resident's advance directive was completed. 2. Medical record review for Resident 130 was initiated on 1/6/26. Resident 130 was admitted to the facility on [DATE]. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 130's Admission/readmission Summary Note dated 12/10/25, showed Resident 130 provided information he did have an advance directive and he would ask his daughter to bring a copy. Review of Resident 130's H&P examination dated 12/11/25, showed Resident 130 had the capacity to make medical decisions. Review of Resident 130's IDT Conference Summary dated 12/12/25, showed under the progress notes social services section, no AHCD completed. The SSA offered to complete AHCD, but the resident had declined. On 1/7/26 at 0912 hours, an interview was conducted with Resident 130. Resident 130 stated he had an advance directive at home. Resident 130 stated the facility asked him about the advance directive, however he was not asked to bring a copy of it when he was admitted to the facility. On 1/7/26 at 1004 hours, an interview and concurrent medical record review for Resident 130 was conducted with SSA 2. SSA 2 verified Resident 130's advance directive was offered but the resident declined. SSA 2 verified she interviewed the resident about an advance directive. SSA 2 reviewed the admission summary note showing the resident had an advance directive and the facility would ask the resident's daughter to bring a copy, and conflicting information on the social services progress note showing Resident 130 did not have AHCD. SSA 2 could not answer the discrepancy. SSA 2 stated when she interviewed Resident 130, she also discussed the POLST and the resident was a full code. SSA 2 was unable to provide a copy of the POLST. On 1/12/26 at 1351 hours, an interview was conducted with the DON. The DON was informed and verified the above findings. 3. On 1/6/26 at 1004 hours, an observation and concurrent interview was conducted with Resident 13. Resident 13 was awake and lying in bed. Resident 13 stated his brother would assist him with any legal documents he needed. Medical record review for Resident 13 was initiated on 1/6/26. Resident 13 was admitted to the facility on [DATE]. Review of Resident 13's IDT Conference Summary dated 10/23/25, showed under section IV. Notes, Resident 13 had advanced directive and would have the family member bring the copy. Review of Resident 13's H&P examination dated 10/25/25, showed Resident 13 had the capacity to understand and make decisions. Review of Resident 13's medical record failed to show a copy of the advanced directive and documented evidence the facility staff followed up with the resident's family member. On 1/8/26 at 1042 hours, an interview and concurrent medical record review for Resident 13 was conducted with the SSD. The SSD stated the social services department was responsible for the advanced directive- explaining to the resident/responsible party what it was, the benefits of having one, how to formulate one, and following up with the responsible party to bring the advanced directive of the resident if there was already one established. The SSD stated she would give the responsible parties her email address for them to send the copy during her meeting with the resident and (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible parties, would do a follow up telephone call or even via text message to remind them of the need of the advanced directive copy. The SSD further stated she would document each follow-up conversation and once the copy was available, it would be uploaded in the resident's medical records. The SSD verified she was not able to give Resident 13's brother her email address and did not follow up with the brother to give the facility a copy of the resident's advanced directive. On 1/13/26 at 1415 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **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 one final sampled resident (Resident 17) reviewed for physical restraint was free from unnecessary restraints. * The facility failed to assess the need for the use of the wheelchair alarm, determine least restrictive interventions before physical restraints were utilized, and develop and implement interventions to prevent and address any risks related to the use of the restraints for Resident 17. These failures had the potential for increased risk of physical harm and negative potential outcome to the resident. Findings: Review of the facility's P&P titled Use of Restraints revised and reviewed 1/2025 showed:- Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully;- Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls; and- When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented. The Policy Interpretation and Implementation section showed: - Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body;- The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition, and this restricts his/her typical ability to change position or place, that device is considered a restraint; and- Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms. On 1/5/26 at 1119 hours, during the initial tour of the facility, Resident 17 was observed in the activity room, up on his wheelchair and working with the Activity Staff. There was a chair alarm at the back of Resident 17's wheelchair and attached to the resident. The Activity Staff stated Resident 17 had episodes of getting up from the wheelchair unassisted. Medical record review for Resident 17 was initiated on 1/16/26. Resident 17 was readmitted to the facility on [DATE]. Review of Resident 17's care plan for risk for fall dated 9/23/25, showed interventions included the use of the bed pressure pad alarm and wheelchair alarm to alert the staff of the resident's attempts to rise unassisted. Review of Resident 17's H&P examination dated 9/24/25, showed Resident 17 could make needs known but had no capacity to make medical decisions. Review of Resident 17's Nursing - Safety Device Observation/assessment dated [DATE], showed resident's weakness and balance deficit contributed to the resident's need to use safety device. The recommended type of safety device was bed sensor pad. Review of Resident 17's MDS assessment dated [DATE], showed Resident 17 was dependent with mobility. Review of Resident 17's Order Summary Report showed a physician's order dated 12/29/25, for the use of bed pressure pad alarm and wheelchair alarm to alert staff of the resident's attempts to rise unassisted. Further review of Resident 17's medical record failed to show an assessment for the use of the wheelchair alarm was completed prior to use, least restrictive interventions were implemented before physical restraints were utilized, and interventions to prevent and address any risks related to the use of the restraints were developed and implemented. On 1/7/26 at 0815 hours, an observation and concurrent interview was conducted with Resident 17. Resident 17 was awake and sitting in the wheelchair with the red chair alarm attached to the resident. Resident 17 just smiled when asked with questions but did not respond. On 1/7/26 at 1016 hours, an observation and concurrent interview for Resident 17 was conducted with CNA 2. CNA 2 (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was with Resident 17 in the room. Resident 17 was awake and sitting in the wheelchair with the chair alarm attached to the resident. CNA 2 stated Resident 17 could express simple needs in English language like water or help. CNA 2 stated Resident 17 used the bed and chair alarm because the resident would try to get out of the bed or wheelchair and the resident was unsteady and high risk for fall. On 1/7/26 at 1029 hours, an interview was conducted for Resident 17 with LVN 7. LVN 7 verified they used the bed and wheelchair alarm for Resident 17 to prevent the resident from fall, and it alerted the staff when the resident tried to get out of the bed or wheelchair. LVN 7 stated Resident 17 needed maximum assistance with mobility, but he would try to get out of the bed or wheelchair. On 1/7/26 at 1049 hours, an interview and concurrent medical record review for Resident 17 was conducted with RN 1. RN 1 stated prior to the use of physical restraints, the licensed nurse should conduct an assessment for the device to be used which included assessing the medical symptoms why the use of device being considered and cognitive function, the least restrictive interventions should be implemented prior to the use of the restraint and it should be documented, inform the physician and obtain the consent from the resident or resident's representative, explained to them the risks and benefits, and monitor the resident every shift. RN 1 stated the facility used bed pressure pad alarm and chair alarm for those residents who were impulsive, with poor safety awareness, who tried to get out of bed or chair without calling for assistance and for those who had multiple history of falls. RN 1 further stated they did not consider the bed or chair alarm as physical restraint, but it was only a safety device. RN 1 verified an assessment for the use of wheelchair alarm was not completed prior to use, least restrictive interventions were not implemented before the bed and wheelchair alarms were utilized, and interventions to prevent and address any risks related to the use of the restraints were developed and implemented for Resident 17. On 1/7/26 at 1140 hours, an interview and concurrent medical record review for Resident 17 was conducted with the DON. The DON was informed and acknowledged the findings for Resident 17. Cross reference to F552.

