STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555404	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Village Healthcare Center	17040 Arnold Dr. Riverside, CA 92518

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to treat residents with respect and dignity when: 1. For Resident 19, Certified Nursing Assistant (CNA) did not fully close the privacy curtain to cover resident's body while providing care; 2. For Resident 47, the staff did not answer call lights in a timely manner, and; 3. For Resident 55, the staff did not respond to resident's requests to provide care. These failures resulted in not ensuring residents' rights to be treated with dignity and respect and could potentially result in negative physical or psychosocial outcomes, such as embarrassment, or changes in mood and/or behavior. Findings: 1. On April 29, 2025, at 10:21 a.m., during a concurrent observation and interview with CNA 1, CNA 1 was observed providing care to Resident 19 in her room. CNA 1 was changing Resident 19's clothes and the privacy curtain was observed half drawn and Resident 19's body was exposed. CNA 1 stated she was in a hurry because the therapy told her Resident 19 would be next for treatment. CNA 1 further stated, I forgot to fully close the curtain. On May 1, 2025, Resident 19's record was reviewed. Resident 19 was admitted to the facility on [DATE], with diagnoses which included dementia (memory loss). A review of Resident 19's Minimum Data Set (MDS - a tool for assessment), dated February 10, 2025, indicated Resident 19 had a BIMS (Brief Interview for Mental Status - a tool used to assess cognition) score of 02 which indicated severe cognitive impairment. On May 1, 2025, at 10:32 a.m., during interview with Registered Nurse (RN) 1, RN 1 stated privacy was important and CNA1 should have fully closed the curtain and should not expose Resident 19's body while providing care. RN 1 stated she would feel embarrassed if someone would saw her body. RN 1 further stated, It's a dignity issue. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On May 1, 2025, at 3:32 p.m., an interview with the Director of Nursing (DON) was conducted. The DON stated she expected all staff to always treat residents with respect and dignity. The DON stated the CNA 1 should have drawn the privacy curtains while providing care to residents. A review of the facility's policy and procedure titled, Dignity, dated February 2021, indicated, .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .Residents are treated with dignity and respect at all times .Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures . 47374 2. On May 1, 2025, at 2:35 p.m., an observation of the call lights and nurse response during change of day shift (7 a.m. to 3 p.m.) to evening shift (3 p.m. to 11 p.m.) was conducted. The CNAs were observed standing near the central nurse station talking to each other while the call lights in two rooms were observed on. The call lights were were answered with an average time of 5 -10 minutes. On May 1, 2025, at 3:40 p.m., an interview with Resident 47 was conducted. Resident 47 stated the call lights were not being answered timely especially during the day and evening shift. Resident 47 stated he could not do many things for himself after his stroke and several times his roommate had to go into the hallway to find a nurse to help him. Resident 47 further stated he felt disrespected and unimportant when he had to wait for the nurse for a prolonged time. A review of Resident 47's medical record indicated Resident 47 was admitted to the facility on [DATE], with the diagnoses which included cerebral infarction (when blood flow to the brain is blocked causing brain tissue to die) and hemiplegia (paralysis or severe weakness on one side of the body). Resident 47's Minimum Data Set (MDS - an assessment tool), dated April 1, 2025, indicated Resident 47 had a BIMS (Brief Interview for Mental Status) score of 15 (cognitively intact). On May 2, 2025, at 3:40 p.m., an interview was conducted with Director of Nursing (DON). The DON stated her expectation was for the nurses to answer lights as soon as possible, and if unable to assist immediately inform the residents of their return time. The DON stated the resident's sense of well-being or self-worth were not being promoted when call lights are not being answered as soon as possible. 49113 3. On April 29, 2025, at 10:14 a.m., during an interview with Resident 55, Resident 55 stated he turned on the call light to request for assistance to transfer from wheelchair to bed, on the night of April 24, 2025. Resident 55 stated he waited for at least 15- 20 minutes and no staff came, then his roommate (Resident 48) went to get help. On April 29, 2025, at 10:34 a.m., during an interview with Resident 48, Resident 48 confirmed the incident alleged by Resident 55 on April 24, 2025. Resident 48 stated he used his call light for staff assistance and they never came. Resident 48 stated he got out of his bed and went to get help for Resident 55 after 20 minutes had passed and no staff responded to their call light. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On May 2, 2025, at 3:40 p.m., during an interview with the DON, the DON stated the call lights should be answered timely. The DON stated it was every staffs responsibility to answer the lights. The DON stated the concern was resident's needs would not be met timely and there was a potential for resident falls. A review of the facility's policy and procedure titled, Dignity, dated February 2021, indicated, .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being .and feelings of self-worth and self-esteem .Residents are treated with dignity and respect at all times .Demeaning practices and standards of care that compromise dignity are prohibited .Staff are expected to promote dignity and assist residents; for example; promptly responding to a resident's request for toileting assistance . A review of the facility's policy and procedure titled, Answering The Call Light, dated September 2022, indicated, .to ensure timely responses to resident's requests and needs .answer the resident call system immediately .answering an auditory request for assistance .if resident needs assistance indicate approximate time it will take for you to respond .if you can not fulfill the resident's request .ask the nurse supervisor for help .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47374 Based on interview and record review, for seven of 16 residents reviewed for Advanced Directive (AD - a written statement of an individual's wishes regarding his/her medical treatment) the facility failed to ensure a copy of the AD was readily available in the resident's records when: 1. For Resident 9, the facility did not follow up with resident representative (RR) to obtain a copy of the resident's AD. This failure had the potential for Resident 9's wishes regarding his medical treatment would not be honored; 2. For Residents 29, 30, 39, 55, 160 and 209, a written information regarding formulating an AD was not provided to the resident or RR. This failure had the potential for Residents 29, 30, 39, 55, 160 and 209 to not be aware of how to formulate an AD. Findings: 1. On May 1, 2025, Resident 9's record was reviewed . Resident 9 was admitted on [DATE], with diagnoses which included acute kidney failure (a condition in which kidneys suddenly can not filter waste from the blood). A review of Resident 9's Advance Directive Acknowledgement dated February 5, 2024, indicated Resident 9 had executed an AD. A review of Resident 9's Minimum Data Set (MDS - an assessment tool), indicated Resident 9 had BIMS (Brief Interview for Mental Status) score of 12 (moderate cognitive impairment). Further review of Resident 9's record indicated there was no AD readily available for review in Resident 9's chart. On May 1, 2025, at 9:56 a.m., an interview was conducted with the Social Service Director (SSD). The SSD stated the residents were inquired regarding information if they have an AD or not. The SSD stated if the resident have an AD, it should be in the resident's electronic file or a hard copy in the resident's chart. The SSD stated it was important for a physical copy of the AD to be readily available in the resident's chart so that the facility staff and the physician would be aware of the wishes of the resident and to honor their wishes. The SSD stated a copy of Resident 9's AD was not uploaded in the resident's electronic record as well as in the paper chart, and was not readily available for the facility when needed. The SSD stated Resident 9's AD should have been followed up from the resident's family member. 