STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555418	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis Healthcare Center	718 Bartlett Ave Hayward, CA 94541

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Cross Reference F607, F610 Based on interview and record review, the facility failed to report allegations of abuse involving one of 18 sampled residents (Resident 27) to the appropriate agencies including the California Department of Public Health (CDPH), within the required timeframe. This failure to report allegations of abuse placed Resident 27 at risk of further abuse. A review of Resident 27's Face Sheet (information containing contact details, brief medical history at-a-glance) indicated Resident 27 was admitted to the facility on [DATE] with diagnoses which hemiplegia and hemiparesis due to a stroke (hemiplegia means paralysis on one side of the body and hemiparesis means weakness in one side of the body).Resident 27's Minimum Data Set (MDS, a standardized assessment tool) dated 3/20/26 indicated Resident 27 had a Brief Interview for Mental Status (BIMS, an assessment tool for cognition) score of 8, which is reflective of moderate cognitive impairment (decline in one or more cognitive abilities, such as memory, attention, language, reasoning, and problem-solving).A review of Resident 27 ?s SBAR Situation, Background, Assessment, and Recommendation notes (SBAR, is a structured communication framework that can help teams share information about the condition of a resident) dated 3/21/26, indicated, Resident reported to admission coordinator during her rounds that a lady hit him on the head last night, and he would like to go home. Writer checked on resident and he said a lady punched my face and it's not the 1st time. She rushes me when I need to use the bathroom. PT denies pain, no injuries were noted and no bruising on the face.During an interview on 4/7/26 at 3:34 p.m., Resident 27 stated that a lady placed her open hand on his face then pushed his head on the bed. The resident stated this incident made him feel unsafe and angry.During an interview on 4/7/26 at 12:10 p.m. with the Director of Nursing (DON), DON stated that the facility conducted an internal investigation of the alleged abuse incident. However, the DON explained that they did not report the incident to the state agency, because the facility investigation concluded that CNA 1 was just 'rude' to Resident 27 and did not hit him on the face. The DON acknowledged that the facility might be dinged (or receive a deficiency) for failing to report the alleged abuse incident.During an interview with the Social Service Director (SSD), SSD stated that the Administrator handled the facility internal investigation. SSD also stated that the alleged abuse incident was not reported to the Ombudsman, local law enforcement agency and the state agency.During an interview on 4/9/26 at 2:13 p.m. with the Administrator (Adm), the Adm confirmed that the incident was not reported to the state agency.Review of the facility's policy, titled Abuse neglect exploitation and misappropriation prevention program dated 2001 indicated policy statement residents have the right to be free from abuse neglect misappropriation of resident property and exploitation.9. Investigate and report any allegations within timeframes required by federal requirements.10. Protect residents from any further harm during investigations.According to Code of Federal Regulation 42 CFR S483.12(c)(1):(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not report Resident 27's alleged abuse investigation results to the State Agency.This failure placed Resident 27 at risk for further harm and abuse.A review of Resident 27's Face Sheet (information containing contact details, brief medical history at-a-glance) indicated Resident 27 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis due to a stroke (hemiplegia means paralysis on one side of the body and hemiparesis means weakness in one side of the body).During a review of Resident 27's Minimum Data Set (MDS, a standardized assessment tool), dated 3/20/26, it indicated that Resident 27 had a Brief Interview for Mental Status (BIMS, an assessment tool for cognition) score of 8, reflective of moderate cognitive impairment (decline in one or more cognitive abilities, such as memory, attention, language, reasoning, and problem-solving).Resident 27?s SBAR Situation, Background, Assessment, and Recommendation notes (SBAR, is a structured communication framework that can help teams share information about the condition of a resident) dated 3/21/26 indicated, Resident reported to admission coordinator during her rounds that a lady hit him on the head last night, and he would like to go home. Writer checked on resident and he said a lady punched my face and it's not the first time. She rushes me when I want to use the bathroom. Pt denies pain, no injuries noted no bruising on the face.During an interview with Resident 27 on 4/7/26 at 3:34 p.m., Resident 27 stated that a lady placed her open hand on his face then pushed his head back toward the bed. The resident stated this incident made him feel unsafe and angry.During an interview on 4/7/26 at 12:10 p.m. with the Director of Nursing (DON), DON stated that the facility conducted an internal investigation into the alleged abuse incident. However, the DON explained they did not report the incident to the state agency because the facility investigation concluded that CNA 1 was just 'rude' to Resident 27 and did not hit him on the face. The DON acknowledged that the facility might be dinged (or receive a deficiency) for failing to report the alleged abuse incident.During a concurrent record review and interview on 4/7/26 at 1:04 p.m. with the Director of Staff Development (DSD), Employee Counseling Form (ECF) dated 3/27/26 that was addressed to Certified Nursing Assistant (CNA) 1 was reviewed. The ECF documented a verbal warning that was issued to CNA 1. The ECF also read, It has been reported that on multiple occasions, you have displayed rude and unprofessional behavior toward residents under your care. Additionally, there was a specific incident in which you were reported to have acted aggressively toward a resident (Resident 27). The DSD stated she called CNA 1 on 3/27/26 to schedule a one-on-one abuse retraining following the abuse allegation on 3/21/26. CNA 1 never returned to the facility and eventually resigned on 3/29/26.A review of the facility's Incident Investigation Report form dated 3/23/26 indicated, CNA removed from run. DSD planned Inservice, but CNA went on leave. A review of the facility's Daily Assignment Sheets (DAS), the DAS indicated that CNA 1 continued to work in the facility after the abuse allegation without the abuse Inservice. The DAS indicated that CNA 1 went back to work in the facility on 3/24/26, 3/25/26,3/26/26 and 3/27/26. The DAS also indicated that on 3/27/26, CNA 1 worked and was assigned to Resident 27's room and gave care to Resident 27's two roommates (Inservice training means mandatory, on-the-job education sessions designed to update staff on clinical skills, safety protocols, and regulatory compliance). During an interview with the Social Service Director (SSD), SSD stated that the Administrator handled the facility internal investigation. SSD also stated that the alleged abuse incident was not reported to the Ombudsman, the local law enforcement agency, or the state agency.During an interview on 4/9/26 at 2:13 p.m., with the Administrator (Adm), the Adm confirmed that the incident was not reported to the state agency.A review of the facility's policy, titled Abuse neglect exploitation and misappropriation prevention program dated 2001 indicated policy statement residents have the right to be free from abuse neglect misappropriation of resident property and exploitation.2. Develop and implement policies and protocols to prevent and identify: a. abuse or (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mistreatment of residents b. neglect of residents.9. Investigate and report any allegations within timeframes required by federal requirements.10. Protect residents from any further harm during investigations.