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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 observation, interview, and medical record review, the facility failed to ensure one of one final sampled resident (Resident 83) reviewed for psychotropic medication use was free from the unnecessary psychotropic drugs. * The facility failed to ensure Resident 83's monthly behavior summary was accurately monitored and recorded for the use of mirtazapine (antidepressant) medication. This failure had the potential to place the residents at risk of receiving unnecessary medications and increased risk of serious medication adverse reactions.Findings: Medical record review for Resident 83 was initiated on 1/6/26. Resident 83 was admitted to the facility on [DATE]. Review of Resident 83's Order Summary Report dated 1/7/26, showed the following physician's order:- dated 5/30/25, to administer mirtazapine tablet 7.5 mg, one tablet by mouth at bedtime for depression manifested by poor oral intake less than 50%.- dated 9/26/25, to monitor behavior episodes of depression (for the use of mirtazapine medication)manifested by poor oral intake less than 50%. Review of Resident 83's Amount Eaten for 30 days, from 12/10/25 to 1/8/26, showed Resident 83 was consuming less than 50% of his meals for a total of 65 episodes. Review of the Resident Psychotherapeutic Drug Summary Sheet for December 2025 showed under the behavior data, Resident 83 consumed less than 50% of his meals for a total of 41 episodes. On 1/8/26 at 1355 hours, an interview and concurrent medical record review for Resident 83 was conducted with the ADON. The ADON verified the meal percentage monitoring for the use of the mirtazapine medication for Resident 83 was not accurate when compared to the summary of the behavior record. On 1/12/2026 at 1351 hours, an interview was conducted with the DON. The DON was informed and verified the above findings.

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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 timely notify and accurately sent the Notification of Proposed Transfer/Discharge to the Office of the State Long-Term Care (LTC) Ombudsman (an advocate for residents of nursing homes) when two of three sampled residents (Residents 156 and 158) reviewed for closed records. * The facility failed to ensure notification of proposed transfer was sent to the Ombudsman timely for Resident 156. * The facility failed to ensure the Notice of Proposed Transfer was accurately sent to the Ombudsman for Resident 158. These failures had the potential for the Ombudsman not to be able to advocate for the residents in protecting their rights from inappropriate transfer and discharge.Findings: Review of facility's P&P titled Transfer or Discharge Notices revised 3/2025 showed the residents (or resident representatives) are notified of an impending transfer or discharge and the reasons for the move in writing and in a language and manner they understand. A copy of the notice is sent to the Office of the State Long -Term Care Ombudsman. A copy of the notice is sent to the Office of the State Long Term- Care Ombudsman at the same time the notice of transfer or discharge is provided to the residents and representatives. 1. Closed medical record review for Resident 156 was initiated on 1/5/26. Resident 156 was admitted to the facility on [DATE], and transferred to the acute care hospital on [DATE]. Review of Resident 156's physician order dated 10/29/25, showed transfer the resident to the acute care hospital. Bed hold for seven days. Review of Resident 156's Notification of Proposed Transfer/discharge date d 12/15/25, showed it was faxed to the Ombudsman on 12/15/25. On 1/12/26 at 0906 hours, an interview and concurrent medical record review for Resident 156 was conducted with SSA 1. SSA 1 verified the Notification of Proposed Transfer/Discharge was not sent in a timely manner to the Ombudsman when Resident 156 was discharged on 10/29/25. SSA 1 further stated they missed sending the Notification of Proposed Transfer/Discharge the day Resident 156 was transferred to the acute care hospital. On 1/13/26 at 1415 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Closed medical record review for Resident 158 was initiated on 1/12/26. Resident 158 was admitted to the facility 10/26/25, and discharged [DATE] to lower level of care. Review of Resident 158's physician order dated 11/5/25, showed to transfer Resident 158 to acute rehabilitation per the resident's family request. Review of Resident 158's Notice of Proposed Transfer/discharge date d 11/5/25, showed the Ombudsman was notified. However, the email address of the assigned Ombudsman to the facility was different from the email address the facility sent for the notification of transfer of Resident 158. On 1/12/26 at 0920 hours, an interview and concurrent medical record review for Resident 158 was (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted with the SSD. The SSD was informed and verified the findings. On 1/12/26 at 1351 hours, an interview was conducted for Resident 158 with the DON. The DON was informed and verified the 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 interview, medical record review, and facility P&P review, the facility failed to develop a comprehensive plan of care to reflect the individual care needs for one of 28 final sampled residents (Resident 20). * The facility failed to develop a care plan problem to address Resident 20's nephrostomy tubes (a thin catheter inserted through the back into the kidney to drain urine directly into a bag, bypassing a blockage or leak in the urinary tract). This failure posed the risk of not providing appropriate, consistent, and individualized care to this resident. Findings: Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered, Development, Implementation & Revision revised January 2025 showed the comprehensive, person-centered care plan:a. includes measurable objectives and timeframes.b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.c. includes the resident's stated goals upon admission and desired outcomes.d. builds on the residents' strengths; ande. reflects currently recognized standards of practice for problem areas and conditions. Medical record review for Resident 20 was initiated on 1/8/26. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's H&P examination dated 11/19/25, showed Resident 20 had the capacity to understand and make decisions. Review of Resident 20's Order Summary Report showed a physician's order dated 12/29/25, to cleanse the right and left nephrostomy tube with saline, pat dry and cover with dry dressing. Review of Resident 20's comprehensive care plans failed to show an individualized care plan problem was developed to address Resident 20's nephrostomy tubes. On 1/8/26 at 1012 hours, an interview and concurrent medical record review for Resident 20 was conducted with RN 1. RN 1 verified Resident 20 had a nephrostomy tube on both right and left kidney. RN 1 verified there was no specific care plan for the care and monitoring of signs and symptoms of infection for Resident 20's nephrostomy tubes. RN 1 verified the findings. On 1/12/26 at 1334 hours, an interview for Resident 20 was conducted with the DON. The DON was informed and verified the findings. Cross Reference to F690.