2. On May 1, 2025, Resident 29 's record was reviewed. Resident 29 was admitted to the facility on [DATE], with diagnoses that which included cerebral vascular accident (CVA - a condition where blood flow to the brain is interrupted, causing brain tissue damage). Further review of Resident 29's record indicated there was no documented evidence written information regarding formulating an AD being given to Resident 29. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On May 1, 2025, a review Resident 39's record indicated Resident 39 was admitted on [DATE], with diagnoses which included fracture (break) of the right and left tibia (the shinbone) and mandible (the lower jawbone). A further review of Resident 39's record indicated there was no documented evidence written information regarding formulating an AD was provided to Resident 39. 4. On May 1, 2025, Resident 209's record was reviewed. Resident 209 was admitted to the facility on [DATE], with diagnoses which included urinary tract infection, inflammatory polyarthropathy (joint swelling and pain affecting five or more joints). A review of Resident 209's Advance Directive Acknowledgement, dated April 24, 2025, indicated Resident 209 did not have an AD, and there was no documentation the resident was provided written information regarding formulating an AD. 49113 5. On April 30, 2025, Resident 30's record was reviewed. Resident 30 was admitted on [DATE], with diagnoses which included hemiplegia/hemiparesis (partial paralysis on one side of the body), slurred speech, facial weakness, difficulty walking, dysphagia (difficulty swallowing), and hypertension. A review of Resident 30's History and Physical, dated March 24, 2025, indicated Resident 30 had the capacity to make decisions. A review of Resident 30's Advance Directive Acknowledgement, dated _____, indicated Resident 30's did not have an AD, and there was no documentation the resident was provided written information regarding formulating an AD. 6. On April 29, 2025, Resident 55's record was reviewed. Resident 55 was admitted to the facility on [DATE], with diagnoses which included fusion of the spine (procedure joining two or more vertebrae of the spine), cauda equina syndrome (damaged to bundle of nerves at the end of the spinal cord), and difficulty walking. A review of Resident 55's History and Physical, dated April 15, 2025, indicated Resident 55 had the capacity to make medical decisions. A review of Resident 55's Minimum Data Set (MDS - a resident assessment tool), dated April 18, 2025, indicated Resident 55 had a BIMS score of 13 (cognitively intact). A review of Resident 55's Advance Directive Acknowledgement, dated _____, indicated Resident 30's did not have an AD, and there was no documentation the resident was provided written information regarding formulating an AD. 7. On April 30, 2025, Resident 160's record was reviewed. Resident 160 was admitted to the facility on [DATE], with diagnoses which included cerebral infarction (blood flow to the brain is blocked), hemiplegia (weakness on one side of the body), difficulty walking, dysphagia (difficulty swallowing), and diabetes mellitus (too much sugar in the blood). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 160's History and Physical, dated February 27, 2025, indicated Resident 160 did not have the capacity to understand and make decisions. A review of Resident 160's MDS, dated [DATE], indicated Resident 160 had a BIMS score of 6 (severe cognitive impairment). A review of Resident 30's Advance Directive Acknowledgement, dated _____, indicated Resident 160's did not have an AD, and there was no documentation the resident's representative was provided written information regarding formulating an AD. On May 1, 2025, at 9:56 a.m., during an interview with the SSD, the SSD stated she was not providing written information to the resident or RR regarding formulating an AD. The SSD stated there was no documentation a written information regarding formulating an AD was provided to the resident or RR. The SSD stated Residents 9, 29, 30, 39, 55, 160, and 209 should have been provided written information regarding formulating an AD. A review of the facility's policy and procedure titled, Advance Directives, dated December 2016, indicated, . Advance Directives will be respected in accordance with state law and facility policy .Upon admission, the resident will be provided with written information concerning the right .to formulate an advance directive if he or she chooses to do so .Written information will include a description of the facility's policies to implement advance directives .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 .Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his legal representative, about the existence of any written advance directives .Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record .If a resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to provide a comfortable homelike environment, for two of four residents reviewed for environment (Residents 37 and 14), when the peeled painted walls were observed damaged behind the resident's headboard. In addition, peeled painted walls were observed in rooms [ROOM NUMBER]. This failure had the potential for residents not to experience comfortable and pleasant stay in the facility. Findings: 1. On April 29, 2025, at 9:30 a.m., Resident 37 was observed sleeping in her bed. Multiple peeled painted walls were observed damaged behind the headboard of Resident 37's bed. On April 30, 2025 at 9:20 a.m., the walls behind Resident 14's headboard was observed to have peeled paint. In addition, on April 30, 2025 at 1:29 p.m., multiple peeled painted wall was observed behind residents headboard in rooms 9B and 22. On May 2, 2025, at 10:10 a.m., an interview was conducted with the Maintenance Supervisor (MS). The MS stated he was aware of the condition of the painted walls. The MS further stated the damaged painted walls should have been fix and repainted. On May 2, 2025, at 10:20 a.m., an interview was conducted with the Administrator (ADM). The ADM stated he expected maintenance to check and fix any damaged wall or surfaces in the rooms. The ADM further stated the walls should have been fixed and the facility should have a homelike environment feeling for all the residents. A review of the facility's policy and procedure titled, Homelike Environment, dated February 2021, indicated, . Residents are provided with a safe, clean, comfortable and homelike environment .The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include .clean sanitary and orderly environment . 49113 2. On May 2, 2025, at 10:10 a.m., an interview was conducted with the MS. The MS stated he was aware of the condition of the painted walls. The MS further stated the damaged painted walls should have been fix and repainted. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On May 2, 2025, at 10:20 a.m., an interview was conducted with the Administrator ADM. The FA stated he expected maintenance to check and fix any damaged wall or surfaces in the rooms. The FA further stated the walls should have been fix and the facility should have a homelike environment feeling for all residents. A review of the facility's policy and procedure titled, Homelike Environment, dated February 2021, indicated, . Residents are provided with a safe, clean, comfortable and homelike environment .The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include .clean sanitary and orderly environment .