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, for three of 18 sampled residents (Residents 37, 3 and 6), the facility failed to ensure pharmaceutical services were provided when ordered medications were not available for administration.1. For Resident 37, the physician-ordered as-needed pain medication was not available for administration. This resulted in Resident 37's inadequate pain management.2. Resident 3's physician-ordered Namenda tablet 10 mg (Memantine HCl - indicated for the treatment of moderate to severe dementia of the Alzheimer's type) was not available for administration. This failure had the potential to result in decreased therapeutic benefit and decline in overall functioning.3. Resident 6's physician-ordered Ipratropium-Albuterol Solution (medication used to help control the symptoms of lung diseases) was not available for administration. This failure had the potential to increase the risk for ineffective airway clearance and exacerbation of respiratory symptoms.1.During a review of Resident 37's admission Record (AR) dated 4/8/26, the AR indicated Resident 37 was admitted to the facility on [DATE] with diagnoses that included pneumonia (a common, often serious lung infection causing inflammation in the air sacs (alveoli), filling them with fluid or pus) and kidney cyst (a fluid-filled sac that develops on one or both kidneys, typically harmless and common with age, causes pain, blood in urine or infection). During a review of Resident 67's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 3/12/26, the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of 14. A BIMS score of 13-14 is an indication of intact cognitive status. During an interview on 4/6/26 at 12:30 p.m. with Resident 37, Resident 37 stated not receiving Norco (a narcotic pain medication) in the morning due to the facility running out of supply, and medication has not yet arrived from the pharmacy. Resident 37 stated Tylenol was provided but did not relieve the pain, which remained at 8-9 out of 10 (0 as not having pain and 10 being the worst pain). During an interview on 4/6/26 at 2:27 p.m. with Registered Nurse (RN) 1, RN 1 stated the physician ordered Norco at 11:15 a.m. and the order was sent to the pharmacy. RN 1 stated, if the medication was available in E-kit, nurses would obtain the medication from there and administer it to the resident, RN 1 could not confirm if Resident 37 was given Norco from the E-kit. During an interview on 4/6/26 at 2:33 p.m. with RN 2, RN 2 stated, sending a text message to the physician in the morning about Resident 37's Norco. RN 2 stated Resident 37 was given Ibuprofen (treats pain) for pain and routine gabapentin (a prescription anticonvulsant medication primarily used to treat nerve pain). RN 1 was unable to answer why Resident 37 was not given Norco. During a review of Resident 37's Order Listing Report (OLR) dated 4/8/26, the OLR indicated the following physician orders for pain: -Acetaminophen (Tylenol) 325 mg 2 tablets by mouth every 4 hours as needed for mild pain (1-3 out of 10) or temperature of more than 100 degrees Fahrenheit (F). -Ibuprofen oral tablet 200 mg 1 tablet by mouth every 12 hours as needed for mild to moderate pain, take with food. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Hydrocodone-Acetaminophen 5-325 mg 1 tablet by mouth every 6 hours as needed for pain. During a review of Resident 37's Medication Administration Record (MAR) for April 2026, the MAR indicated Resident 37 complained of seven out of 10 pain. Resident 37 was given Tylenol 650 mg on 4/6/26 at 6:43 a.m. for 7 out of 10 pain (moderate). During a telephone interview on 4/9/26 at 1:45 p.m. with Pharmacy Technician (PTech), PTech stated the last Norco refill request was sent by the facility on 4/6/26, the pharmacy had not received any prior refill requests. PTech stated refill requests should be sent before the medication runs out. During a review of Resident 37's Norco Controlled Drug Record (CDR) dated 3/24/26, the CDR indicated the last Norco dose was given on 4/5/26 at 10:28 p.m. During a review of the new CDR dated 4/6/26, the CDR indicated the first dose administered from the newly delivered bubble pack was on 4/6/26 at 2:53 p.m. During a review of the facility's policy and procedure (P&P) titled ordering and Receiving Controlled Medications last revised January 2023, the P&P indicated refills should be requested from the pharmacy a minimum of three days in advance of need to assure an adequate supply is on hand. 2. During a concurrent observation, interview, and record review on 04/07/2026 at 7:08 a.m., with RN 3, RN 3 stated she would prepare Resident 3's medications that included Namenda 10 mg tablet, scheduled at 9 a.m. RN 3 checked the medication carts for Resident 3's Namenda 10 mg tablet. RN 3 stated there was no supply of Resident 3's Namenda 10 mg tablet. During a review of facility's AR indicated Resident 3 was admitted on [DATE], with diagnoses that included dementia. Resident 3's physician's Order Listing Report indicated Namenda Tablet 10 mg (Memantine HCl) Give 1 tablet by mouth two times a day for dementia. During an interview on 04/07/2026 at 2:50 p.m., with RN 3, RN 3 stated she ordered Resident 3's Namenda 10 mg tablet from the pharmacy, and RN 3 was informed that Resident 3's Namenda 10 mg tablet would not be available for refill until 04/16/2026. 3. During a concurrent observation, interview, and record review on 04/06/2026 at 11:30 a.m. with Registered Nurse (RN) 2, RN 2 stated she would prepare to administer Resident 6's medications that included Ipratropium-Albuterol Solution 0.5-2.5 milligram(mg)/3 milliliter (ml), scheduled at 8 a.m. RN 2 stated Resident 6 was using the Ipratropium-Albuterol Solution 0.5-2.5 mg/3ml every four hours for shortness of breath. RN 2 checked the medication carts and could not find Resident 6's Ipratropium-Albuterol Solution supplies. Director of Staff Development (DSD) stated she would order Resident 6's Ipratropium-Albuterol Solution from the pharmacy. RN 2 stated there was no supply of Resident 6's Ipratropium-Albuterol solution. During a review of facility's admission Record (AR) indicated Resident 6 was admitted on [DATE], with diagnoses that included chronic pulmonary edema and acute and chronic respiratory failure with hypoxia (low levels of oxygen in your body tissues). Resident 6's physician's Order Listing Report indicated Ipratropium-Albuterol Solution 0.5-2.5 (3) mg/3ml, 3 ml inhale orally every 4 hours for sob [shortness of breath]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 04/06/2026 at 12:05 p.m., with RN 1, RN 1 checked Resident 6 in her room. RN 1 stated that Resident 6 was asleep, RN 1 stated she checked Resident 6's respiratory rate, and Resident 6 was using accessory muscles when breathing (body had to work extra hard to take in air, either because of intense exertion or a medical condition that could cause breathing difficulty).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that medication error rate was below 5%. There were four errors out of 31 medication pass observations which resulted in 12.9% error rate. 1. Resident 6's Resident 6's physician-ordered Ipratropium-Albuterol Solution (medication used to help control the symptoms of lung diseases) was not available for administration. Resident 6's Minoxidil (medication used to treat high blood pressure) oral tablet was not administered. Resident 6's Hydralazine (medication used to treat high blood pressure) oral tablet was not administered. These failures had the potential to affect Resident 6's health and safety due to worsening of respiratory illness and high blood pressure.2. Resident 6's Namenda tablet 10 mg (Memantine HCl - indicated for the treatment of moderate to severe dementia of the Alzheimer's type) was not available for administration. This failure had the potential to affect Resident 6's health due to decreased level of medicine that would allow it to work most effectively. Findings:1. During a concurrent observation, interview, and record review on 04/06/2026 at 11:30 a.m. with Registered Nurse (RN) 2, RN 2 stated she would prepare to administer Resident 6's medications that included Minoxidil oral tablet 2.5 milligram (mg) scheduled at 09:00 a.m., Ipratropium-Albuterol Solution 0.5-2.5 mg/3 milliliter (ml), scheduled at 08:00 a.m., and Hydralazine HCL oral tablet 100 mg scheduled at 12:00 p.m. RN 2 stated Resident 