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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 observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the highest physical well-being for two of 28 final sampled residents (Residents 9 and 31). * The facility failed to initiate a change of condition, notify the physician and resident representative when Resident 9 was involved in an allegation of abuse. * The facility failed to ensure Resident 31 was continuously monitored when the resident had dysuria (painful or difficult urination) and antibiotic use. These failures had the potential for the residents not to receive the appropriate care and monitoring to prevent the development of complications and/or delayed medical treatments.Findings: 1. Review of the facility's P&P titled Abuse, Neglect, Exploitation or Misappropriation – Reporting and Investigating revised 1/2025 showed all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. The Administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: - The resident's representative; and - The resident's attending physician. Review of the facility's P&P titled Charting and Documentation revised 1/2025 showed all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Medical record review for Resident 9 was initiated on 1/5/26. Resident 9 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 9's H&P examination dated 9/26/25, showed Resident 9 had capacity to make medical decisions. Review of the facility's SOC 341 form dated 12/30/25, showed a resident had reported an allegation of physical abuse by Resident 9. Review of Resident 9's plan of care showed a care plan problem dated 12/30/25, addressing Resident Psychosocial- Emotional/Trauma: At risk for decreased psychosocial well-being and adjustment issues, emotional distress and ineffective coping skills, poor impulse control, adverse effects on function, mental, physical, social, or spiritual wellbeing related to alleged/suspected abuse from roommate. The interventions included contacting resident representative/friend for comfort and support. Review of Resident 9's medical record failed to show a change of condition assessment was initiated when Resident 9 was involved in the allegation of abuse on 12/30/25. Further review failed to show (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the physician and resident representative were notified on the allegation of abuse. On 1/8/26 at 0937 hours, an interview and concurrent medical record review for Resident 9 was conducted with MDS 2. MDS 2 stated for the allegation of abuse, the licensed nurse was responsible for completing the incident report, the change in condition assessment, developing a care plan, and notification of physician and resident representative. MDS 2 reviewed and verified Resident 9's medical record failed to show a change of condition was initiated and the physician and resident representative were notified. On 1/8/26 at 1315 hours, an interview and concurrent medical record review for Resident 9 was conducted with the DON. The DON stated for abuse allegations, a change of condition should be completed for the perpetrator and victim. The DON further stated the facility's protocol was to assess the resident and inform the physician and resident's responsible party. The DON reviewed and verified Resident 9's medical record failed to show a change of condition was initiated, notification of the resident's physician and resident representative. 2. Review of the facility's P&P titled Change in a Resident's Condition or Status revised 1/2025 under the Policy Interpretation and Implementation section, showed the nurse would record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. On 1/6/26 at 0830 hours, an observation and concurrent interview was conducted with Resident 31. Resident 31 stated at times she had pain when urinating. Resident 31 stated she reported it to the nurses. Resident 31 stated she was getting antibiotics through her vein every day. Medical record review for Resident 31 was initiated on 1/6/26. Resident 31 was admitted to the facility on [DATE]. Review of Resident 31's H&P examination dated 12/11/25, showed Resident 31 had the capacity to understand and make decisions. Review of Resident 31's eINTERACT Change in Condition Evaluation dated 12/30/25 at 1300 hours, showed Resident 31 complained of pain with urination which started this morning. The attending physician was notified and ordered urinalysis and culture. Review of Resident 31's Order Summary Report showed a physician's order dated 1/3/26, to administer ceftriaxone sodium (antibiotic medication use to treat bacterial infection in many different parts of the body) one gram intravenously every 24 hours for UTI for seven days. Further review of Resident 31's medical record failed to show documented evidence the facility staff continued to monitor the resident when the resident had changed in condition of dysuria and used of antibiotics. On 1/12/26 at 1001 hours, an interview and concurrent medical record review for Resident 31 was conducted with RN 1. RN 1 stated having dysuria, UTI, and use of antibiotics were considered changes in the resident's condition. RN 1 stated when there was a change in condition, the licensed nurses should continuously monitor the resident specific to the changed in condition every shift for at least three days and as needed. RN 1 stated when the resident was receiving antibiotics whether it was administered orally or intravenously, the licensed nurses should continuously monitor the resident throughout the course of antibiotics and another three days after the completion days of the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	antibiotics to further observe for any adverse reactions from the medication. RN 1 verified Resident 31 was not continuously monitored every shift when the resident experienced dysuria and when receiving antibiotics for the UTI. RN 1 further stated when the resident had a change in condition, it was important for the nurses to monitor or assess the resident on each shift to observe if there were worsening signs and symptoms of the condition or adverse reactions from the medication, and they could notify the physician to further assess the resident, change the treatment if needed and modify the plan of care specific to the change in condition. On 1/13/26 at 1415 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings for Resident 31.

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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 provide the necessary care and services for one of three final sampled residents (Resident 20) nephrostomy tube (a small tube inserted through the back into the kidney to drain urine when the normal urinary pathway is blocked). * The facility failed to ensure a physician's order was obtained for the care and monitoring of nephrostomy tube for Resident 20. This failure had the potential for the risk of infection and affected the well-being of the residents. Findings: On 1/5/26 at 1025 hours, during the initial tour of the facility, an observation and concurrent interview for Resident 20 was conducted. Resident 20 was sitting in bed and observed with a leg drainage bag attached to both thighs. Resident 20 stated the drainage was from his kidneys. Resident 20 further stated his drainage bag sometimes had blood. Medical record review for Resident 20 was initiated on 1/8/26. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's H&P examination dated 11/19/25, showed Resident 20 had the capacity to understand and make decisions. Review of Resident 20's Order Summary Report dated 1/6/26, showed a physician's order dated 12/29/25, to cleanse the right and left nephrostomy tube with saline, pat dry, and cover with dry dressing. However, further review of the order summary report failed to show a physician's order for the care and monitoring of the nephrostomy tubes. On 1/8/26 at 0951 hours, an interview for Resident 20 was conducted with CNA 4. CNA 4 verified Resident 20 had two drainage bags for his urine. CNA 4 stated she emptied the drainage bags at the end of her shift and as needed. CNA 4 stated she measured the urine output and reported it to the nurse. On 1/8/26 at 1012 hours, an interview and concurrent medical record review for Resident 20 was conducted with RN 1. RN 1 verified Resident 20 had a nephrostomy tube on both right and left kidney. RN 1 was able to show a physician's order for the treatment on the incision site, verified and acknowledged there was no physician's order for the care and monitoring of the nephrostomy tube. On 1/12/26 at 1334 hours, an interview for Resident 20 was conducted with the DON. The DON was informed and verified the findings. Cross Reference to F656.

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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 appropriate GT care and services were provided for one of two final sampled residents (Resident 101) reviewed for GT. * The facility failed to ensure Resident 101's enteral formula bottle was labeled with the correct name of the resident. This failure had the potential to negatively impact the resident's well-being.Findings: Review of the facility's P&P titled Enteral Nutrition dated January 2025 showed adequate nutritional support through enteral nutrition is provided to residents as ordered. The nurses confirm the physician's order for enteral nutrition is complete before administration. During the initial tour on 1/5/26 at 1027 hours, Resident 101 was observed in bed with the GT feeding. The feeding was Glucerna 1.5 cal (enteral feeding formula) and it was infusing via GT feeding machine at 45 ml per hour. The enteral formula bottle was labeled with different name of a resident. LVN 6 was summoned to Resident 101's bedside and verified the findings. LVN 6 verified and acknowledged the GT feeding bottle of Resident 101 had an incorrect name. Medical record review for Resident 101 was initiated on 1/6/26. Resident 101 was admitted to the facility on [DATE]. Review of Resident 101's H&P examination dated 7/30/25, showed Resident 101 could not make medical decisions by himself. Review of Resident 101's Order Summary Report showed a physician's order dated 1/6/26, to administer enteral feeding Glucerna 1.5 at 45 ml per hour via GT for a total of 900 ml. On 1/7/26 at 0947 hours, an interview and concurrent medical record review for Resident 101 was conducted with RN 1. RN 1 verified Resident 101 was on enteral feeding. RN 1 stated the licensed nurses must make sure the physician order, correct formula, and correct resident was verified before administration on enteral feeding. RN 1 was informed of the findings and verified the findings. RN 1 stated the enteral feeding bottle name of the resident label should have been corrected. On 1/12/26 at 1351 hours, an interview for Resident 101 was conducted with the DON. The DON was informed and verified the above findings.