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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** 50204 Based on observation, interview and record review, the facility failed to develop a comprehensive care plan to address the contractures (shortening and hardening of muscles) of the feet, for one of two residents, (Resident 10). This failure had the potential for Resident 10 not to receive the appropriate interventions tailored to her needs and further worsening of the contractures of the feet. Findings: On April 29, 2025, at 9:37 a.m., during the initial tour of the facility, Resident 10 was observed laying on her bed in her room with both ankles extended in a downward position with no adaptive devices on her feet. Resident 10 was not able to flex both ankles upward. On April 30, 2025, at 9:41 a.m., during an interview with Certified Nursing Assistant (CNA) 2, she stated Resident 10 had the foot drop for a long time already. CNA 2 stated they only put heel pads to protect her from skin breakdown. On May 1, 2025, Resident 10's record was reviewed. Resident 10 was admitted to the facility on [DATE], with diagnoses which included cerebral infarction (disrupted blood flow to the brain). A review of Resident 10's History and Physical, dated December 17, 2023, indicated Resident 10 can make needs known but could not make medical decisions. A review of Resident 10's Progress Notes, from a physician's follow up appointment, dated August 26, 2024, indicated Resident 10 had a contractures of the feet. A review of Resident 10's Minimum Data Set (MDS - a tool for assessment), dated February 10, 2025, indicated Resident 10 had impairment on both sides of lower extremities (part of the body that includes hip, knee, ankle, foot). A review of Resident 10's REHAB: JOINT MOBILITY ASSESSMENT (assessment tool evaluating the range and quality of movement at a joint), dated February 11, 2025, indicated Resident 10 had severe joint immobility condition for both ankles. There was no documented evidence a care plan was initiated to address Resident 10's contractures of both feet. On April 30, 2025, at 3:47 p.m., during a concurrent interview and record review with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 10 had history of stroke and had contractures on both feet. LVN 1 stated Resident 10 had no care plan to address contractures. LVN 1 further stated care plan should have been initiated to prevent worsening of the contractures. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 30, 2025, at 4:33 p.m., during a concurrent interview and record review with the Director of Nursing (DON). The DON stated there was no care plan initiated or in placed to manage the contractures of the feet for Resident 10. The DON stated a care plan should have been initiated or in placed to manage the contractures of Resident 10's feet. The DON further stated without a care plan, Resident 10 would not receive functional needs and services that maintain physical well-being. A review of the facility's policy and procedure titled, Care Plans, Comprehensive Person- Centered, dated December 2026, indicated, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .The comprehensive, person-centered care plan will .Described the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being .Aid in preventing or reducing decline in the resident's functional status and/or functional levels .Enhance the optimal functioning of the resident by focusing on a rehabilitative program . A review of the facility's policy and procedure titled, Resident Mobility and Range of Motion, dated July 2017, indicated, .The care plan will be developed by the interdisciplinary team based on the comprehensive assessment, and will be revised as needed .The care plan will include specific interventions, exercises and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000 Based on observation, interview and record review, the facility failed to ensure professional standards of practice during medication administration and the facility's policy and procedure were implemented, for three of 10 residents observed during medication administration (Residents 48, 55, 31, and 161), when: 1. Resident 48's medication was placed on a shelf next to Resident 55, readily available for use. This failure had the potential for Resident 48's medication be administered to Resident 55; 2. The identification of Resident 31 was not verified prior to administering the medications. This failure had the potential for the medications to be administered to the wrong resident; and 3. Resident 161 was not provided privacy while administering the medications. This failure had the potential to affect Resident 161's psychosocial and mental status. Findings: 1. May 1, 2024, at 7:44 a.m., during a medication pass observation with Licensed Vocational Nurse (LVN) LVN 3, LVN 3 was observed to have 1 open packet of Lidocaine Patch 5% (topical medication for pain relief) labeled for Resident 48 sitting on a shelf next to Resident 55. Resident 55's record was reviewed. Resident 55's Admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which included fusion of the spine (procedure joining two or more vertebrae of the spine), cauda equina syndrome (damaged to bundle of nerves at the end of the spinal cord), and difficulty walking. Resident 55's Minimum Data Set (MDS- an assessment tool), indicated Resident 55 had a BIMS (Brief Interview for Mental Status) score of 13 (cognitively intact). A review of Resident 55's physician's orders, dated April 16, 2025, indicated, .Lidocaine Patch 4% Lidocaine, Apply to bilateral knee pain topically one time a day for bilateral knee pain and remover per schedule . On May 1, 2025, at 2:33 p.m., during an interview with LVN 3 , LVN 3 confirmed she left 1 Lidocaine Packet 5% belonging to Resident 48 open and readily available for use on the shelf by Resident 55. LVN 3 stated the medication belonged to Resident 48. LVN 3 stated she did not put the medication back into the cart nor discarded it and she should have. LVN 3 stated she should not have had another resident's medication out while administering to a different resident. LVN 3 stated the resident could have used the medication and could have adverse effect from the medication. On May 1, 2025, at 3:48 p.m., during an interview with the Director of Nursing (DON), the DON stated open medication should not be open and left unattended in the presence of another resident. The DON stated the expectation was staff should handle one resident medication at a time to decrease the risk for any medication errors. The DON stated potential concerns was if the resident was confused and used the medicine, there was a possibility of adverse side effects. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, Administering Medications, revised April 2019, indicated . Medications are administered in a safe and timely manner, and as prescribed .Medications ordered for a particular resident may not be administered to another resident . 2. On May 1, 2025, at 8 a.m., during a medication pass observation with LVN 3, LVN 3 was observed administering medication to Resident 31 without verifying the resident's identity. Resident 31's record was reviewed. Resident 31's Admission Record, indicated the resident was initially admitted to the facility on [DATE], with diagnoses which included fracture (break) of right wrist and hand, bradycardia (slow heart rate), and difficulty walking. Resident 31's History and Physical, dated April 13, 2025, indicated Resident 31 had the capacity to understand and make decisions. Resident 31's Minimum Data Set (MDS - a resident assessment tool), indicated Resident 31 had a BIMS score of 15 (cognitively intact). A review of Resident 31's Medication Administration Record, indicated a physician's order which indicated, Sodium Chloride Oral Tablet (Sodium Chloride) Give 0.5 tablet by mouth three times a day for hyponatremia (low sodium levels) by mouth three times a day. On May 1, 2025, at 2:33 p.m., during a concurrent interview and record review with LVN 3. LVN 3 acknowledged she did not verify the resident before administering the medication to Resident 31. LVN 3 stated the facility's process was for the licensed nurse to check every single resident identification by confirming the name and date of birth of the resident before she administers the medication to make sure she did not give the medication to the wrong resident. On May 1, 2025, at 3:39 p.m., during an interview with the DON, the DON stated her expectation was licensed staff nurses was to identify resident