6 was using the Ipratropium-Albuterol Solution 0.5-2.5 mg/3ml, every four hours for shortness of breath. RN 2 checked the medication carts and could not find Resident 6's Ipratropium-Albuterol Solution supplies. RN 2 stated there was no supply of Resident 6's Ipratropium-Albuterol solution. RN 2 stated Resident 6's blood pressure was 103/50 and pulse of 52. RN 2 stated she would not administer Resident 6's Minoxidil oral tablet 2.5 mg since the parameter was to hold for systolic blood pressure (SBP) of <100, and Resident 6's SBP was 103. RN 2 stated that Resident 6's pulse was also 52. RN 2 stated she would also hold Resident 6's Hydralazine HCl oral tablet 100 mg since the SBP of <100 or HR >100. RN 2 stated she would clarify the physician order for the parameters. Director of Staff Development (DSD) stated she would order Resident 6's Ipratropium-Albuterol Solution from the pharmacy, and DSD further added that RN 2 should follow the physicians orders parameter for the medications. RN 2 showed DSD the parameters for Resident 6's Minoxidil oral tablet 2.5 mg and Hydralazine HCl oral tablet 100 mg, and DSD did not provide any guidance. During an observation and interview on 04/06/2026 at 12:05 p.m. with RN 1, RN 1 checked Resident 6 in her room. RN 1 stated that Resident 6 was asleep, RN 1 stated she checked Resident 6's respiratory rate, and Resident 6 was using accessory muscles when breathing (body had to work extra hard to take in air, either because of intense exertion or a medical condition that could cause breathing difficulty). A review of the facility's admission Record indicated Resident 6 was admitted on [DATE] with diagnoses that included chronic pulmonary edema, acute and chronic respiratory failure with hypoxia (low levels of oxygen in your body tissues), end stage renal disease, and hypertension. Resident 6's physician's Order Listing Report indicated Ipratropium-Albuterol Solution 0.5-2.5 (3) mg/3ml, 3 ml inhale orally every 4 hours for sob [shortness of breath]. Resident 6's physician's Order Listing Report indicated Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3 ML, 3 ML inhale orally every 4 hours for sob [shortness of breath]. Minoxidil Oral Tablet 2.5 MG (Minoxidil) Give 1 tablet by mouth one time a day for HTN [hypertension] Hold for SBP [systolic blood pressure] < 100. Hydralazine HCl Oral Tablet 100 MG (Hydralazine HCl) Give 1 tablet by mouth every 8 hours for HTN Hold for SBP < 100 or HR >100.During a review of Resident 6's medication administration record (MAR) for the month of April 2026, it read Minoxidil Oral Tablet 2.5 MG (Minoxidil) give 1 tablet by mouth one time a day for HTN Hold for SBP<100 scheduled at 09:00 a.m., was not given. Hydralazine HCl Oral Tablet 100 MG (Hydralazine HCl) give 1 tablet by mouth every 8 hours for HTN, Hold for SBP < 100 or HR > 100 scheduled at 12:00 p.m. was marked 4, indicating the Vital Signs outside of parameter. Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML inhale orally every 4 hours for sob scheduled at (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	08:00 a.m. was not given.During an interview on 04/06/2026 at 02:20 p.m., RN 2 stated that Resident 6's Ipratropium-Albuterol solution was not given at 08:00 a.m.2. During a concurrent observation and interview on 04/07/2026 at 7:08 a.m. with RN 3, RN 3 stated she would prepare Resident 3's medications that included Namenda 10 mg tablet. RN 3 checked the medication carts for Resident 3's Namenda 10 mg tablet. RN 3 stated there was no supply of Resident 3's Namenda 10 mg tablet.During a review of facility's AR, it indicated Resident 3 was admitted on [DATE] with diagnoses that included dementia. Resident 3's physician's Order Listing Report indicated Namenda Tablet 10 mg (Memantine HCl) Give 1 tablet by mouth two times a day for dementia.During a review of Resident 3's MAR for the month of April 2026, it indicated Namenda Tablet 10 MG (Memantine HCl) give 1 tablet by mouth two times a day for dementia scheduled at 09:00 a.m. It was marked 2 indicating Drug Refuse by Resident 3 on 04/07/2026.During an interview on 04/07/2026 at 2:50 p.m., with RN 3, RN 3 stated she ordered Resident 3's Namenda 10 mg tablet from the pharmacy, and RN 3 was informed that Resident 3's Namenda 10 mg tablet was not available for refill until 04/16/2026.

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F 0761 Level of Harm - Minimal harm or potential for actual 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 record review, the facility failed to ensure safe storage of medications when:- East Medication Cart had multiple medications that were either opened without open date or were stored beyond use-by dates.- A bottle of Potassium Chloride solution (used to treat low levels of potassium, a mineral, in a patient's blood) was stored outside the required temperature. - Narcotic storage safe was not permanently affixed. These deficient practices had the potential to result in unauthorized access, compromised medication integrity, and increased risk of medication errors for all residents who rely on the facility for safe medication management.During a concurrent observation and interview on 4/7/26 at 3:02 p.m. with Licensed Vocational Nurse (LVN) 2, the East Medication Cart had the following medications:-Budesonide inhalation suspension (a daily corticosteroid medication used to prevent asthma symptoms (wheezing, shortness of breath) by reducing inflammation in the lungs) that was opened but not dated.-Budesonide 0.25 mg/2 ml, opened but not dated.-Breo Ellipta (a prescription dry powder inhaler used daily to control asthma (ages 5+) and COPD), with open date 2/1/26.LVN 2 stated it is necessary to label the medication with the date it was opened to ensure staff are aware of its expiration. LVN 2 acknowledged uncertainty regarding the duration for which Budesonide inhalation suspension remains suitable for use after opening but stated that Breo Ellipta is only good for six weeks from the open date. LVN 2 stated, the Breo Ellipta should have been disposed of, as it had surpassed the six-week period.During a concurrent observation and interview on 4/7/26 at 3:15 p.m. inside the medication room with LVN 1, inside the refrigerator was a 150 ml-bottle of Potassium Chloride 10% solution. The bottle did not have any sticker to refrigerate. LVN 1 stated she did not know if it needed to be kept inside the refrigerator. The refrigerator had an internal temperature of 43.8 degrees F. During a review of the manufacturer's prescribing information (Rx information) provided by the facility, the Rx information indicated the following:- Budesonide inhalation suspension, vials can be stored for 2 weeks after opening the protective foil envelope but must be thrown away if not used within 2 weeks of opening.- Breo Ellipta, must be thrown away in the trash 6 weeks after opening or when the counter reads 0, whichever comes first. Write the date you open the tray on the label on the inhaler.-Potassium Chloride solution should be stored at room temperature, between 68F to 77FDuring a concurrent observation and interview on 4/9/26 at 12:32 p.m. with Director of Nursing (DON), the narcotic bubble packs were stored in a safe that was not secured to the wall. DON stated she had been rearranging items and forgot to request maintenance to attach the safe to the wall. The safe contained multiple bubble packs of narcotic medications for destruction.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on interview and record review, the facility failed to ensure that potentially hazardous foods (Foods that must be kept at a particular temperature to minimize the growth of food poisoning bacteria that may be in the food, or to stop the formation of toxins are cooled rapidly) were kept in proper temperature before storing. Cool Down Log's consistently listed the expected temperature of the menu items monitored at 1 hour, 2 hours, and at 4 hours. These failures had the potential to cause food borne illness.Findings:During a concurrent interview and record review on 04/06/2026 at 02:29 p.m. in the kitchen with Dietary Manager (DM), DM stated that if there was left over food or a dish that needs to be prepared ahead of time before serving, the kitchen staff follows the cool down method. DM showed the Cool Down Log, the log listed the menu item, date, time and expected temperature for the product. The Cool Down Log temperature showed same temperature for all the menu items listed in the two pages of documents for the 1 hour at 140 degrees, Fahrenheit (F), 2 hours at 68 F, and 4 hours at 39 F. DM stated the staff must be writing the expected temperature, and not the actual menu item temperature. During a review of the facility's untitled policy and procedures indicted Rapid Cooling 1. Potentially hazardous foods. This is defined as cooling from 135 F to 70 F within two hours and then to a temperature of 41 F or below within the next 4 hours. The total cooling time between 135 F and 41 F is not to exceed 6 hours.