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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, facility P&P review, and facility document review, the facility failed to ensure the recommendation from Dialysis Center and fluid restriction were followed for two of three final sampled residents (Residents 10 and 113) reviewed for dialysis. * The facility failed to ensure the physician's order for 1500 ml of fluid restriction was followed and carried out accordingly for Resident 10. * The facility failed to follow up on a dialysis recommendation to check Resident 113 for C-diff (a harmful bacterium causing diarrhea and colitis often triggered by antibiotic use that disrupts gut bacteria). These failures had the potential of not identifying potential negative outcomes for the residents on dialysis.Findings: Review of the facility's P&P titled Care of Residents on Hemodialysis, Coordination of Care, Evaluation and Communication, revised 1/2025 showed the Dialysis Center, by telephone or in writing, will notify the facility of the following: - any medication given during dialysis care; and - the Dialysis Center and the facility shall communicate via telephone or use of Dialysis Communication papers, matters of difficulty with transportation, emergent changes in the resident's condition or other significant findings. 1. Medical record review for Resident 113 was initiated on 1/5/26. Resident 113 was admitted to the facility on [DATE]. Review of Residents 113's MDS admission assessment dated [DATE], showed a BIMS score of 13, meaning cognitively intact. Review of the Dialysis Center Hemodialysis Communication Observation/assessment dated [DATE], showed a recommendation from Dialysis Center to check Resident 113 for possible C-diff and loperamide (antidiarrheal medication) 4 mg was given at the Dialysis Center. Review of Resident 113's Order Summary Report showed a physician's order dated 12/31/25, for loperamide 2 mg give two tablets by mouth one time a day every Monday, Wednesday and Friday, to administer prior to dialysis transportation pick up for loose stool. On 1/7/26 at 1114 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 verified the recommendation from the Dialysis Center dated 12/29/25, to check for Resident 113 for possible C-diff was not communicated to the facility MD. On 1/13/26 at 1415 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 10 was initiated on 1/7/26. Resident 10 was admitted to the facility on [DATE], with a diagnosis of ESRD. Review of Resident 10's H&P examination dated 11/26/25, showed Resident 10 had no capacity to understand and make decisions. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 10's Order Summary Report showed a physician's order dated 11/26/25, for fluid restriction of 1500 ml/24 hours as follows: * Dietary to provide 840 ml of fluid: - 280 ml at breakfast - 280 ml at lunch - 280 ml at dinner * Nursing to provide 660 ml of fluid: - 120 ml for the 11-7 shift - 270 ml for the 7-3 shift - 270 ml for the 3-11 shift Review of Resident 10's MAR for December 2025 showed the fluid restriction record for nursing to provide 660 ml of fluids for 24 hours. However, further review of Resident 10's medical record failed to show documented evidence of the fluid intake from the dietary to provide 840 ml for 24 hours. On 1/8/26 at 0959 hours, an interview for Resident 10 was conducted with CNA 4. CNA 4 verified Resident 10 had dialysis and a fluid restriction order. CNA 4 stated she reported to the nurse on how much fluids Resident 10 consumed for each meal but did not record the amount of fluids, only the meal percentage. On 1/8/26 at 1003 hours, an interview and concurrent medical record review for Resident 10 was conducted with RN 1. RN 1 verified Resident 10 was a dialysis resident and on fluid restriction of 1500 ml per day as per physician order. RN 1 stated the licensed nurses documented in the MAR for the fluids given by nursing. RN 1 was asked about the documentation of fluid intake coming from the dietary. RN 1 verified and acknowledged there was no fluid intake was recorded from the dietary. On 1/12/26 at 1334 hours, an interview for Resident 10 was conducted with the DON. The DON was informed and verified the 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 facility P&P review, the facility failed to ensure one of 20 kitchen staff (Dietary Aide 3) was competent in preforming the task in the food and nutrition department. * The facility failed to ensure Dietary Aide 3 was competent in the manual dishwashing procedure. This failure posed the risk for the dishes, pots, and pans used to cook the residents' food to not be cleaned and sanitized properly. Findings: Review of the facility's document titled Dietary Aide Competency Checklist signed by Dietary Aide 3 and the DSS on 10/9/25, showed Dietary Aide 3 was competent in washing and cleaning the utensils as directed and performed dishwashing/cleaning procedures. Review of the facility's document titled Dietary In-Service, Topic: Cleaning and Sanitizing Dishes, Utensils, Pots and Pans dated 11/10/25, showed Dietary Aide 3 was in attendance. Review of the facility's P&P titled 3-Compartment Procedure for Manual Dishwashing dated 2023 showed the following:Step 2: Rinse, scrape, or soak all items before washing. Use a brush, cloth, or nylon scrubber,Step 3: The first compartment of the sink is meant for washing. Fill the first compartment with detergent per manufactures instructions and hot water, Step 4: The second compartment is for rinsing. Fill the second compartment with clean hot water. Immerse washed items and rinse thoroughly, making sure detergent is removed, andStep 5: The third compartment is for sanitizing. Fill the third compartment with clean, clear water to the fill line and sanitizer to meet the required concentration on the test strip container. Immerse all washed items per sanitizer manufacturer guidelines. On 1/5/26 at 0855 hours, during the initial tour of the kitchen with the DSS, an observation of manual warewashing and concurrent interview was conducted. During the observation there were soiled pans in the wash and rinse sink compartments with no water. In addition, the third sink compartment had dishes not fully submerged in the sanitizing solution. Dietary Aide 3 was asked to demonstrate the manual dish washing procedure. Dietary Aide 3 stated he would use the soap with a scrubbing sponge and then would rinse the dishes. When Dietary Aide 3 was asked what did the water line labeled on the outside of the wash and rinse sinks meant, Dietary Aide 3 stated it was where the water should be filled up to. Dietary Aide 3 stated he had drained the water in both the wash and rinse compartments when he started washing the dishes. The DSS confirmed the manual warewashing sink's wash and rinse compartments should be filled with water to the indicator line on the outside of the sink. The DSS also stated the dishes in the sanitizing solution in the third compartment of the warewashing sink should be fully submerged in the sanitizing solution for one minute. Cross reference to F812, example #4.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, and facility document review, the facility failed to ensure the menu and recipes were followed. * The facility failed to ensure 75 of 75 residents on regular diets were served the correct portion size for the entree of the lunch meal. * The facility failed to ensure the puree broccoli recipe was followed for 19 of 19 residents on the puree diet. These failures posed the risk for 75 residents on regular diets and 19 residents on puree diets to not meet their nutritional needs.Findings: 1. Review of facility's document titled Cooks Spreadsheet dated 1/5/26, showed the regular diet would serve four ounces of the Southern style patty for the regular sized portions and three ounces for small sized portions. On 1/5/26 at 0930 hours, during the initial tour of the kitchen with the DSS, a lunch preparation observation and concurrent interview was conducted with [NAME] 1. [NAME] 1 was observed portioning the ground beef for the Southern style patty. [NAME] 1 stated he was using a two-ounce scoop to form the patties. [NAME] 1 stated the portion sizes for the Southern style patty were to be two to three ounces. On 1/7/25 at 1024 hours, an interview was conducted with the RD. The RD was made aware and acknowledged all recipes should be followed. 2. Review of the facility's document titled Recipe: Pureed (IDDSI Level #4) Vegetables dated 2025 showed to measure out the total number of portions (based on the portion size indicated on the cook's spreadsheet) needed for puree diets, and puree on a low speed to a paste consistency before adding any liquid. The document further showed to gradually add warm liquid if needed. On 1/6/26 at 1000 hours, an observation of the puree preparation and concurrent interview was conducted with [NAME] 1. [NAME] 1 stated he was preparing twenty-four servings of broccoli for the puree diets. [NAME] 1 was observed adding broccoli and unmeasured amount of vegetable broth to a blender to be pureed. [NAME] 1 blended the broccoli mixture. After blending the broccoli mixture, the broccoli mixture was observed at a liquid consistency. [NAME] 1 stated he will add thickener as he goes to get the correct texture. On 1/7/25 at 1024 hours, an interview was conducted with the RD. The RD was made aware and acknowledged all recipes should be followed.