typically with their identification wrist band to verify they have the right resident. The DON stated licensed nurses was expected to follow the medication administration guidelines and verify all residents prior to administration. The DON further stated some consequences was the possibility of adverse reactions, abnormal vitals signs, hospitalization depending on reactions or even death. On May 1, 2025, at 4:20 p.m., during an interview with LVN 4, LVN 4 stated the facility's process during medication administration was the licensed nurse introduced themselves and verify the resident by their wrist band and/or ask the resident their name and date of birth. LVN 4 stated residents change rooms all the time and the outside name plaque on the door may not be updated. LVN 4 stated the licensed nurse need to verify the resident to prevent administering the wrong medicine to the wrong patient. LVN 4 further stated if you do not verify the resident and give the wrong medicine to a resident there was a possibility of an allergic reaction or possible death. A review of the facility's policy and procedure titled, Administering Medications, revised April 2019, indicated . Medications are administered in a safe and timely manner, and as prescribed .The individual administering medications verifies the resident's identity before giving the resident his/her medications .Methods of identifying .include .a. Checking identification band .The individual administering the medication check the label THREE (3) times to verify the right resident .before giving the medication . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a medication pass observation on May 1, 2025, 08:06 a.m., with LVN 3, LVN 3 was observed not providing privacy during medication administration to Resident 161. Resident 161's record was reviewed. Resident 161's Admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which included fracture (break) of left femur (thigh bone), difficulty walking, diabetes (too much sugar in the blood), and hypertension (high blood pressure). Resident 161's MDS, dated [DATE], indicated Resident 161 had a BIMS score of 13 (cognitively intact). On May 1, 2025, at 2:43 p.m., during a concurrent interview and record review with LVN 3. LVN 3 acknowledged she did not provide privacy while administering medications to Resident 161. LVN 3 stated she should always provide privacy and dignity when administering medication because it was their right. LVN 3 stated she should have pulled the curtain or closed the door when administering Resident 161 medications. On May 1, 2025, at 3:52 p.m., during an interview with the DON, the DON stated resident the licensed nurse should have provided privacy when administering medications to the resident. The DON stated staff should have pulled the curtain or closed the door. On May 1, 2025, at 5:51 p.m., during a follow-up interview with the DON, the DON stated residents needed privacy during medication administration. The DON also stated the resident could feel embarrassed or exposed. The DON further stated the expectation was licensed staff should provide privacy for the resident during medication administration. A review of the facility's policy and procedure titled, Dignity, revised February 2021, indicated, .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being .Residents are treated with dignity and respect at all times Staff promote, maintain and protect resident privacy, including bodily privacy .during treatment procedures

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to provide appropriate care and treatment to manage contractures, for one of one resident reviewed for range of motion (ROM-the full movement potential of a joint) (Resident 10). This failure had the potential for Resident 10 to have further worsening of the feet contractures and contribute to pain and discomfort. Findings: On April 30, 2025, at 9:47 a.m., Resident 10 was observed laying on her bed with both feet extended in a downward position. Resident 10 was wearing soft blue foam heel pads to cover the ankles. On April 30, 2025, at 9:41 a.m., during an interview with Certified Nursing Assistant (CNA) 2, she stated Resident 10 had the foot drop for a long time already. CNA 2 stated they only put heel pads to protect her from skin breakdown. On April 30, 2025, at 10:35 a.m., during an interview with Certified Restorative Nursing Assistant (CRNA) 1, CRNA 1 stated she would provide ROM exercises to the residents after she received the order from the licensed nurse or rehab staff. CRNA 1 stated there was no order for ROM exercises for Resident 10, so she did not provide any ROM treatment/exercises to the resident. CRNA 1 stated Resident 10 had contractures on her feet and should have been included in the list for RNA exercises. On April 30, 2025, Resident 10's record was reviewed. Resident 10 was admitted to the facility on [DATE], with diagnoses which included cerebral infarction (disrupted blood flow to the brain). A review of Resident 10's History and Physical, dated December 17, 2023, indicated Resident 10 can make needs known but cannot make medical decisions. A review of Resident 10's REHAB: JOINT MOBILITY ASSESSMENT (assessment tool evaluating the range and quality of movement at a joint), dated August 2, 2023, and February 11, 2025, indicated Resident 10 had severe joint immobility on both ankles. A review of Resident 10's Physical Therapy PT Discharge Summary, dated January 9, 2024, indicated, . Discharge Instructions .RNA program (program to restore care, helps patient to regain or maintain functional abilities) for ROM . A review of Resident 10's Progress Notes, from a physician's follow up appointment dated August 26, 2024, indicated Resident 10 had contracture on both feet. A review of Resident 10's Minimum Data Set (MDS - a tool for assessment), dated February 10, 2025, indicated Resident 10 had impairment on both sides of lower extremities (part of the body that includes hip, knee, ankle, foot). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 30, 2025, at 3:47 p.m., during a concurrent interview and record review with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 10 had both feet contracted and were using a heel pad to protect the heels from skin breakdown. LVN 1 stated there was no indicated physician order that would maintain or prevent further contractures of Resident 10's feet. LVN 1 further stated Resident 10 should have been referred to the physical therapist for a device and a therapy program to prevent further contractures and to prevent foot drop. On April 30, 2025, at 4:33 p.m., during an interview with the Director of Nursing (DON), the DON stated she expected the nurses and the rehabilitation therapists to follow the facility's policy and procedure to address residents contractures. The DON further stated Resident 10 should have been placed in the contracture management program and should have received device that prevent further worsening of the contractures. On May 1, 2025, at 3:20 p.m., during an interview with the Physical Therapist (PT), the PT stated Resident 10 condition was called ankle dorsiflex contracture (joint was limited in its ability to bend upward) and the resident was not wearing a proper device to manage or maintain the structure of the joints. The PT stated Resident 10 should have been recommended to wear a device to maintain the proper alignment of the joints. The PT stated Resident 10 should have received the proper contracture management and should have been picked up for rehab therapy and continue RNA maintenance program to avoid further decline of joint contractures and possible foot drop. The PT further stated, She would be a good candidate. A review of the facility's policy and procedure titled, Resident Mobility and Range of Motion, dated July 2017, indicated, .Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM .Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility . A review of the facility's policy and procedure titled, Restorative Nursing Program, dated May 2023, indicated, .It is the policy to assist each and every resident to achieve the highest level of self-care possible. The concept of self-care is an integral part of the daily nursing care and includes at least the following . Proper positioning and body alignment .passive range of motion exercises .