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an effective infection control program when: The following infection control issues were identified regarding Resident 5: a. Intravenous fluid bag that was not infused remained hung and connected to the resident's midline catheter (Intravenous fluid therapy, commonly referred to as IV fluid therapy, is a medical term that delivers fluids directly into the bloodstream to correct a medical condition. A midline catheter is an IV catheter that is inserted in the vein in the upper arm used to deliver the IV fluids to the resident's body).b. Resident 5's midline dressing was peeling off, compromising the site.c. The garbage bin located beside the resident's oxygen concentrator was overflowing with used Personal Protective Equipment (PPE is specialized gear, clothing, or equipment worn by individuals to minimize exposure to hazards that cause infections; an oxygen concentrator is a medical device that provides extra oxygen to residents who needs it).2. Resident 15's oxygen concentrator humidifier was missing its opening date and initial label (a humidifier for oxygen concentrator is a device that adds moisture to the oxygen gas before it is delivered to the resident).3. The used PPE disposal bin inside an enhanced barrier precaution room (EBP) was overflowing with used PPE gowns. The PPE disposal bin was touching a folding chair and resident's walker (EBP refers to a room where staff are required to wear PPE during high contact care activities to prevent the spread of infection).4. Resident 25, who did not require transmission-based precautions (TBP), was placed in a room with residents on droplet precautions (TBP are extra infection-control steps taken in healthcare settings when a resident has a known or suspected contagious disease. These measures stop germs from spreading via direct contact, droplets (coughing/sneezing), or airborne particles, ensuring safety for others).5. Residents under droplet/contact precautions were allowed to stay in common areas shared by residents without TBP (droplet precautions mean taking special safety measures to stop the spread of germs that travel short distances (usually less than 3-6 feet) through the air when an infected person talks, coughs, or sneezes; contact precautions are special safety rules used in hospitals and nursing homes to stop the spread of germs that are passed by touching).6. The garbage bin inside the droplet/contact precaution room was inaccessible.7. Multiple staff entered a droplet/contact isolation room without donning required PPE and/or not following the proper sequence of donning PPE. These failures placed the residents at increased rate of healthcare- associated infections. 1a. During an initial tour of the facility on 4/06/26 at 10:25 a.m., Resident 5's one-liter intravenous fluid bag was half full and was not infused yet remained hung and connected to the resident's midline catheter. During a review of Resident 5's admission Record printed on 4/8/26, the record indicated Resident 5 was admitted to the facility on [DATE]. A review of the Physician's Orders (PO) dated 4/8/26, indicated an order with a start date of 4/5/26 and an end date of 4/5/26 of Dextrose Intravenous Solution 5% (dextrose) use 75 cc. intravenously every shift for high sodium (Dextrose Intravenous Solution 5% is a form of IV fluid, cc or cubic centimeter is a form of measurement). During a concurrent observation and interview with the Director of Nursing (DON) on 4/6/26 at 10:32 a.m. in Resident 5's room, the DON acknowledged that the IV fluid had finished infusing. The DON stated that the IV should have been disconnected from the midline to prevent infection. During an interview on 4/8/26 at 10:52 a.m. with the Infection preventionist (IP), IP stated that Resident 5's IV fluids should have been disconnected from the midline once the order was completed and the midline should have been capped to minimize the risk of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, (Intravenous Administration of Fluids and Electrolytes, revised April 2016 indicated,. Steps in the procedure.8. When infusion is complete: a. for intermittent therapy: clamp tubing and disconnect from catheter; . b. During a concurrent observation and interview with Registered Nurse (RN) 1 on 4/8/26 at 10:00 a.m. in Resident 5's room, Resident 5's midline dressing was observed to be lifting. RN 1 described the inner lower and upper part of the midline catheter dressing was peeling off. RN 1 further stated that this failure in dressing integrity created a risk for infection and potential for the midline to be dislodged. Review of Resident 5's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 1/14/26 under Section C, indicated Resident 5 had severe cognitive impairment. During a review of Resident 5's midline insertion record (MIR) dated 4/3/26 indicated the midline was inserted on 4/3/26. The MIR instructions indicated changing the midline dressing every seven days and as needed if the dressing was soiled or not intact. During a concurrent interview and record review on 4/8/26, at 10:05 a.m., with RN 1, Resident 5's PO and Medication Administration Record (MAR) were reviewed. The PO and MAR lacked documentation which indicated that the licensed nurses were monitoring the midline catheter dressing for soilage or integrity. RN 1 acknowledged that the condition of the dressing should have been monitored. During a review of the facility's policy and procedure (P&P) titled, Peripheral and Midline IV Dressing Changes, dated, General Guidelines. 4. Change the dressing if it becomes damp, loosened, or visibly soiled and: . c. immediately if the dressing or site appears compromised .6. Assess the peripheral/midline access device at least every 4 hours (every 1-2 hours for residents with cognitive impairment) .8. For midline catheters, measure arm circumference and compare to baseline when clinically indicated to assess for edema and possible deep vein thrombosis. c. During an initial tour of the facility on 4/06/26 at 10:25 a.m., Resident 5 was observed to be in an EBP room. Resident 5's garbage bin beside the oxygen concentrator was overflowing with used PPE gowns. During a review of Physician's Orders dated 4/8/26, indicated, an order of Oxygen at 2 liters per minute via nasal cannula as needed to keep oxygen saturation above 92% (Nasal cannula is a tube used to deliver oxygen through the nose, oxygen saturation is the measurement of oxygen in the blood). During a concurrent observation and interview with the DON on 4/6/26 at 10:32 a.m., in Resident 5's room, DON stated the used PPE gowns should be disposed of by the staff in the appropriate used PPE disposal bin which was located behind Resident 5's room door because of the risk of spread of infection. DON also stated the used PPE gowns should not be beside the oxygen concentrator door because of the risk of cross contamination (unintentional transfer of harmful bacteria, viruses, or allergens from one surface, food, or person to another). During an interview on 4/8/26 at 10:52 a.m., with the IP, IP stated that Resident 5 was on EBP due to the presence of a gastrostomy tube and a history of drug-resistant infection to the resident's foot wound. Stated the risk of not disposing of the PPE properly was the spread of infection (a gastrostomy is a tube placed in the stomach through a small opening in the belly used to deliver food, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	liquids, and medications directly to the stomach). 