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and facility document review, the facility failed to ensure a vegetarian meal substitute was served for two nonsampled residents (Residents 94 and 163) who were on vegetarian preference diet. * The facility failed to ensure Residents 94 and 163 received a vegetarian meal substitute equivalent in nutritive value to the main entree served. This failure posed the risk for the residents' nutritional needs, specifically protein needs to not be met.Findings: Review of the facility's document titled Cooks Spreadsheet dated 1/6/26, showed Regular diets were to receive three ounces of pork with pear sauce. Review of the nutritional information provided by the facility for the pork during lunch on 1/6/26, showed the three ounces would provide 15.75 grams of protein. Review of the nutritional information provided by the facility for the tofu during lunch on 1/6/26, for the vegetarian lunch meal alternate, showed the three ounces would provide nine grams of protein. On 1/6/26 at 1000 hours, an interview was conducted with the DSS. The DSS stated the residents who had vegetarian meal preference were to receive stir fried tofu with zucchini for their lunch meal. When asked about the vegetarian meal preference menu, the DSS stated the facility had no menu for the vegetarian diets. The DSS added she spoke with the RD who approved the vegetarian meal substitutions. On 1/6/26 at 1218 hours, a tray line observation was conducted. Resident 94 and 163's lunch tray in the meal cart was observed to have tofu with zucchini in placed of the three ounces of pork with pear sauce for the residents on the regular diets. On 1/7/26 at 0908 hours, an interview was conducted with [NAME] 1 and the DSS. When asked how [NAME] 1 determined what vegetarian meal substitution to serve for the day, the DSS stated there were several vegetarian options to choose from and the cook was responsible to decide which vegetarian meal substitution to serve for the meal. [NAME] 1 stated the vegetarian meal substitutions did not have recipes to follow. When asked how he determined the portion size of the vegetarian meal substitution, [NAME] 1 stated he used the same portion size as the regular diet on the menu spreadsheet. On 1/7/26 at 1024 hours, an interview was conducted with the RD. The RD stated the vegetarian meal preference was an alternate to the regular diet. The RD verified the vegetarian meal preference did not have a menu, recipes or cook spreadsheet for the cook to follow to ensure the vegetarian meal preference was equivalent in nutritive value to the regular menu entree served.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Base on observation, interview, and facility document review, the facility failed to ensure the proper food texture was followed for 12 of 12 residents on an IDDSI Level 6 diet (Soft and Bite-Sized diet, for people who can chew but need food that's soft, tender, moist, and cut into small pieces (about 1.5cm x 1.5cm for adults) that mash easily with a fork, requiring chewing before swallowing). * The facility failed to ensure the meat, vegetables, and bread were properly prepared for the 12 residents on IDDSI Level 6 diet. This failure posed the risk for the 12 residents with swallowing and/or chewing difficulties on mechanically altered diets to not receive the diet texture as ordered by the physician.Findings: Review of the professional reference International Dysphagia Diet Standardization Initiative (IDDSI) a level 6 diet, Soft and Bite-Sized diet should have ?bite-sized' pieces no larger than 1.5 cm equivalent to half an inch. The food must be soft, tender and moist throughout but with no separate thin liquid. According to the IDDSI Audit Tool for the Soft and Bite-Sized diet, the critical tests include Appearance and Fork/Spoon Pressure Test. The appearance test involves measuring food piece size and making sure the food has no separate liquid. The fork/spoon pressure test includes pushing down on a 15 mm by 15 mm (.5 inch) sample with a dinner fork or teaspoon, with enough pressure that the thumb nail turns white, the food can be squashed and will not return to original shape making sure the food has no separate liquid. https://www.iddsi.org/ Review of the facility's document titled General Preparation Recipe: IDDSI Level 6/Soft and Bite Size dated 2025 showed the following:1. Complete regular recipe, measure out the total number of portions (based on the portion size indicated on the cook's spreadsheet) needed for the IDDSI Level 6/Soft and Bite Size diets,2. Chop into pieces 1.5 cm x 1.5 cm in size. May moisten food item with sauce or gravy if desired, served at the appropriate thickness, and3. Utilize critical tests and IDDSI audit to confirm texture level 6 specifications. On 1/5/26 at 1223 hours, during the dining observation, Resident 100 was observed in the Dining Room. Resident 100's lunch meal consisted of meat with gravy, vegetables, mashed potatoes with gravy, and a roll. The meat and vegetables were minced or finely chopped consistency. The roll was partially moistened, and the top half of the roll appeared dry in texture. On 1/6/26 at 1000 hours, a meal preparation observation for IDDSI Level 6/Soft and Bite-Sized diets and concurrent interview was conducted with the DSS and [NAME] 1. [NAME] 1 stated he was preparing 12 soft and bite-sized portions of pork. [NAME] 1 measured 12 three-ounce portions of cooked pork. [NAME] 1 put the pork in the Robot Coupe (a food processor). [NAME] 1 blended the pork in the Robot Coupe to obtain a shredded consistency. [NAME] 1 then added seven ounces of gravy and stated he added the gravy so the pork would not be dry. The texture of the pork appeared shredded in consistency. [NAME] 1 then added 12 portions of cooked canned green beans to the Robot Coupe and blended the product. The canned green beans appeared minced in texture. [NAME] 1 added 12 portions of cooked broccoli and one ounce of butter to the Robot Coupe and blended the product. The broccoli appeared minced in texture. The DSS was asked how the employees were trained on IDDSI food textures. The DSS stated she trained the cooks. The DSS added she learned IDDSI food textures from watching the training videos. When asked if an IDDSI audit tool was used to test the different IDDSI food textures for accuracy, the DSS stated no testing was currently being performed on the IDDSI food textures. On 1/7/2026 at 1024 hours, an interview was conducted with the RD. The RD stated she was involved in training the kitchen staff on the IDDSI menus. The RD stated she checked the texture of the IDDSI diets during meal tray line and had no concerns. The RD was made aware the soft/bite-sized pork and broccoli served on 1/6/26 were not the correct texture for IDDSI Level 6/Soft and Bite-Sized diet. The RD acknowledged and stated all diets must be the correct texture in accordance with the physician's order. On 1/7/2026 at 1124 hours, an interview was conducted with the ST. The ST stated she was involved in training the kitchen staff on the IDDSI diet textures. The ST stated she monitored the residents' meal trays to (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	check food textures. The ST was made aware and acknowledged the soft/bite-sized pork and broccoli served on 1/6/26, were not the appropriate texture. The ST added all food textures should be in accordance with the physician's diet order. The ST was made aware of the roll serve to Resident 100 on 1/5/26, and acknowledged the roll was not completely soaked and the meat and vegetables were not soft/bite-sized texture.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **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 necessary adaptive equipment was provided for one of 28 final sampled resident (Resident 11). * The facility failed to provide Resident 11 with a plate guard as per the physician's order. This failure had the potential for Resident 11 not being able to consume his food and drinks without the necessary assistive device.Findings: Review of the facility's P&P titled Adaptive Equipment Policy dated January 2025 showed the provision of the supplies and equipment to support self-care of the residents. Restorative and supportive care includes the assessment of self-feeding skills, providing adaptive devices, and retraining program based on resident needs and capabilities. On 1/5/26 at 1238 hours, an observation of Resident 11 and concurrent interview was conducted with LVN 5 at the bedside. Resident 11 was observed in bed eating his food from the food tray using his right hand. Resident 11's right extremity was observed weak. LVN 5 was asked if Resident 11 had an adaptive equipment to use for eating. LVN 5 was not aware and verified there was no plate guard on Resident 11's food plate. On 1/6/26 at 0847 hours, a follow-up observation was conducted with Resident 11. Resident 11 was observed without an adaptive equipment in the resident's plate. Medical record review for Resident 11 was initiated on 1/6/26. Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's Order Summary Report dated 1/6/26, showed a physician's order dated 1/4/26, for Resident 11's use of a plate guard during all meals to facilitate independence with self-feeding three times a day. Review of Resident 11's plan of care showed a care plan problem initiated on 8/22/25, addressing Resident 11's ADL/Mobility. The intervention initiated on 1/4/26, was for the use of the Adaptive Feeding Equipment: plate guard to be provided during all meals to facilitate independence with self-feeding. On 1/7/26 at 0927hours, an interview and concurrent medical record review for Resident 11 was conducted with RN 1. RN 1 verified there was a physician's order for a plate guard as an assistive device for Resident 11 during meals. RN 1 was informed and acknowledged the findings. RN 1 stated the adaptive equipment for eating should have been with the food tray for Resident 11 to use. On 1/12/26 at 1351 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 document review, the facility failed to ensure the Facility Assessment was complete. * The facility failed to ensure the Facility Assessment included the active involvement of the required individuals in developing the Facility Assessment, plan to maximize recruitment and retention of direct care staff, and a contingency plan for staffing needs. This failures had the potential to not meet the residents' care needs if the assessed population's needs and resources were not comprehensively identified and addressed.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's Assessment reviewed on 1/15/25, did not show the direct care staff member, direct care representatives, residents, residents' representatives, and residents' family members who were actively involved in developing the Facility Assessment, the plan to maximize recruitment and retention of the direct care staff, and a contingency plan for staffing needs. On 1/8/26 at 1440 hours, an interview and concurrent facility document review of the Facility Assessment was conducted with the Administrator. The Administrator verified the Facility assessment dated [DATE], had no direct care staff, direct care representatives, residents' representatives, and family members who were actively involved in developing the Facility Assessment. The Administrator further verified there were no documentation of a plan to maximize recruitment and retention of the direct care staff and a contingency plan for staffing needs in the Facility Assessment. The Administrator stated he was not aware of the current guidance. The Administrator verified and acknowledged the Facility Assessment was not updated based on the latest guidance from the CMS.