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49113 Based on observation, interview, and record review, the facility failed to ensure sufficient staff were provided to meet the needs of the residents when: 1. For five of 55 residents (Residents 55, 48, 31, 163, and) complained that staff failed to assist with activities of daily living (ADL- daily care activities) in a timely manner; and 2. The facility did not meet the required minimum of Actual Total CNA Direct Care Service Hours the actual CNA DHPPD of 2.4 hours for the month of March 2025, for 16 out of 31 days reviewed, and for the month of April 2025, for 11 out 30 days reviewed. These deficient practices caused feelings of frustrations and anger, among the residents, and negatively affected the quality of care for the residents. Findings: 1a. On April 29, 2025, at 11:09 a.m., during an interview with Resident 55, Resident 55 stated he was sliding off his bed and used his call light and yelled out for the nurse aound late night of April 24, 2025. Resident 55 stated he yelled out for over 15 to 20 minutes, and no staff came. Resident 55 stated his roommate got up and pulled his call light and the staff still did not come. Resident 55's record was reviewed. Resident 55's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses which included fusion of the spine (procedure joining two or more vertebrae of the spine), cauda equina syndrome (damaged to bundle of nerves at the end of the spinal cord), and difficulty walking. Resident 55's Minimum Data Set, (MDS - a resident assessment tool), dated April 18, 2025, indicated Resident 55 had a BIMS (Brief Interview for Mental Status) score of 13 (cognitively intact). 1b. On April 29, 2025, at 10:34 a.m. during an interview with Resident 48, he acknowledged and confirmed that Resident 55 waited for his call light too long. Resident 48 stated he used his call light and staff never came. Resident 48 stated he had to go to the nurse station to get help. Resident 48 stated his light was on for at least 20 minutes. Resident 48 also stated staff would take forever to answer the call light and it happened more than once and sometimes the wait was over 30 minutes. Resident 48's record was reviewed. Resident 48's Admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which included disorders of kidney and ureter (problems filtering urine), pulmonary nodule (mass in the lungs), muscle wasting and difficulty walking. Resident 48's MDS, dated [DATE], indicated Resident 48 had a BIMS score of 15 (cognitively intact) and uses a wheelchair as primary mode of locomotion. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1c. On April 30, 2025, at 1:37 p.m., during an interview with Resident 31, Resident 31 stated staff would take a long time to answer the call light about over 30 minutes. Resident 31 stated it was mostly in the evening that the staff would respond to the call light. Resident 31's record was reviewed. Resident 31's Admission Record indicated the resident was initially admitted to the facility on [DATE], with diagnoses which included a fracture (break) of right wrist and hand, bradycardia (slow heart rate), and difficulty walking. Resident 31's History and Physical, dated April 13, 2025, indicated Resident 31 had the capacity to understand and make decisions. Resident 31's MDS, dated [DATE], indicated Resident 31 had a BIMS score of 15 (cognitively intact). 1d. On May 2, 2025, at 3:43 p.m. during an interview with Resident 163, Resident 163 stated the staff does not look at the call light. Resident 163 stated she waited up to an hour at night waiting for pain medicine. Resident 163 stated she was wet and waited for over 30 minutes. Resident 163's record was reviewed. Resident 163's Admission Record, indicated the resident was initially admitted to the facility on [DATE], with diagnoses which included saddle embolus of pulmonary artery (condition where large blood clot lodges in main lung artery), muscle wasting, and difficulty walking, Resident 163's History and Physical, dated April 13, 2025, indicated Resident 163 had the capacity to make medical decisions. Resident 163's MDS, dated [DATE], indicated Resident 163 had a BIMS score of 15 (cognitively intact). 1e. On May 2, 2025, at 3:51 p.m., during an interview with Resident 162, Resident 162 stated it would take staff over an hour to answer the call light. Resident 162 stated she was left soiled and wet. Resident 162's record was reviewed. Resident 162's Admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which included respiratory failure with hypoxia (lungs not able to deliver enough oxygen), congestive heart failure (heart does not pump blood well), difficulty walking, obesity (too much body fat), and muscle wasting. Resident 162's MDS, dated [DATE], indicated Resident 162 had a BIMS score of 13 (cognitively intact) and required assistance with bathing, dressing, and using the toilet. 2. On May 2, 2025, at 11:22 a.m., a concurrent interview and record review of the facility's Census and Direct Care Service Hours Per Patient Day, (DHPPD - measures the number of hours of direct care given to patients in skilled nursing facilities) with the Director of Staff Development (DSD) was conducted. The DSD acknowledged and confirmed records for multiple days in March 2025, and April 2025, indicated the Actual Total CNA Direct Care Service Hours were below the required minimum of 2.4 hours for 16 of the 31 days reviewed for March 2025, and eleven (11) of 30 days reviewed for April 2025. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Actual Total DCSH hours were below 2.4 hours (hrs,) on the following dates: - March 1, 2025 (Saturday): 2.3 hrs. (CNA DCSH); - March 3, 2025 (Monday): 2.31 hrs. (CNA DCSH); - March 9, 2025 (Sunday): 2.29 hrs. (CNA DCSH); - March 10, 2025 (Monday): 2.39 hrs. (CNA DCSH); - March 15, 2025, (Saturday): 2.38 hrs. (CNA DCSH); - March 16, 2025 (Sunday): 2.10 hrs. (CNA DCSH); - March 17, 2025 (Monday): 2.34 hrs. (CNA DCSH); - March 18, 2025 (Tuesday): 2.38 hrs. (CNA DCSH); - March 19, 2025 (Wednesday): 2.39 hrs. (CNA DCSH); - March 21, 2025 (Friday): 2.30 hrs. (CNA DCSH); - March 22, 2025 (Saturday): 2.34 hrs. (CNA DCSH); - March 23, 2025 (Sunday): 2.28 hrs. (CNA DCSH); - March 24, 2025 (Monday): 2.24 hrs. (CNA DCSH); - March 29, 2025 (Saturday): 1.96 hrs. (CNA DCSH) - March 30, 2025 (Sunday): 2.30 hrs. (CNA DCSH); - March 31, 2025 (Monday): 2.21 hrs. (CNA DCSH). - April 5, 2025 (Saturday): 2.33 hrs. (CNA DCSH); - April 6, 2025 (Sunday): 2.11 hrs. (CNA DCSH); - April 7, 2025 (Monday): 2.34 hrs. (CNA DCSH); - April 9, 2025 (Wednesday): 2.32 hrs. (CNA DCSH); - April 11, 2025, (Friday): 2.37 hrs. (CNA DCSH); - April 12, 2025 (Saturday): 2.28 hrs. (CNA DCSH); - April 13, 2025 (Sunday): 2.30 hrs. (CNA DCSH); (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- April 15, 2025 (Tuesday): 2.39 hrs. (CNA DCSH); - April 19, 2025 (Saturday): 2.18 hrs. (CNA DCSH); - April 20, 2025 (Sunday): 2.24 hrs. (CNA DCSH) and - April 28, 2025 (Monday): 2.36 hrs. (CNA DCSH). On May 5, 2025, at 2:27 p.m., during an interview with the DSD, the DSD stated normally there should be seven CNAs and one Restorative Nurse Assistant (RNA) on the day (AM - 6:30 a.m. to 2:30 p.m.) shift, six CNAs on the PM (2:30 p.m. to 10:30 p.m.) shift and four CNAs on the Night (NOC - 10:30 p.m. to 6:30 a.m.). A concurrent record review and interview with the DSD of the Nursing Staffing Assignment and Sign-In Sheet, for the mentioned dates indicated CNA staffing was not met according to Facility Assessment Projections. Facility CNA staffing was less than projected number per shift on the following dates: - March 1, 2025 (Saturday): AM shift - 6 CNAs (9 residents each); PM shift 5 CNAs (11 residents each); - March 3, 2025 (Monday): AM shift - PM shift 5 CNAs (11 residents each); - March 5, 2025 (Wednesday): AM shift - 6 CNAs (9 residents each); - March 10, 2025 (Monday): PM shift 5 CNA's (11 residents each); - March 16, 2025 (Sunday): PM shift 4 CNAs (14 residents each); - March 17, 2025 (Monday): AM shift 6 CNAs (9 residents each); PM shift 5 CNAs (11 residents each); - March 18, 2025 (Sunday): AM shift 6 CNAs (9 residents each); NOC shift 3 CNAs (18 residents each); - March 21, 2025 (Friday): AM shift 6 CNAs (10 residents each); - March 22, 2025 (Saturday): PM shift 5 CNAs (11 residents each); - March 24, 2025 (Monday): AM shift 6 CNAs (10 residents each); PM shift 4 CNAs (14 residents each); - March 29, 2025 (Saturday): AM shift 5 CNAs (11 residents each); PM shift 5 CNAs- 11 residents each; - March 30, 2025 (Sunday): AM shift 7 CNAs -8 residents each; PM shift 5 CNAs- 11 residents each; NOC shift 4 CNAs -14 residents each and - March 31, 2025 (Sunday): AM shift 6 CNAs (9 residents each); PM shift 5 CNAs (11 residents each); (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- April 