STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555426	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Postacute Care	1233 A Street Fresno, CA 93706

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on observation, interview, and record review, the facility failed to meet professional standards of quality and practices by not following facility's policy and procedures (P&Ps) for four of 19 sampled residents (Residents 32, 64, 59 and 1) and other residents when:1.Resident 32 was administered 5 LPM (liter per minute-a unit of measurement for the flow rate of oxygen) of oxygen therapy (a colorless, tasteless gas essential to living organisms) through a nasal cannula (a thin, flexible tube with two prongs that fit into the nostrils and deliver oxygen) without a physician's order.This failure resulted in Resident 32 receiving oxygen therapy without a physician's order which had the potential to result in shortness of breath, oxygen toxicity (lung damage that happens from breathing in too much extra oxygen therapy), and other serious medical conditions.2. LVN 2 did not follow Resident 64's physician's order to check heart rate prior to administering Metoprolol Tartrate (medication used to treat high blood pressure [hypertension], angina [chest pain], and to improve survival after a heart attack. It works by slowing the heart rate and relaxing blood vessels to improve blood flow) to Resident 64 on 4/9/26.This failure placed Resident 64 at risk for low pulse rate and low blood pressure and had the potential for negative outcomes such as heart failure and falls.3. LVN 1 did not follow physician's order for Aspirin 81 mg Chewable when Aspirin 81 mg Enteric Coated was administered to Resident 59 on 4/9/26. This failure resulted in a medication error by administering wrong medication to Resident 59.4. LVN 2 left and kept the medication cart computer screen containing resident's electronic health information visible for unauthorized staff, residents and families.This failure had the potential to place the facility at risk for unauthorized access to residents' health information.5. Resident 1 was not assessed by Licensed Nurses for significant weight gain of 10% (percent) in six months and 7.5% in three months for the months of March and April 2026. This failure had the potential for Resident 1 to experience unrecognized negative outcomes including fluid retention, decline in oral intake, worsening of shortness of breath, decrease in functional mobility and delay in implementing necessary interventions to prevent further weight gain.1.During an observation on 4/7/26 at 12:38 p.m. in Resident 32's room, Resident 32 was observed lying in bed with a nasal cannula in his nose. Resident 32's nasal cannula was observed connected to the oxygen concentrator (medical device that helps residents breathe). The oxygen concentrator was observed on the right side of the bed turned on at 5 LPM. During an observation on 4/8/26 at 10:15 a.m. in Resident 32's room, Resident 32 was observed lying in bed with a nasal cannula in his nose. Resident 32's nasal cannula was observed connected to the oxygen concentrator. The oxygen concentrator was observed on the right side of the bed turned on at 5 LPM. During a concurrent observation and interview on 4/8/26 at 11:25 a.m. with Registered Nurse (RN) 4, in Resident 32's room, Resident 32 was observed lying in bed with a nasal cannula in his nose. Resident 32's nasal cannula was observed connected to the oxygen concentrator. The oxygen concentrator was observed on the right side of the bed turned on at 5 LPM. RN 4 stated Resident 32's (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nasal cannula was administering 5 LPM of oxygen therapy. RN 4 stated licensed nursing staff administered oxygen to Resident 32 and were responsible for ensuring oxygen therapy was administered per physician orders. During a concurrent interview and record review on 4/8/26 at 11:36 a.m. with RN 4, Resident 32's, Order Summary Report (OSR), dated 4/8/26, was reviewed. RN 4 stated Resident 32 did not have an active order for nasal cannula oxygen therapy. RN 4 stated oxygen was a medication and required a physician order to administer. RN 4 stated Resident 32 received nasal cannula oxygen therapy without a physician order. RN 4 stated Resident 32 did not have any documented history of administering or titrating oxygen therapy on his own. RN 4 stated Resident 32 had acute respiratory failure (condition in which lungs cannot adequately exchange oxygen and carbon dioxide), chronic obstructive pulmonary disease (COPD- progressive, long term-lung disease that causes obstructed airflow, making it difficult to breathe), and congestive heart failure (CHF- chronic, progressive condition where heart muscle is too weak to pump blood) which placed him at risk of increased carbon dioxide