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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, facility documents review, and facility P&P review, the facility failed to maintain an accurate medical record for five of 28 final sampled residents (Residents 13, 15, 87, 99, and 113). * The facility failed to ensure the section D of the POLST was completed for Resident 15, 87, and 99. * The facility failed to ensure Resident 113's blood pressure access site was accurately documented in the resident's medical record. * The facility failed to document the correct site of the blood pressure reading for Resident 13 who had an AVF in the right upper arm. These failures had the potential for the residents' care needs not being met as their medical information was inaccurateFindings: Review of facility's P&P titled Charting and Documentation review dated 1/2025 showed the documentation in the medical record will be objective (not opiniated or speculative), complete and accurate. 1. Medical record review for Resident 15 was initiated on 1/6/26. Resident 15 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 15's POLST dated 9/25/25, showed under Section D-Information and Signatures, the boxes for Advance Directive, Advance directive not available or No Advance Directive were left blank. On 1/6/26 at 0905 hours, an interview and concurrent medical record review for Resident 15 was conducted with MDS 1. MDS 1 stated the SSD was responsible to review the POLST for completion. MDS 1 verified and acknowledges Resident 15's POLST section D was incomplete. 2. Medical record review for Resident 87 was initiated on 1/7/26. Resident 87 was admitted to the facility on [DATE]. Review of Resident 87's POLST dated 4/4/25, showed under Section D-Information and Signatures, the boxes for Advance Directive, Advance directive not available or No Advance Directive were left blank. On 1/6/26 at 0935 hours, an interview and concurrent medical record review for Resident 87 was conducted with the MDS 1. MDS 1 stated the SSD was responsible to review the POLST for completion. MDS 1 verified and acknowledges Resident 87's POLST section D was incomplete. 3. Medical record review for Resident 99 was initiated on 1/7/26. Resident 99 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 99's POLST dated 2/11/25, showed under Section D-Information and Signatures, the boxes for Advance Directive, Advance directive not available or No Advance Directive were left blank. On 1/6/26 at 0955 hours, an interview and concurrent medical record review for Resident 99 was conducted with MDS 1. MDS 1 stated the SSD was responsible to review the POLST for completion. MDS 1 verified and acknowledges Resident 99's POLST section D was incomplete. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/7/26 at 1140 hours, an interview and concurrent medical record review was conducted with the SSD for Residents 15, 87, and 99. The SSD verified the section D on the POLST was not completed for Resident 15, 87, and 99. The SSD stated the section D on the POLST should be completed and accurate so the care team can care for the residents appropriately. On 1/13/26 at 1426 hours, an interview was conducted with the DON. The DON was made aware and acknowledged the above findings. 4. Review of the facility's P&P titled Care of Residents on Hemodialysis, Coordination of Care, Evaluation and Communication revised 1/2025 showed to provide nursing care that maintains the patency of an arteriovenous shunt; prevent complications (e.g.) – infections, bleeding and trauma) and identify specific measure to be followed if complications occur. Do not perform blood pressure or venous puncture on arm with shunt. Signs alerting staff of no blood pressure measurements, or venous punctures to affected extremity maybe posted at bedside for safety. Medical Record Review for Resident 113 was initiated on 1/5/26. Resident 113 was admitted to the facility on [DATE]. Review of Residents 113's MDS admission assessment dated [DATE], showed a BIMS score of 13 (cognitively intact). Review of Resident 113's Care Plan Report initiated on11/19/25, showed a care plan problem with focus on dialysis, resident requires hemodialysis and had an AV Graft located on the LUA. The intervention included to avoid taking blood pressure, performing venipuncture, giving injections, strenuous activity, or applying restrictive clothing or restraints on the left AV site extremity. Review of Resident 113's Order Summary Report showed a physician's order dated 11/18/25, to avoid taking blood pressure, performing venipuncture, giving injections, strenuous activity, or applying restrictive clothing or restraints on the left upper arm AV site extremity and no blood pressure, no blood draws no needle stick on left upper arm. Review of Resident 113's Weights and Vitals Summary showed Resident 113's blood pressure reading documentation on the following dates:- date 12/21/25 at 2333 hours, 132/87 mmHg on the left arm;- date12/22/25 at 0911 hours, 130/65 mmHg on the left arm;- dated 12/22/25 at 1724 hours, 138/62 mmHg on the left arm;- dated 12/22/25 at 2319 hours, 126/78 mmHg on the left arm;- dated 12/24/25 at 1825 hours, 126/88 mmHg on the left arm;- dated 12/24/25 at 2005 hours, 123/67 mmHg on the left arm;- dated 12/25/25 at 0148 hours, 141/67 mmHg on the left arm;- dated 12/26/25 at 1322 hours, 126/80 mmHg on the left arm;- dated 12/27/25 at 1103 hours, 125/76 mmHg on the left arm; - dated 12/27/25 at 2345 hours, 127/76 mmHg on the left arm;- dated 12/28/25 at 0927 hours, 125/60 mmHg on the left arm;- dated 12/29/25 at 0917 hours, 126/63 mmHg on the left arm;- dated 12/29/25 at 1900 hours, 111/57 mmHg on the left arm;- dated 12/29/25 at 2125 hours, 111/57 mmHg on the left arm;- dated 1/2/26 at 0854 hours, 142/74 mmHg on the left arm;- dated 1/4/26 at 1847 hours, 107/60 mmHg on the left arm; - dated 1/5/26 at 1926 hours, 102/96 mmHg on the left arm; and- dated 1/6/26 at 0850 hours, 146/70 mmHg on the left arm. On 1/7/25 at 1107 hours, an interview was conducted with Resident 113. Resident 113 stated that she never allowed the licensed nurses to take her blood pressure on the left upper arm. On 1/7/26 at 1114 hours, an interview and concurrent medical record review for Resident 113 was (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted with LVN 3. LVN 3 verified Resident 113 had an AV shunt on the left arm, and the licensed nurses' documentation of Resident 113's blood pressure readings was on the left arm. LVN 3 stated the blood pressure readings should not be taken on Resident 113's left upper arm to prevent infection and risk for blood clot. On 1/13/26 at 1415 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 5. On 1/6/26 at 1004 hours, an observation and concurrent interview was conducted with Resident 13. Resident 13 was observed awake and lying in bed. Resident 13 was observed with AVF on the right upper arm. Resident 13 stated the AVF on his right upper arm was his dialysis access. Resident 13 stated he had dialysis every Mondays, Wednesdays and Fridays. Resident 13 stated he had been on dialysis for a long time. Resident 13 further stated the nurses checked his blood pressure on his left arm and he would remind them not to take the blood pressure or blood draw on his right arm. Medical record review for Resident 13 was initiated on 1/6/26. Resident 13 was admitted to the facility on [DATE]. Review of Resident 13's H&P examination dated 10/25/25, showed Resident 13 had the capacity to understand and make decisions. Review of Resident 13's Order Summary Report showed a physician's order dated 10/23/25, to not take blood pressure, no needle stick, and no blood draw on right upper extremity due to the presence of AVF dialysis access. Review of Resident 13's Weights and Vitals Summary for October, November and December 2025, and January 2026 showed multiple documentation of Resident 13's blood pressure readings taken on r/arm. On 1/8/26 at 1313 hours, an interview was conducted for Resident 13 with CNA 1. CNA 1 stated Resident 13 was well known to her. CNA 1 stated Resident 13's dialysis access was on the right upper arm and knew not to take the blood pressure on the arm where the dialysis access was. CNA 1 stated she would take the blood pressure of the