5, 2025 (Saturday): AM shift 5 CNAs (11 residents each); PM shift 5 CNAs (11 residents each); NOC shift 3 CNAs (18 residents each); - April 6, 2025 (Sunday): AM shift 5 CNAs (11 residents each); - April 7, 2025 (Monday): AM shift 6 CNAs (9 residents each); PM shift 5 CNAs (11residents each); - April 9, 2025 (Wednesday): PM shift 5 CNAs (11 residents each); - April 11, 2025 (Friday): AM shift 6 CNAs (9 residents each); PM shift 5 CNAs (11 residents each); - April 12, 2025 (Saturday): AM shift 6 CNAs (9 residents each); PM shift 5 CNAs (11 residents each); - April 13, 2025 (Sunday): AM shift 6 CNAs (9 residents each); - April 15, 2025 (Tuesday): AM shift 6 CNAs (9 residents each; PM shift 5 CNAs (11 residents each); - April 19, 2025 (Saturday): AM shift 6 CNAs (9 residents each); PM shift 4 CNAs (13 residents each); NOC shift 3 CNAs (17 residents each). - April 20, 2025 (Sunday): PM shift 5 CNAs (10 residents each); NOC shift 3 CNAs (17 residents each); and - April 28, 2025 (Monday): AM shift 6 CNAs (9 residents each); PM shift 5 CNAs (10 residents each); NOC shift 3 CNAs (13 residents each). The facility did not meet the expected assigned number of staffing ratio for CNA's as indicated in the Facility Assessment Projections, for staff ratio on the following dates: - March 18, 2025 (Sunday): NOC shift 3 CNAs -18 residents - April 5, 2025 (Saturday): NOC shift 3 CNAs -18 residents each. - April 19, 2025 (Saturday): NOC shift 3 CNAs -17 residents each. - April 20, 2025 (Sunday): NOC shift 3 CNAs -17 residents each and - April 28, 2025 (Monday): NOC shift 3 CNAs -13 residents each. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On May 2, 2025, at 3:01 p.m. during an interview with the DSD, the DSD stated it was hard for 3 CNAs to cover 17 residents on a shift where indicated. The DSD stated the Actual Total CNA Direct Care Service Hours were not met on documented dates reviewed. The DSD also stated it was not enough CNAs to provide residents safe, efficient, and adequate care. The DSD stated it was a higher risk for resident falls and residents not getting help to the restrooms. The DSD also stated low staffing affects resident falls and she was working on staffing for the NOC shift. The DSD stated her expectation was to meet the correct number of staffing to provide adequate care for residents to meet their needs. The DSD further stated based on the numbers outlined staffing care was not adequate and she addressed the concern with administration. On May 2, 2025, at 6:22 p.m. during a concurrent interview and record review with the Director of Nursing (DON), the DON stated call lights should be answered. The DON stated all staff were responsible for answering the call lights. The DON stated the concern was a potential for falls and her expectation was that staff answer call lights timely. The DON further stated the Actual Total CNA Direct Are Service Hours were not met on documented dates reviewed and should be 2.4 hours and above. The DON also stated not having the required hours met, meant less staff available to provide care. The DON stated with delays care could be affected. The DON further stated some possible concerns were impaired skin integrity if residents were left soiled in urine and a potential for falls. The DON stated her expectation was staff provide adequate care. The DON stated based on the dates reviewed the facility was not able to meet the required DHPPD hours for the CNAs. A review of the facility's policy and procedure titled, Certified Nursing Assistant, indicated, .The primary purpose of this position is to provide residents with routine daily nursing care and services in accordance with the resident's assessment and care plan and as directed by supervisor .Assist residents in accordance to their needs ranging from minimal assistance to total dependent care on activities of daily living (ADLs). A review of the facility's policy and procedure titled, Staffing, dated October 2017, indicated, .Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all resident in accordance with resident care plans and the facility assessment . A review of the facility's policy and procedure titled, Answering the Call Light, dated September 2022, indicated, .The purpose of this procedure is to ensure timely responses to the resident's requests ans needs . Answer the resident call system immediately .If the resident needs assistance, indicate the approcimate time it will take for you to respond .

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to ensure, for one of one resident reviewed for dental (Resident 22), a dental consultation was provided for the resident. This failure had the potential to result in Resident 23 not receiving the dental services needed to maintain her highest practicable level of well-being. Findings: On April 29, 2025, at 4:07 p.m., Resident 22 was observed missing some upper and lower teeth. In a concurrent interview with Resident 22, he stated he could chew well, I don't have postiza (denture- artificial teeth), and had not seen the dentist. On May 1, 2025, Resident 22's record was reviewed. Resident 22 was admitted to the facility on [DATE], with diagnoses which included dysphagia (difficulty in swallowing). A review of Resident 22's Order Summary, included the following physician's order: - Dental Health Services as needed, date ordered July 3, 2021; and - .Dysphagia Mechanical Soft Texture (texture of food to make them easier to chew and swallow) ., date ordered February 5, 2025. A review of Resident 22's Dental Hygiene Progress notes, dated November 18, 2024, indicated Resident 22 had no dentures and was edentulous (no teeth). A review of Resident 22's Minimum Data Set (MDS - a resident assessment tool), dated May January 23, 2025, indicated Resident 22 had a BIMS (Brief Interview for Mental Status - a tool used to assess cognition) score of 05 which indicated severe cognitive impairment. On May 1, 2025, at 10:25 a.m., during a concurrent interview and record review with the Social Service Director (SSD), the SSD stated there was no documentation Resident 22 was seen by the dentist since last year. The SSD stated Resident 22 should have been seen by the dentist. The SSD further stated Resident 22 would not be able to eat properly and could lead to weight loss if Resident 22 would not provide dental services. On May 1, 2025, at 3:35 p.m., the Director of Nursing (DON) was interviewed. The DON stated she expected the nurses and SSD to follow facility's policy and procedure for dental services. The DON stated the resident should have been seen by the dentist. The DON further stated Resident 22 had the potential not to eat the food and could lead to weight loss if dental issues would not be addressed. A review of the facility's policy and procedure titled, Dental Services, dated December 2016, indicated, . Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care .Social services representatives will assists residents with appointments, transportation arrangements .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47374 Based on observation, interview, and record review, the facility failed to store, prepare, and serve foods under safe and sanitary conditions when the staff placed a four-ounce (unit of measurement) soup ladle directly on the table instead of the clean container in between serving of the soup for the residents, for . This failure had the potential to put the vulnerable residents at risk for foodborne illnesses. Findings: On April 29, 2025, at 12:15 p.m., during the dining room observation, the Certified Restorative Nurse Assistant (CRNA) was observed to use the four-ounce ladle to serve soup into a bowl and then placed the ladle on the tablecloth instead of the clean container. On April 29, 2025, at 12:25 p.m., an interview with the CRNA was conducted. The CRNA stated she placed the ladle on the tablecloth in between serving of the soup to the residents. The CRNA stated she had been trained to place the used soup ladle on the clean tray. The CRNA further stated she should not have placed the ladle on the tablecloth as it might cause cross-contamination and illness in the residents. On April 29, 2025, at 12:55 p.m., an interview with the Director of Food and Dietary (DND) was conducted. The DND stated the CRNA had been trained in how to serve the crockpot soup of the day by the DND and the ladle should not have been placed on the table in between serving residents. The DND further stated the concern of illness for residents from the risk of cross-contamination was possible.