2. During an initial tour of the facility on 4/06/26 at 10:28 a.m. in Resident 15 's room, Resident 15 was observed to be lying in bed receiving oxygen via nasal cannula at 4 liters per minute from an oxygen concentrator. Resident 15's oxygen concentrator humidifier was missing its open date and initial label. During a review of Resident 15's admission Record printed on 4/8/26, the record indicated Resident 15 was admitted to the facility on [DATE]. During a review of Physician's Orders dated 4/8/26, it indicated, an order of Oxygen at 2-4 liters per minute via nasal cannula continuously to keep oxygen saturation above 92%. During a concurrent observation and interview with DON on 4/6/26 at 10:42 a.m. in Resident 15's room, DON stated the humidifier should have its open date and time label to prevent infection. During an interview on 4/8/26 at 10:52 a.m. with the IP, IP stated that Resident 15's humidifier should have its open date and time label to prevent infection. During a review of the facility's policy and procedure (P&P) titled, (Departmental (Respiratory Therapy)- Prevention of Infection), .General Guidelines1. Distilled water used in respiratory therapy must be dated and initialed when opened and discarded after twenty-four (24) hours. Steps in the Procedure. Infection Control Considerations Related to Oxygen Administration.2. Use distilled water for humidification per facility protocol 3. [NAME] bottle with date and initials upon opening and discard after twenty-four (24) hours. 3. During an observation on 4/6/26 at 3:10 p.m., the PPE disposal bin in room [ROOM NUMBER] positioned behind the door, was overflowing with used PPE gowns. The overflowing bin was touching a folded chair and a walker, which were stored behind the door beside the overflowing PPE disposal bin. During a concurrent observation and interview with Certified Nursing Assistant (CNA) 3 on 4/6/26 at 3:18 p.m. in room [ROOM NUMBER], CNA 3 acknowledged that the used PPE gowns in the used PPE disposal bin should not be overflowing. CNA 3 stated that the walker and folding chair should not be stored behind the door touching the overflowing used PPE gowns, as this posed a risk for the spread of infection. During a concurrent observation and interview with Occupational Therapist (OT) 1 on 4/6/26 at 3:22 p.m., in room [ROOM NUMBER], OT 1 confirmed that the walker stored behind room [ROOM NUMBER]'s door which was touching an overflowing disposal bin of used PPE gowns was currently being used by a resident. During a concurrent observation and interview with the DON on 4/6/26 at 3:30 p.m., in room [ROOM NUMBER], the DON acknowledged that the used PPE gowns disposal bin should not be overflowing. The DON further stated that storing a walker and folding chair behind the door where they touched the overflowing disposal bin with used PPE gowns, posed a risk for infection transmission. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, revised October 2018, the P&P indicated, . Policy Statement: An infection prevention and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	control program(IPCP) is established and maintained to provide a safe sanitary and comfortable environment and to help the development and transmission of communicable diseases and infections. 4. During an observation on 4/6/26 at 10 a.m., Resident 51's room had a Droplet Precautions sign posted on the wall at the entrance. Resident 51's roommates, Resident 1, was present in the room while Resident 3 was out. During an interview on 4/6/26 at 10:04 a.m. with Registered Nurse (RN) 3, RN 3 stated she did not know which resident was on droplet precautions or why. RN 3 reviewed the medical records and stated she could not find this information after checking the Change of Condition tab in the computer for all three residents in the room. During a concurrent observation and interview on 4/6/26 at 10:12 a.m. with Resident 1, inside the residents' room, Resident 1 was in the wheelchair at the bedside while Resident 51 was sitting on the assigned bed. Resident 1 stated making occasional visits to the facility's common areas such as the activity room. Resident 3 was not in the room. During a joint interview on 4/6/26 at 11:41 a.m. with Director of Nursing (DON) and Infection Preventionist (IP), both DON and IP stated Residents 1 and 3 leave the room for activities. IP stated there were no available beds to move the roommates, though alternatives could have been considered but did not. During a concurrent observation and interview on 4/7/26 at 2:58 p.m. with Activity Director (AD), Resident 3 was still on the outside patio with a visitor. AD stated Resident 3 had previously been in the activity room, engaged in a one-on-one ball throwing session with a staff member. AD also stated yesterday, Resident 3 participated in the scheduled activity. 5. During an interview on 4/6/26 at 10:06 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 51 tested positive for the Human Metapneumovirus (hMPV, a virus that can infect the nose, throat and lungs) on 4/1/26. At the time, Resident 51 shared a room with Resident 1 and Resident 25 (now discharged). Afterward, Resident 3 replaced Resident 25 as Resident 51's roommate starting 4/2/26. During a review of Resident 51's Lab Results Report dated 4/1/26, the report indicated Resident 51 tested positive for hMPV. During review of the facility's census dated 4/1/26 to 4/6/26, the facility census indicated on 4/1 and 4/2/26, Residents 1, 25 and 51 shared the same room. Following Resident 25's discharge, Resident 3 was transferred into the bed previously assigned to Resident 25 on 4/3/26. During a review of Resident 51's Order Listing Report (OLR) dated 4/7/26, the OLR indicated Resident 51's physician's order for isolation with contact and droplet precaution due to positive hMPV dated/effective 4/2/26. 6. During an observation on 4/6/26 at 10:12 a.m., there was no garbage bin designated for PPE disposal. Several staff members, including DON, Nurse Consultant (NC) and LVN 1, did not know where the garbage bin was and they stated they would search for it. The room's door was fully open and pressed against the wall. Eventually, LVN 1 found the garbage bin folded behind the door. The garbage bin appeared to be made of fabric and was collapsible. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. During concurrent observations and interviews and record review on 4/6/26 from 11:07 a.m. to 11:13 a.m., the following were observed: Certified Nursing Assistant (CNA) 4 made Resident 3's bed without appropriate PPE, left the room to access the linen closet, then retrieved linen from another location. CNA 4 then returned to the room and placed a draw sheet on the bed, wearing only gloves and a mask. Registered Nurse (RN) 4 entered the room, placed a blood pressure cuff on Resident 51's right wrist, also wearing only gloves and a mask. CNA 5 entered the room, talked to Resident 51, also not wearing PPE except a surgical mask. CNA 5 stated she was not aware of the Droplet Precaution signage. IP provided the facility's policy and procedure (P&P) titled Isolation-Initiating Transmission-Based Precaution last revised December 2025. IP stated the facility did not have a specific P&P for Droplet Precaution. The P&P indicated the transmission-based precaution remain in effect until the attending physician or infection preventionist discontinues them. 7. During a concurrent observation and interview on 04/06/2026 at 11:30 a.m., with Registered Nurse (RN) 2, RN 2 stated she would need to check Resident 6's blood pressure and pulse before she administers Resident 6's medications. RN 2 stated Resident 6 was in an enhanced precaution barrier room (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. EBP involves gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition), because she's on dialysis treatment. RN 2 put on a pair of gloves, opened a package of gown, and RN 2 put the gown over her head in the neck hole, and tied the sleeve around her back, RN 2 did not insert her arms in the sleeves of the gown. RN 2's gown appeared to look like an apron. After checking Resident 2's blood pressure and pulse, RN 2 exited the room and prepared to administer Resident 2's medications. RN 2 entered the room and put on a pair of gloves before donning the gown. Resident 6 was asleep, and did not take her medication, RN 2 exited the room