resident on the left arm. However, CNA 1 stated the CNAs could not record the vital signs in the computer, so they would give the vital signs record to the charge nurses. CNA 1 stated when she recorded the vital signs in the paper, she usually would not specify which arm she took the blood pressure. CNA 1 stated the nurses already knew the long-term residents so they should know the CNAs would not check the blood pressure where the dialysis access was. CNA 1 further stated she would only specify in her vital signs record which arm she checked the blood pressure if the resident was newly admitted in the facility. On 1/8/26 at 1346 hours, an interview and concurrent medical record review was conducted for Resident 13 with LVN 4. LVN 4 stated Resident 13 was known to her and verified the resident had been in the facility since October 2025. LVN 4 verified Resident 13 had an AVF on his right upper arm. LVN 4 stated both CNAs and nurses checked the resident's vital signs. LVN 4 stated for the residents with dialysis access, the CNAs should let the nurses know which arm they checked the blood pressure, and the nurses should be familiar with the resident's dialysis access site. LVN 4 verified Resident 13's Weights and Vitals Summary for the months of October, November, and December 2025 and January 2026 had multiple documentation of Resident 13's blood pressure readings taken on r/arm. LVN 4 verified the r/arm documentation in Resident 13's Weights and Vitals Summary meant (continued on next page)

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	555328	A. Building B. Wing	01/13/2026

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Fountain Valley Post Acute	11680 Warner Avenue Fountain Valley, CA 92708

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	right arm. On 1/13/26 at 1415 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings for Resident 13.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, and facility document review, the facility failed to ensure the facility had the contract to provide the necessary care for one of two final sampled residents (Resident 2) reviewed for hospice services. * The facility failed to ensure Resident 2 had an election of hospice benefit contract between the facility and hospice provider. This failure posed a risk of delayed communication and the provision of hospice care between the hospice provider and the facility.Findings: Medical record review for Resident 2 was initiated on 1/5/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Order Summary Report showed a physician's order dated 12/24/25, to admit Resident 2 to the facility under Hospice Provider A, under routine level of care. Review of the Resident 2's Election of Hospice Benefit Contract dated 12/24/25, showed the signed contract for hospice services was between Facility A and Hospice Provider A. On 1/8/26 at 1018 hours, an interview and concurrent medical record review was conducted with MDS 2. MDS 2 was asked about the process of admitting the residents to hospice services. MDS 2 stated the residents need to have an order from the MD, and the licensed nurse would tell the Social Service department of the order. MDS 2 was asked regarding the Election of Hospice Benefit Contract, MDS 2 was unsure and verified Resident 2's Election of Hospice Benefit Contract dated 12/24/25, showed a contract was between Hospice Provider A and a different facility. On 1/13/26 at 1415 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to maintain the infection control program and practices to help prevent the development and transmission of diseases and infections. * The two washing machines used for residents were not maintained to ensure cleanliness and free from potential contamination. * The facility failed to ensure CNA 3 donned the appropriate PPE when providing care to Resident 40 on EBP. These failures had the potential for the spread of infection in the facility.Findings: 1. Review of the facility's P&P titled Laundry Washing Machine Policy dated 1/2025, under the Policy Interpretation and Implementation sections showed for routine cleaning, washing machines shall be cleaned daily at minimum and as needed, and staff will clean and disinfect door seals, gaskets, detergent dispensers, control panels and handles. On 1/6/26 at 1528 hours, a laundry room inspection was conducted with the Maintenance Director, Maintenance Assistant, and Housekeeper. The Housekeeper stated the facility had two washing machines used for the residents. The two washing machines used to wash the residents' soiled sheets and clothing were observed with dust and dirt accumulation, and brown to dark brown debris around the washing machine doors, door seals, gaskets and enclosures. The Maintenance Director verified the above findings. The Maintenance Assistant stated the maintenance staff would do a deep cleaning of the two washing machines once a week. The Housekeeper stated they would clean the washing machines at the start and at the end of the day by wiping with disinfectants. The Maintenance Director stated there would be no accumulation of dust and debris materials if the washing machines were maintained daily. On 1/7/26 at 1500 hours, an interview was conducted with the IP. The IP stated she would do rounds in the laundry room once a week to check if the surroundings were maintained and the staff were following the protocols. The IP was informed and acknowledged the findings for the two washing machines. The IP stated the washing machines should be maintained clean and sanitary from the inside and out to avoid contamination of the linens and other related items used by the residents and if the machines were not maintained properly, these could harbor germs or bacteria. 2. Medical record review for Resident 40 was initiated on 1/5/26. Resident 40 was admitted to the facility on [DATE]. Review of Resident 40's Order Summary Report showed a physician's order dated 12/20/25, for Enhanced Barrier Precautions – staff to utilize gowns and gloves for high-contact resident care activities - left knee incision site. Review of Resident 40's H&P examination dated 12/20/25, showed Resident 40 had the capacity to understand and make decisions. On 1/5/25 at 0921 hours, during the initial tour of the facility, Resident 40's room was observed with visible PPE posting and presence of PPE cart hanging on resident door. Resident 40's room had a sign outside the door showing Stop – Enhanced Barrier Precaution. Everyone must: Clean their hands, including before entering and when leaving the room. The sign further showed providers and staff must also wear gloves and a gown for the following high-contact resident care activities.- Dressing,- Bathing/Showering,- Transferring,- Changing linens, - Providing hygiene- Changing briefs (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or assisting with toileting- Devices care or use: central line, urinary catheter, feeding tube, tracheostomy- Wound care: any skin opening requiring a dressingDo not wear the same gown and gloves for the care of more than one person. On 1/5/26 at 0935 hours, an observation and concurrent interview was conducted with CNA 3. CNA 3 was observed changing Resident 40 without a gown. CNA 3 verified she did not use a gown when changing Resident 40 who was on EBP. On 1/7/26 at 1346 hours, an interview and concurrent medical record review was conducted with the IP. The IP verified Resident 40 was on Enhanced Barrier Precaution for the left knee incision site and stated all staff need to use a gown and gloves when performing ADL care to all the residents on EBP. The IP acknowledged CNA 3 did not use the proper PPE when providing care to Resident 40. On 1/13/26 at 1415 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0558 Level of Harm - Potential for minimal harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide reasonable accommodations to meet the needs for two of 28 final sampled residents (Residents 87 and 99). * The facility failed to ensure Resident 87 and 99's call light were within the residents' reach. This failure posed a risk in a delay in providing care to the residents and the potential to negatively impact on the residents' well-being.Findings: Review of the facility's P &P titled Answering the Call Light reviewed on 1/2025 showed under the general guidelines section, when the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. 