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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** 40000 Based on observation, interview, and record review, the facility failed to ensure resident's information was protected from unauthorized use, for one of five residents observed during medication administration (Resident 161), when the electronic health record of Resident 161 was left open and unattended by the licensed nurse. This failure had the potential for Resident 161's record to be disclosed to other people not authorized in the provision of care and treatment. Findings: On May 1, 2025, 08:06 a.m., during a medication pass observation with Licensed Vocational Nurse (LVN) 3, LVN 3 was observed to leave the computer open and unattended with Resident 161's resident information viewable to persons not directly related to the resident's care. Resident 161's record was reviewed. Resident 161's Admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which included fracture (break) of left femur (thigh bone), difficulty walking, diabetes (too much sugar in the blood), and hypertension (high blood pressure). Resident 161's Minimum Data Set (MDS - a resident assessment tool), dated May 3, 2025, indicated Resident 161 had a BIMS (Brief Interview of Mental Status) score of 13 (cognitively intact). On May 1, 2025, at 2:35 p.m., during a concurrent interview and record review with LVN 3, LVN 3 acknowledged she left the computer open and unattended which was a Health Insurance Portability and Accountability Act (HIPPA - law to protect patient sensitive health information) violation. LVN 3 stated the facility's policy was for the staff to close or lock the computer monitor when leaving the medication cart. LVN 3 stated she should have closed her laptop. LVN 3 further stated there was a possibility resident information could get stolen, which violates the resident's privacy. On May 1, 2025, at 3:44 p.m., during an interview with the Director of Nursing (DON), the DON stated her expectation staff should lock their screen before going into a patient room. Stated the concern was a violation of HIPPA. The DON also stated resident information was risk and available to person who was not involved with Resident 161's care. The DON further stated the expectation was for the resident's personal information and health information to be maintained. A review of the facility's undated policy and procedure titled, HIPPA COMPLIANCE, indicated, .It is the intent of the facility to adhere to the Omnibus Health Insurance Portability and Accountability Act (HIPPA) Privacy, Security, Enforcement and Breach Notification Rules .It is our intent to assure that policies, procedures and practices are developed, implemented, staff trained breaches avoided and compliance monitored . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Dignity, revised February 2021, indicated, .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being .and feelings of self-worth and self-esteem .Staff protect confidential clinical information .Staff promote, maintain and protect resident privacy, including bodily privacy .during treatment procedures .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when: 1. Two used diapers were found on top of resident cabinet drawer in room [ROOM NUMBER]; 2. One direct care staff was observed wearing long artificial finger nails while providing care to the residents; 3. The Certified Restorative Nursing Assistant (CRNA) did not wear personal protective equipment (PPE-equipment used to protect against infection or illness) when providing care to a resident with an active of Methicillin-Resistant Staphylococcus Aureus (MRSA - a bacteria resistant to many antibiotics [medication used to treat infections]) wound infection; 4. The CRNA did not clean and disinfect (use of chemicals to reduce the number of germs or virus particles on surfaces) the Hoyer lift (mechanical device use for lifting) after resident use; 5. The CRNA did not conduct proper handwashing after providing care to a resident with active infections of MRSA of the wound; and 6. The Certified Nursing Assistant (CNA) was observed not wearing a mask during resident care while exhibiting cold symptoms. These failures had the potential to increase the spread of pathogens (germs) and infections from staff to residents which could lead to serious illness. Findings: 1. On April 29, 2025, at 9:38 a.m., during a concurrent observation and interview with Licensed Vocational Nurse (LVN) 3, two used white diapers were found on top of the resident cabinet drawer in room [ROOM NUMBER]. LVN 3 stated used diapers should have been tossed into the trash bin and should have not been placed on top of the resident's cabinet drawer. LVN 3 further stated soiled diapers would contaminate the surface of the cabinet and would cause spread of germs and infection. On May 1, 2025, at 2:58 p.m., an interview was conducted with the Infection Preventionist (IP). The IP stated all soiled materials such as diapers should have been placed in the trash bins. The IP stated soiled diapers would contaminate the surface and would spread infections. On May 1, 2025, at 4:53 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated she expected all nurses to follow the facility's policy and procedure for infection control program. The DON stated soiled materials such as diapers should have been discarded to prevent contamination and spread of infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, Infection Prevention and Control Program, dated October 2018, indicated, .An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections . 2. On April 29, 2025, at 10:57 a.m., an observation was conducted with the Director of Staff Development (DSD). The DSD was observed to have long artificial nails when providing care to the residents. On April 29, 2025, at 11:35 a.m., an interview was conducted with the DSD. The DSD stated she was involved in the care of residents and I am considered as direct care staff handling residents. The DSD stated she was capable of helping residents in their care, passing food trays in residents' rooms, oral care, and helping to feed residents. The DSD stated that she had artificial nails made of acrylic, that were attached and extended to her natural fingernails (DSD's finger nails were measured to be approximately 1.8 centimeter in length from the tip of the fingers). The DSD further stated long artificial nails should have not been worn because it could harbor germs underneath the artificial nails and would spread germs and infection. On May 1, 2025, at 2:58 p.m., an interview was conducted with the IP. The IP stated the facility's policy indicated nails must have appropriate length, and the nails should not be too long specially for direct care staff. The IP further stated if staff had long nails, these could potentially scratch the skin of the residents, which could lead to skin breakdown and cause infection. According to the web article titled, Guideline for Hand Hygiene in Health-care Settings published by the Centers for Disease Control and Prevention (CDC - a leading national public health institute in the United States), dated 2002, iindicated, .even after careful handwashing, HCWs (health care workers) often harbor substantial numbers of potential pathogens (disease causing viruses, fungi, and bacteria) in the subungual (under the nails) spaces .HCWs who wear artificial nails are more likely to harbor gram-negative pathogens on their fingertips than those who have natural nails, both before and after handwashing . According to the web article titled, WHO (World Health Organization) Guidelines on Hand Hygiene in Health Care, published by the World Health Organization in 2009, indicated .Long, sharp fingernails, either natural or artificial, can puncture gloves easily .Each health-care facility should develop policies on the wearing of . artificial fingernails or nail polish by HCWs. These policies should take into account the risks of transmission of infection to patients .recommendations are that HCWs do not wear artificial fingernails or extenders when having direct contact with patients . A review of the facility's policy and procedure titled, Handwashing/Hand Hygiene, dated August 2019, indicated, .Wearing artificial fingernails is strongly discouraged among staff members with direct resident-care responsibilities, and is prohibited among those caring for severely ill or immunocompromised residents .The Infection Preventionist maintains the right to request the removal of artificial fingernails at any time if he or she determines that they present an unusual infection control risk . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On April 30, 2025, at 9:20 a.m., Resident 33's room was observed to have a sign by the door indicating instructions to wear appropriate PPE (gown and gloves) before entering the room. The CRNA was observed entering Resident 33's room and provided care to the resident who was in the bathroom without wearing a gown. In a concurrent interview with the CRNA, she stated she forgot to wear PPE. The CRNA further stated she should have worn PPE when she provided care to Resident 33 to prevent the spread of germs and protect the other residents from infection. A review of Resident 33's Order Summary, indicated the following: - .Isolation with .CONTACT precautions related to MRSA/WOUND . date ordered April 28, 2025; and - .EBP .Enhanced Barrier Precautions due to (High contact resident care activities with colonized or infected MDRO (multidrug-resistant organisms), increased risk of MDRO acquisition due to presence of wounds or indwelling medical devices ., date ordered April 29, 2025. On May 1, 2025, at 3:06 p.m., during an interview with the IP, the IP stated Resident 33 had a history of MDRO and had active infection of the wound and was placed on enhanced barrier precaution. The IP further stated the CRNA should have worn PPE before providing care to Resident 33 to prevent the spread of infection to other residents. A review of the facility's policy and procedure titled, Personal Protective Equipment, dated October 2018, indicated, .Personal protective equipment appropriate to specific task requirements is available at all times . The type of PPE required for a task is based on .The type of transmission-based precaution . A review of the facility's policy and procedure titled, Enhanced Barrier Precautions, dated June 2024, indicated, .To provide guidance and recommendations for implementing Enhanced Barrier Precautions (EBP) to include the use of glove and gown during high-contact care activities for residents .High-Contact Resident Care Activities include activities such as .Changing briefs or assisting with toileting . 