and disposed of the medication. RN 2 stated she would need to check Resident 6's temperature and oxygen level. RN 2 entered Resident 6's room, and only put on a pair of gloves to check Resident 6's temperature and oxygen level. During a concurrent observation and interview on 04/07/2026 at 07:06 a.m., with RN 3, RN 3 stated she would prepare and administer Resident 3's medications. Outside of Resident 3's door was signage indicating the room was in Droplet Precaution. RN 3 was at the vestibule of the room, and started donning PPE, RN 3 put a pair of gloves first, then a gown, and lastly a face shield. RN 3 went to Resident 3's bedside and attempted to administer Resident 3's medications. During a concurrent observation and interview on 04/07/2026 at 07:23 a.m., with RN 3, RN 3 stated she would prepare and administer Resident 1, Resident 1 was in a Droplet Precaution isolation. RN 3 was at the vestibule of Resident 1's door, and started donning PPE, RN 3 put on a pair of gloves first, then a gown, and lastly a face shield. RN 3 went to Resident 1's bedside and administered Resident 1's medications. During a review of Center for Disease Control's Sequence for Putting Om Personal Protective Equipment (PPE) indicated 1. Gown – fully cover torso from neck to knees, arms to end of wrist, and wrap around the back. Fasten in back of neck and waist. 2. Mask or Respirator. Secure ties or elastic bands at middle of head and neck. Fit flexible band to nose bridge. Fit snug to face and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	below chin. Fit-check respirator. 3 Goggles or Face Sheild. Place over face and eyes and adjust to fit. 4. Gloves. Extend to cover wrist of isolation gown.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview and record review, for one of one sampled resident (Resident 23) reviewed for limited range of motion and one randomly sampled resident (Resident 34), the facility failed to ensure residents were treated with dignity and respect during meal service when:1.For Resident 23, who was diagnosed with Parkinson's disease (a progressive, incurable neurological disorder leading to movement issues like tremors, stiffness, and slow movement), staff failed to assist Resident 23 with meals. This failure resulted in difficulty managing use of utensils and consuming the meal.2.Certified Nursing Assistant (CNA) assisted Resident 34 with eating while standing over the resident, rather than sitting or positioning themselves at eye level. This failure had the potential to result in a lack of dignity, comfort, and appropriate interaction during mealtime.During a review of Resident 23's admission Record (AR), the AR indicated Resident 23 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease with dyskinesia (lack of coordination), benign neoplasm (cancer) of the brain, and unspecified glaucoma (a group of eye diseases that damage the optic nerve, often due to high eye pressure, leading to irreversible, permanent vision loss). During a review of Resident 23's Minimum Data Set (MDS, assessment tool used to direct resident care) dated 1/21/26, the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information.) score of 12. A BIMS score of 9-12 is an indication of moderate impairment of cognitive status. The MDS also indicated Resident 23 required partial/ moderate assistance with eating (with the caregiver providing less than half the effort). During a concurrent observation and interview on 4/6/26 from 12:30 to 12:41 p.m. with Resident 23 while inside the resident room during lunch service, Resident 23 stated staff set her meal tray down on the over-bedtable and left. There were no staff in the room assisting Resident 23. Resident 23 stated having to feed herself despite right shoulder and arm pain and Parkinson's-related tremors. Resident 23 stated occasionally eating with her hands as using utensils could be difficult and messy but must manage independently, given limited options. Resident 23 ate with the right hand holding the utensil, was able to move the left hand, but not enough to effectively grasp a utensil. No staff offered help or checked in to ensure that Resident 23's needs were met adequately. During a review of the facility's policy and procedure (P&P) titled, Assistance with Meals last revised March 2022, the P&P indicated all residents will be encouraged to eat in the dining room and facility staff will serve resident trays and will help residents who require assistance with eating. 2. During a review of Resident 34's Facesheet (information containing contact details, brief medical history at-a-glance) indicated, Resident 34 was admitted to the facility on [DATE] with diagnoses that included dementia (loss of memory, language, problem-solving and other thinking abilities) and muscle weakness. During a review of Resident 34's Minimum Data Set (MDS, a comprehensive assessment tool), dated 2/12/26, indicated Brief Interview for Mental Status (BIMS, a screening tool to identify resident's cognitive status) score of 3, indicating Resident 34 had a severely impaired cognition. During an observation on 4/9/26 at 12:20 p.m., Resident 34 was sitting in a chair in the dining room and was being assisted to eat by Certified Nursing Assistant (CNA) 2. CNA 2 was observed to be (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	standing beside Resident 34 while assisting the resident to eat. During a concurrent observation and interview on 4/9/26 at 12:27 p.m., the Director of Staff Development (DSD) was also in the dining room while Resident 34 was being assisted to eat by CNA 2. DSD acknowledged that CNA 2 should be seated beside the resident and should not be standing while assisting the resident to eat because of dignity issues. During a review of the facility's policy and procedure (P&P) titled, Assistance with Meals, dated 2001, the P&P indicated, . 2. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: a. not standing over residents while assisting them with meals.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, for one of two residents reviewed under personal property (Resident 44), the facility failed to exercise reasonable care for the protection of the residents' personal property from potential theft or loss when staff did not complete a timely and accurate reconciliation of Resident 44's personal items inventories. This failure had the potential to result in outdated and incomplete inventory records and potentially result in property loss.During a review of Resident 44's admission Record (AR), the AR indicated Resident 44 was admitted to the facility on [DATE] and was discharged on 3/20/26. During a telephone interview on 4/7/26 at 12:07 p.m. with Resident Representative (RR) 1, RR 1 stated when RR 1 came to the facility to retrieve Resident 44's personal belongings, RR 1 noted several items were missing. RR 1 stated she had a list of personal items provided to the facility on two occasions, on 2/13/26 and 2/14/26, however, the facility has not yet responded to these inquiries. During a concurrent interview and record review on 4/9/26 at 9:30 a.m. with Assistant Director of Nursing (ADON), Resident 44's personal inventories were reviewed. The medical record indicated multiple inventory sheets for various dates that included 2/12/25, 2/14/26, 2/16/26, 3/6/26 and 3/15/26. ADON stated RR 1 alleged several personal items were missing when RR 1 came to pick up Resident 44's belongings on 4/4/26 and refused to sign for the released items. ADON stated she instructed RR 1 to bring a list of the missing personal items that were brought since admission, but RR 1 claimed a list was already given to staff, which the facility could not verify. ADON stated personal inventory procedures were inconsistently followed by the staff- there should be one inventory list initiated upon admission and updated as items arrived, but Resident 44 had multiple lists, making reconciliation difficult. ADON also stated staff training on inventory procedures occurred regularly, but adherence to the procedures was inconsistent. Resident 44's medical record indicated two handwritten lists of personal items dated 2/13/26 and 2/14/26. Several personal items listed on 2/14/26 that included five pairs of varying colors of socks, a pair of beige pants, a black duffel bag, two pairs of leggings, two long-sleeved shirts and a pair of slippers, were not listed or added in Resident 44's electronic copy of personal inventory sheet/s. Additionally, these items were not in the list of personal items that were released to RR 1. During a review of the facility's policy and procedure (P&P) titled Personal Property last revised August 2022, the P&P indicated a resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary, and the facility will promptly investigate any complaints of misappropriation or mistreatment of resident's property.