1. On 1/5/26 at 0834 hours, an observation and concurrent interview was conducted with Resident 87. Resident 87 was observed lying in bed. Resident 87's call light was hanging on the left side of the bed far from the resident. Resident 87 attempted to reach for the call light. Resident 87 stated she was unable to see the call light and unable to reach the call light. On 1/5/26 at 0841 hours, an observation and concurrent interview was conducted with LVN 1. Resident 87 was lying in bed and the call light was not within reach. LVN 1 verified the call light was not within Resident 87's reach. LVN 1 further stated the call light should be within the reach of the resident to ensure the resident's safety and allowed the resident to communicate with the facility staff when she needed assistance. Medical record review for Resident 87 was initiated on 1/7/26. Resident 87 was admitted to the facility on [DATE]. Review of Resident 87's H&P examination dated 4/24/25, showed the resident had no capacity to understand and make decisions. Review of Resident 87's care plan for risk for fall revised 8/12/25, showed interventions included to keep the call light within reach. Review of Resident 87's MDS assessment dated [DATE], showed Resident 87 had a BIMS score of 2, which meant the resident had severe cognitive impairment. 2. On 1/5/26 at 1110 hours, an observation was conducted inside Resident 99's room. Resident 99 was lying in bed with the call light on the floor, behind the head of the bed. On 1/5/26 at 1118 hours, an observation and concurrent interview was conducted with the DON inside Resident 99's room. The DON verified Resident 99's call light was on the floor, behind the head of the bed and not within the resident's reach. Medical record review for Resident 99 was initiated on 1/7/26. Resident 99 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 99's H&P examination dated 2/11/25, showed the resident had no capacity to understand and make decisions. Review of Resident 99's care plan for impaired vision as evidenced by legal blindness revised 11/16/24, showed interventions included to keep the call light within reach. On 1/13/26 at 1425 hours, an interview was conducted with the DON. The DON was informed and verified the above findings. The DON further stated the call light needed to be within the resident's reach and accessible for the residents at all times, so the residents could call for assistance from the facility staff.

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F 0583 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility P&P review, the facility failed to ensure privacy was provided for one of 28 final sampled residents (Resident 2). * The facility failed to ensure Resident 2 was provided with privacy when the resident received wound treatment in front of two other residents in the activity room. This failure had the potential to negatively affect the dignity of the resident and violate the resident's rights to privacy.Findings: Review of the facility's P&P titled Resident Rights revised 1/2025 showed the employees shall treat all the residents with kindness, respect and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:- be treated with respect, kindness, and dignity; and- privacy and confidentiality. 1. Medical record review for Resident 2 was initiated on 1/5/26. Resident 2 was admitted to the facility on [DATE]. Review of Residents 2's MDS assessment dated [DATE], showed cognitive skills for daily decision making severely impaired. Review of Resident 2's Order Summary Report showed a physician's order dated 1/12/26, to cleanse left forearm skin tear with normal saline pat dry apply triple antibiotic ointment and cover with dry dressing every day for 14 days. On 1/12/26 at 1004 hours, during an observation of Resident 2 in the activity room, Resident 2 was sitting in the wheelchair with two other residents and staff at the table. Resident 2's left forearm skin tear was bleeding. On 1/12/26 at 1013 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 was observed going to the activity room. LVN 1 brought the treatment supplies, put on gloves and cleaned Resident 2's skin tear. Resident 2 was exposed to the facility staff, and residents who were in the activity room during the skin tear treatment. LVN 1 verified he did not provide privacy to the resident when providing the treatment. LVN 1 further stated he should have brought Resident 2 to her room to do the treatment. On 1/12/26 at 1050 hours, an interview was conducted with the DON. The DON verified Resident 2 was not provided with complete privacy during the skin tear treatment. The DON stated Resident 2 should have been in her room to ensure the resident's privacy was protected during the treatment of the left forearm skin tear. On 1/13/26 at 1415 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 - Potential for minimal harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care for one of one final sampled resident reviewed for respiratory care (Residents 150). * The facility failed to ensure Resident 150's nasal cannula was stored in a sanitary condition. This failure posed the risk for the resident's oxygen equipment to become contaminated with pathogens and had the potential to negatively impact the resident's medical condition.Findings: Review of the facility's P&P titled Departmental Respiratory Therapy Prevention of Infection reviewed dated 1/2025 showed keep the oxygen cannula and tubing used as needed in a plastic bag when not in use. Medical record review for Resident 150 was initiated on 1/6/26. Resident 150 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 150's H&P examination dated 7/24/25, showed the resident had capacity to understand and make medical decisions. Review of Resident 150's Order Summary Report showed an order dated 12/31/25, for the administration of oxygen at a rate of 4 LPM via nasal cannula as needed for shortness of breath. On 1/5/26 at 1133 hours, an observation was conducted in Resident 150's room. A nasal cannula attached to oxygen tubing was observed hanging by the right side of the bed loop around the bed remote control. On 1/5/26 at 1137 hours, an observation and concurrent interview was conducted with the DON. The DON was informed the nasal cannula attached to the oxygen tubing was hanging by the right side of the bed and looped around the bed remote control. The DON stated the nasal cannula should be stored in a clean plastic bag when not in use to prevent infection. The DON further stated if the nasal canula was not stored in a bag, it could be exposed to bacteria and cause respiratory infection which could affect the resident. On 1/6/26 at 0755 hours, an observation and concurrent interview was conducted with Resident 150 in the resident's room. Resident 150 stated she uses oxygen intermittently for shortness of breath. On 1/3/26 at 1427 hours, an interview was conducted the DON. The DON acknowledged and verified the above findings.

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F 0761 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and facility P&P review, the facility failed to ensure the medications in the medication room was stored properly. * The facility failed to ensure the bisacodyl (use for constipation) suppository medications were stored separately from eye drop medications. This failure had the potential for the medication degradation and contamination.Findings: Review of the facility's P&P titled Medication Labelling and Storage (undated) showed the medications for external use, as well as hazardous drugs and biologicals, are clearly marked as such, and are stored separately from other medications. On 1/6/26 at 1153 hours, an inspection of Medication Room A and concurrent interview was conducted with RN 1. During the inspection, 10 boxes of bisacodyl suppository, 10 boxes of earwax removal drop and three boxes of eye drops were all stored together. RN 1 verified the findings and stated external and internal medications needed to be separated and not stored together to prevent accidental mix up of the medications. On 1/13/26 at 1415 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.