4. On April 30, 2025, at 9:27 a.m., during a concurrent observation and interview with the CRNA, the CRNA was observed coming out of Resident 33's room with the Hoyer lift. The CRNA used the Hoyer lift to transfer Resident 33 to her bed. The CRNA transported the Hoyer lift into the facility hallway then parked the Hoyer lift to the corner of the facility's dining room and did not clean or disinfect the Hoyer lift. The CRNA further stated, I forgot to disinfect the Hoyer lift, and she should have cleaned and disinfected the Hoyer lift to prevent the spread of infection to other residents who will use it. On May 1, 2025, at 3:06 p.m., during an interview with the IP, the IP stated Resident 33 was on enhanced barrier precaution for MRSA of the wound. The IP stated the CRNA should have disinfected or sanitized all medical equipment such as the Hoyer lift before and after use between residents. A review of the facility's policy and procedure titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated October 2018, indicated, .Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA (occupational safety and health administration) Bloodborne Pathogens Standard . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On April 30, 2025, at 9:35 a.m., during concurrent observation and interview with the CRNA, the CRNA was observed providing care in the bathroom to Resident 33 and did not perform hand hygiene after care. The CRNA stated, I forgot to wash my hands. The CRNA further stated she should wash her hands after providing care to the residents to prevent the spread of infection. On May 1, 2025, at 3:06 p.m., the IP was interviewed. The IP stated, staff should wash their hands before and after providing care procedure. The IP further stated infection could spread if staff did not wash hands. A review of the facility's policy and procedure titled, Handwashing/Hand Hygiene, dated August 2019, indicated, .This facility considers hand hygiene the primary means to prevent the spread of infections .All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . 49113 6. On April 29, 2025, at 3:23 p.m., during an observation, Resident 5 was observed lying in a geri-chair (geriatric chair - a specialized cushioned and reclineable chair) being assisted to her room by CNA 5 . CNA 5 was observed sniffling (drawing air through nose to keep mucus from running) with a runny nose and was not wearing a mask. A review of Resident 5's record indicated, Resident 5 was admitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease (lung diseases that block airflow makes it difficult to breathe) and diabetes mellitus (too much sugar in the blood). A review of Resident 5's History and Physical, dated November 25, 2024, indicated Resident 5 was dependent on supplemental oxygen. A review of Resident 5's Minimum Data Set (MDS- assessment tool), indicated Resident 5 had a BIMS (Brief Interview for Mental Status) score of 10 (moderate cognitive impairment). On April 29, 2025, at 3:29 p.m., during a concurrent observation and interview with CNA 5, CNA 5 was observed to be sniffling with a runny nose. CNA 5 stated she started feeling sick about 1 1/2 hours ago. CNA 5 stated she did not report to her supervisor she was ill. CNA 5 stated she should have put on a mask while providing care to the residents. CNA 5 further stated she could possibly get the residents sick and that was critical for the vulnerable residents. On April 30, 2025, at 4:01 p.m., during an interview with the Director of Staff Development (DSD), the DSD stated if staff become sick while on duty, they should notify DSD, their direct Charge Nurse (CN) or the Infection Preventionist (IP) so symptoms could be verified. The DSD stated staff would be sent home if they are sick. The DSD stated staff should not have worked sick without using a mask. The DSD also stated the risk of staff working while sick was the possibility to expose and spread infection to residents and other staff. The DSD further stated there was a high risk of vulnerable residents to further decline. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On April 30, 2025, at 4:17 p.m., during an interview with the DON, the DON stated the facility process was staff should let the IP and immediate supervisor know they were sick. The DON stated if staff was exhibiting symptoms of a runny nose and sniffling staff should have worn a mask. The DON stated if staff report they are ill with a runny nose and still worked they should wear a mask. The DON also stated symptoms should be contained to protect others. The DON further stated the concerns of staff not wearing a mask was the possibility of spreading infection or worse to others. A review of the facility's policy and procedure titled, Employee Infection and Vaccination Status, revised August 2013, indicated, .Reportable Conditions .Employees must report the following conditions to the Infection Preventionist (or designee) .Acute Respiratory Infection (URI) or influenza .The Medical Director and Infection Preventionist will collaborate to determine the significance of any employee health condition in relation to job responsibility and the employees' restrictions regarding direct resident contact .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 50204 Based on observation, interview, and record review, the facility failed to ensure heater equipment in the resident's room was maintained in a safe operating condition, for one of 55 residents (Resident 52), when one baseboard heater cover was observed open, detached and laying on the floor. This failure had the potential to cause a fire and hazardous environment for the residents, staff and visitors. Findings: 1. On April 29, 2025, at 2:30 p.m., during a concurrent observation and interview with Resident 52 inside her room, Resident 52 was observed sitting in a wheelchair looking at the baseboard heater below the window panel. The baseboard heater cover was observed open and detached and laying on the floor. Resident 52 stated her she could feel the warm breeze directly coming from the baseboard heater. Resident 52 stated she could not pass directly because she was afraid that she might burn from the heater. On April 29, 2025, at 2:43 p.m., an interview was conducted with the Maintenance Supervisor (MS). The MS stated the baseboard heater cover was damaged and was detached from the main base of the heater. The MS stated the baseboard cover of the heater should have been fixed to prevent further damage and prevent someone getting burned. The MS further stated, It should have been repaired as soon as possible. On April 29, 2025, at 2:50 p.m., an interview was conducted with the Administrator (ADM). The ADM stated he expected the maintenance staff to repair any damaged devices and make sure residents and staff were free from hazards. The ADM further stated any broken equipment should have been repaired to provide a safe and functional environment for the residents. A review of the facility's policy and procedure titled, Maintenance Service, dated December 2009, indicated, . Maintenance service shall be provided to all areas of the building, grounds, and equipment .The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times .Functions of maintenance personnel include .Maintaining the building in a compliance with current federal, state, and local laws, regulations, and guidelines .Maintaining the building in good repair and free from hazards .maintaining the heat/cooling system .in good working order .Maintenance personnel shall follow established safely regulations to ensure that safety and well-being of all concerned .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 50204 Based on observation, interview, and record review, the facility failed to provide a safe, functional and comfortable environment, when the lint trap of dryer 3 was observed damaged and the lint trap was not cleaned. This failure to maintain a functional environment had the potential to compromise resident safety. Findings: On May 2, 2025, at 9:24 a.m., during a concurrent observation and interview with the Laundry Staff (LS). The lint trap located at the bottom of dryer 3 was observed damaged with an opening at the corner towards the middle of the edge of the screen and filled with thick, soft lint that was collected from the clothes. The LS stated lint trap in dryer 3 was damaged and laundry staff still used it. The LS stated the lint trap was not collected since yesterday and was not cleaned by the laundry staff. The LS further stated the lint trap should have been cleaned and the damaged lint trap of dryer number 3 should have not been used because it could result to fire. A review of record titled, DRYER'S LINT TRAP CLEANING LOG, indicated the lint trap was not cleaned at 12 noon of May 1, 2025 to May 2, 2025 at 8 a.m. In addition, a review of document titled, DAILY STAND UP/CLINICAL MEETING, dated April 28, 2025, indicated the dryer 3 was identified with safety concerns. On May 2, 2025, at 9:45 a.m., an interview was conducted with the Maintenance Supervisor (MS). The MS stated the lint trap of dryer 3 was torn with the screen was ripped off. The MS stated the lint trap 3 should have been fixed, replaced and should have been cleaned per facility policy to prevent hazards such as fire. The MS further stated, It should have been repaired or replaced as soon as possible. On May 2, 2025, at 9:49 a.m., an interview was conducted with the Administrator (ADM). The ADM stated he expected the maintenance staff to repair any damaged equipment and make sure they worked properly. The ADM further stated the damaged equipment should have been replaced or repaired to provide a safe and functional environment for the residents. A review of the facility's policy and procedure titled, Maintenance Service, dated December 2009, indicated, . Maintenance service shall be provided to all areas of the building, grounds, and equipment .The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times .Functions of maintenance personnel include .Maintaining the building in a compliance with current federal, state, and local laws, regulations, and guidelines .Maintaining the building in good repair and free from hazards .