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Cross Reference F609, F610 Based on interview and record review, the facility failed to follow its written policies prohibiting resident abuse, impacting one of 18 sampled residents (Resident 27). This failure to report allegations of abuse placed Resident 27 at risk of potential abuse. Review of Resident 27's Face Sheet (information containing contact details, brief medical history at-a-glance) indicated Resident 27 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis due to a stroke (hemiplegia means paralysis on one side of the body and hemiparesis means weakness in one side of the body).Review of Resident 27's Minimum Data Set (MDS, a standardized assessment tool), dated 3/20/26, indicated Resident 27 had a Brief Interview for Mental Status (BIMS, an assessment tool for cognition) score of 8, indicating Resident 27 had a moderate cognitive impairment (decline in one or more cognitive abilities, such as memory, attention, language, reasoning, and problem-solving).Review of Resident 27 ?s SBAR Situation, Background, Assessment, and Recommendation notes (SBAR, is a structured communication framework that can help teams share information about the condition of a resident) dated 3/21/26, indicated, Resident reported to admission coordinator during her rounds that a lady hit him on the head last night, and he would like to go home. Writer checked on resident and he said a lady punched my face and it's not the 1st time. She also rushes me when I need to use the bathroom. Pt denies pain, no injuries noted or bruising on the face.During an interview on 4/7/26 at 3:34 p.m. with Resident 27, Resident 27 stated that a lady placed her open hand on his face then pushed his face, pinning his head on the bed. The resident stated this incident made him feel unsafe and angry.During a concurrent record review and interview on 4/7/26 at 1:04 p.m. with the Director of Staff Development (DSD), Employee Counseling Form (ECF) dated 3/27/26 that was addressed to Certified Nursing Assistant (CNA) 1 was reviewed. The ECF documented a verbal warning that was being issued to CNA 1. The ECF indicated, It has been reported that on multiple occasions you have displayed rude and unprofessional behavior toward residents under your care. Additionally, there was a specific incident in which you were reported to have acted aggressively toward a resident (Resident 27). The DSD stated she called CNA 1 on 3/27/26 to schedule a one-on-one abuse retraining following the abuse allegation on 3/21/26. CNA 1 did not return to work after the phone call and eventually resigned on 3/29/26.Review of the facility's Daily Assignment Sheets (DAS) indicated CNA 1 still worked in the facility after the abuse allegation. The DAS indicated that CNA 1 continued to work in the facility on 3/24/26, 3/25/26,3/26/26 and 3/27/26. The DAS also indicated that on 3/27/26, CNA 1 worked and was assigned to Resident 27's room and gave care to Resident 27's two roommates. CNA 1 went back to work without the abuse retraining after the abuse allegation.During another concurrent interview and record review on 4/08/26 at 1:22 p.m., with DSD, DAS were reviewed. DSD acknowledged that CNA 1 should not have been assigned to the room where Resident 27 resided because of the risk of further abuse and for the safety and well being of Resident 27.During a concurrent interview and record review on 4/8/27 at 12:06 p.m., with the Director of Nursing (DON), DAS were reviewed . DON confirmed that CNA 1 worked 3/24/26, 3/25/26, 3/26/26 and 3/27/26. The DON stated that CNA 1 should not have entered Resident 27's room and should not have been assigned to Resident 27's roommates on 3/27/26, in order to protect Resident 27 from further abuse, ensure his psychological well-being, and make him feel safe.During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 2001, the P&P indicated, Policy statement: Residents have the right to be free from abuse ,neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from. verbal, mental . or physical abuse.2. Develop and implement policies and protocols to prevent and identify: abuse or mistreatment of residents;.6. Provide staff orientation and training/orientation programs that include topics such as abuse prevention, identification and reporting abuse, stress management and handling verbally or (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physically aggressive resident behavior. 7. Implement measures to address factors that may lead to abusive situations, .c. Instruct staff regarding appropriate ways to address interpersonal conflicts;.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not verify Resident 5?s Intravenous (IV) fluids order with the physician (IV fluids are sterile liquids like water, salt, or sugar solutions that are delivered directly into a vein through a tube . They bypass the digestive system for fast absorption in the body).This failure had the potential to result in life-threatening complications for Resident 5. A review of the admission Record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses which included dysphagia (difficulty swallowing), dementia (a disorder of mental processes caused by brain disease or injury and marked by memory disorder, personality changes, and impaired reasoning) and congestive heart failure (the heart muscle is too weak or stiff to pump blood efficiently, causing blood to back up and fluid to build up in the body).The Physician's Orders dated 4/8/26, indicated an order of Dextrose Intravenous Solution 5% (dextrose) use 75 cc. intravenously every shift for high sodium(Dextrose Intravenous Solution 5% is a form of IV fluid, cc or cubic centimeter is a form of measurement; every shift meant every eight hours in the facility, high sodium or salt in the blood, technically called hypernatremia, means there is too little water for the amount of sodium in your body, usually causing severe dehydration. While mild cases cause thirst, severe or untreated cases can cause serious brain, heart, and kidney complications because sodium pulls water out of body cells, causing them to shrink).A review of Medication Administration Record dated 4/8/26 indicated: the resident received Dextrose Intravenous Solution 5% (dextrose) use 75 cc. intravenously every shift for high sodium from 4/5/26 until 4/8/26.During a concurrent interview and record review on 4/9/26 at 10:05 a.m. with the Director of Nursing (DON), Resident 5's Physician orders and Medication Administration Record were reviewed. The DON stated the resident received 75 ml per hour and not 75 ml every shift or every eight hours to correct the high sodium in Resident 5's body. DON acknowledged that the IV fluids order should have been verified with the physician before it was administered to Resident 5.During an interview on 4/9/26 at 1:45 p.m., Registered Nurse (RN) 1 stated that if an IV fluid order was unclear, she should verify the IV fluids order with the physician before hanging the fluids.During a review of the facility's policy and procedure (P&P) titled, Intravenous administration of fluids and electrolytes, revised April 2016, the P&P indicated, Purpose: The purpose of this procedure is to provide guidelines for the safe and aseptic administration of intravenous fluids and electrolytes for hydration. Preparation: 1.A physician order is necessary to give intravenous fluids and electrolytes.5. The licensed nurse who is responsible for administering the fluids and electrolytes shall be knowledgeable of the following.h. appropriate rates and doses and routes of administration. (electrolytes mean electrically charged minerals found in your blood, sweat, and urine; aseptic mean it is the process of keeping things germ-free to protect health).

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for one of one resident (Resident 44) reviewed for significant medication errors, the facility failed to ensure medications were administered as prescribed by the physician when Registered Nurse (RN) 4 administered 11 units of insulin (a hormone produced by the pancreas that regulates blood sugar by moving glucose into cells for energy) instead of the physician-ordered 6 units. This failure resulted in Resident 44 receiving nearly double the prescribed dose, placing the resident at increased risk of hypoglycemia (abnormally low blood glucose/sugar) and other adverse clinical outcomes.During a review of Resident 44's admission Record (AR) dated 4/8/26, the AR indicated Resident 44 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (a chronic metabolic disorder characterized by high blood sugar (glucose) due to inadequate insulin production) chronic kidney disease (a progressive, long-term condition where damaged kidneys cannot filter blood properly, leading to waste buildup, high blood pressure, and potential kidney failure), bradycardia (a slow resting heart rate of less than 60 beats per minute (bpm), anxiety disorder (persistent, excessive fear or worry that interferes with daily life, functioning, and relationships) and congestive heart failure (a chronic, progressive condition where the heart cannot pump blood efficiently, causing fluid buildup in the lungs and body). During a review of Resident 44's Order Listing Report (OLR), the OLR indicated physician orders that included:-Humalog injection solution 100 units/ml (insulin lispro), inject per sliding scale: If blood sugar is 70-140= 0 units; 141-180= 2 units; 181-220= 3 units; 221-260= 4 units; 261-300= 6 units; 301-350= 8 units; 351-400= 10 units, if blood sugar is greater than 400, give 12 units and call the physician. -Humalog injection solution 100 units/ml, inject 4 units subcutaneously before meals, hold if blood sugar is less than 100. During a telephone interview on 4/8/26 at 6:34 p.m. with RN 4, RN 4 stated, on the early morning of 3/11/26, RN 4 started checking her residents' blood sugar levels and wrote them down on a piece of paper. RN 4 stated, when it was time to administer Resident 44's insulin, she looked at the paper and misread another resident's blood sugar as that of Resident 44's, prepared, and gave the incorrect dose to Resident 44. RN 4 stated she realized she had made a mistake right after giving the injection because it was more than what Resident 44 usually received. RN 4 also stated she documented the administration of 11 units in the progress notes but documented as though she gave 2 units (in addition to the 4 units, for a total of 6 units) in the Medication Administration Record (MAR), although a total of 11 units was actually administered. During a review of Resident 44's Progress Notes (PN) dated 3/11/26, the PN indicated the following:-SBAR (Situation, Background, Assessment, Recommendation-a structured communication framework used by clinicians to convey critical patient information) at 7:28 a.m. indicated, on 3/11/26, RN 4 accidentally administered 11 units of insulin instead of 6 units at 5:50 a.m. The attending physician was notified and ordered hourly blood sugar checks for three hours. Blood sugar was checked at 6:20 a.m. (142), 6:50 a.m. (123), and 7:11 a.m. (150). There were no records of blood sugar checks at 7:50 a.m. and 8:50 a.m. as ordered.-SBAR at 2:29 p.m. indicated Resident 44 had difficulty breathing at 8:41 a.m., was given an inhaler, oxygen at 4 liters/minute via nasal cannula, and nitroglycerin 0.4 mg (a medication used to treat or prevent angina (chest pain) by widening blood vessels, reducing the heart's workload) for chest pain. The physician was notified and physician ordered Lasix 40 (a powerful diuretic causing increased urination) mg once and DuoNeb (breathing treatment) every 4 hours. At 11:29 a.m., Resident 44's BS was 88.During a review of the facility's policy and procedure (P&P) titled Insulin Administration last revised March 2025, the P&P indicated, the type of insulin, dosage requirements, and strength are verified with the order on the medication sheet before administration. The P&P also indicated, after drawing insulin into a syringe, the amount must be re-checked to ensure it matches the order

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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 and record review, for one of three sampled residents (Resident 66) reviewed for closed record, the facility failed to maintain complete and accurate medical records in accordance with professional standards when: Resident 66 left the faciity on 2/12/26 without staff knowledge or permission (elopement, when a resident leaves the facility without staff knowledge or permission), and this was documented in the medical record as leaving Against Medical Advice (AMA, a situation in which a resident chooses to leave a healthcare facility or discontinue recommended care despite the facility's clinical advice to remain).This failure had the potential to result in miscommunication and lack of coordination of care. Resident 66's clinical record did not include comprehensive information describing Resident 66's condition upon return, the time Resident 66 returned to the facility, assessments performed, notifications made to the physician or responsible party, or interventions implemented to ensure resident's safety. This failure had the potential to impede continuity of care and compromise the facility's ability to evaluate and mitigate elopement risk.During a review of Resident 66's admission Record (AR) dated 4/9/26, the AR indicated Resident 66 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (a chronic, severe mental disorder affecting how a person thinks, feels, and acts, causing them to lose touch with reality) disorders of psychological development, encephalopathy (a syndrome of general brain dysfunction characterized by altered mental state, confusion, seizures, and cognitive impairment), history of falling, hemiplegia (severe or total paralysis on one side of the body) and hemiparesis (partial weakness or reduced motor control on one side of the body), weakness and psychoactive substance abuse (harmful or hazardous use of substance including alcohol, illicit drugs, and some prescription medications that alter brain function, mood, consciousness, or perception). During a review of Resident 66's Progress Notes (PN) dated 2/12/26, the PN indicated the following:- 8:36 a.m., Social Service Note (SSN) indicated Resident 66 was missing and had not signed out.- 9:09 a.m., SSN indicated the SSD, nurse and Admissions Coordinator searched for Resident 66 in the front area where Resident 66 usually smoked but did not find Resident 66. The nurse will contact the Sheriff's Office to report Resident 66 missing if Resident 66 did not return by 11:22 a.m. (within the 4-hour mark).-10:54 a.m., Nurse's Note written and signed by Assistant Director of Nursing (ADON), indicated Resident 66 left the facility without signing out, last seen at 7:20 a.m., reported missing to Sheriff at 10:20 a.m. and marked as AMA since Resident 66 did not sign out.-1:35 p.m., SSN indicated the charge nurse contacted the Sheriff, who arrived at the facility, took report, and left to search for Resident 66 but was unsuccessful in finding Resident 66. The [NAME] returned to the facility 10 minutes later and instructed to be notified if Resident 66 returned to the facility.The medical record did not indicate any documentation of further updates about Resident 66's status. During an interview on 4/8/26 at 3:46 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she and ADON completed and signed an Against Medical Advice (AMA) release form (a legal document confirming a resident is leaving the facility voluntarily despite warnings of medical risk from the physician, releases the facility and staff from liability for future injury, complications, or death) after Resident 66 left the facility and went missing. LVN 1 stated, when Resident 66 returned later that afternoon (exact time was not documented), Resident 66 was required to sign the AMA release form before leaving again via Uber. During a concurrent interview and record review on 4/8/26 at 3:57 p.m. with Social Services Director (SSD), SSD stated, following notification to the Sheriff regarding the resident's absence, Resident 66 returned to the facility at 1:50 p.m., prior to the Sheriff's arrival. The AMA release form had already been completed by licensed nursing staff while search for Resident 66 was ongoing, and upon Resident 66's return, the pre-filled AMA form was presented to Resident 66 for signature. When asked whether the risks of discharging against medical advice were explained to Resident 66, SSD stated (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there was not enough time to have that discussion. The AMA form was uploaded on 2/16/26. SSD also acknowledged that she did not document Resident 66's actual return in the progress notes and stated this should have been done. The Progress Notes did not document or clarify whether Resident 66's return occurred before or after the Sheriff's arrival following the report of the missing resident. During an interview on 4/9/26 at 9:30 a.m. with ADON, ADON stated, around 11 a.m. on 2/12/26, the Sheriff's department was notified, and the Sheriff arrived at around 11:45 a.m. ADON stated Resident 66's family returned a call around noon to inquire if Resident 66 had returned, they were informed that Resident 66 had not returned and that law enforcement had been contacted. ADON stated Resident 66 returned in the afternoon and was then asked to sign AMA form. ADON could not, with certainty, distinguish between elopement and AMA, and stated the physician advised treating any resident departure as AMA. During a review of the facility's policy and procedure (P&P) titled Discharging a Resident Without a Physician's Approval, last revised March 2025, the P&P indicated, whether a resident or their representative asks for discharge against medical advice or not, the facility will provide a Notice of Discharge, Discharge Summary, and conduct discharge orientation, before the resident leaves the facility. During a review of another P&P titled Wandering and Elopements last revised March 2019, the P&P indicated when a resident returns after leaving the facility without an authorized leave or pass, the director of nursing or charge nurse must examine the resident for injuries, notify the physician, inform search teams that resident has been found, complete an incident report, and document details in the resident's medical record.