levels, hyperventilation, and respiratory distress if administered oxygen therapy outside of physician prescribed treatments and plan of care. During an interview on 4/10/26 at 8:32 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated oxygen was a medication and required a physician order to be administered. LVN 1 stated it was not within licensed nursing scope of practice to administer oxygen without a physician order. LVN 1 stated administering oxygen without a physician's order placed residents at risk for oxygen toxicity (lung damage that happens from breathing in too much extra [supplemental] oxygen) which could lead to serious medical conditions. During an interview on 4/10/26 at 3:02 p.m. with the Interim Director of Nursing (IDON), the IDON stated oxygen was a medication and a prescribed treatment which required a physician's order. The IDON stated it was not within licensed nursing scope of practice to administer medication, including oxygen therapy, without a physician's order. The IDON stated a physician order for oxygen therapy was essential to ensure oxygen therapy was administered at the correct dose, or LPMs, and duration to be safe and effective for Resident 32. The IDON stated safe and effective oxygen therapy administration prevented hypoxemia (low blood oxygen), oxygen toxicity, and ensured appropriate equipment was used for resident specific needs. The IDON stated facility policy and procedure, as well as standards of practice, were not followed when Resident 32 was administered 5 LPM of oxygen therapy through a nasal cannula with no physician order. During a review of Resident 143's Order Summary Report (OSR), dated 4/9/26, the OSR indicated Resident 32 did not have a physician's order for oxygen therapy through a nasal cannula. During a review of Resident 32's Care Plan Report (CP), undated, the CP indicated, Resident 32 had a diagnosis of acute respiratory failure with hypoxia, COPD, and CHF. The CP indicated, .give medications as ordered by physician. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated 1/2018, the P&P indicated, .verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. During a review of the facility's P&P titled, Physician Orders, dated 1/2018, the P&P indicated, .physician orders are obtained to provide a clear direction in the care of the resident.all orders must be documented. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a professional reference review retrieved from https://pubmed.ncbi.nlm.nih.gov/19377391/ titled, The use of medical orders in acute care oxygen therapy, dated 2009, the professional reference review indicated, . Oxygen is considered to be a drug requiring a medical prescription and is subject to any law that covers its use and prescription . authorized by a physician following legal written instruction to a qualified nurse . 2.During an observation on 4/9/26 at 8:43 a.m. with LVN 2, in Resident 64's room, LVN 2 wrapped the blood pressure cuff (a medical device consisting of a piece of rubber or similar material that is wrapped around a patient's arm and then inflated in order to measure their blood pressure) around Resident 64's right upper arm with blood pressure reading of 130/58. LVN 2 went to the medication cart parked in front of Resident 64's room, prepared Resident 64's two medications of Metoprolol Tartrate and Vitamin D (a fat-soluble nutrient essential for bone health, immune function, and calcium absorption) and placed in medication cup. During an observation on 4/9/26 at 8:56 a.m. with LVN 2, in Resident 64's room, LVN 2 asked Resident 64's name and stated, I have your medicine for your blood pressure and Vitamin D. LVN 2 assisted Resident 64 to sit up at the edge of the bed and administered the two medications. During an observation on 4/9/26 at 8:59 a.m., outside Resident 64's room, LVN 2 was signing the Electronic Medication Administration Record (EMAR- an electronic daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for Metoprolol Tartrate, the EMAR indicated to check Resident 64's pulse rate. LVN 2 went back to Resident 64 and started checking pulse rate in her right wrist. During a concurrent interview and record review on 4/9/26 at 12:40 p.m. with LVN 2, Resident 64's EMAR, dated 4/9/26 was reviewed. The EMAR indicated, Metoprolol Tartrate oral tablet 25 mg (milligrams -metric unit of measurement, used for medication dosage and/or amount) give one tablet by mouth two times a day related to Essential (Primary) Hypertension (abnormally high blood pressure [the amount of force the heart uses to pump blood through the arteries] that is not the result of a medical condition) hold if sbp (systolic blood pressure < (less than)100 and HR< 60. LVN 2 stated the physician ordered a parameter when to hold the medication. LVN 2 stated she did not check Resident 64's pulse rate before administering the Metoprolol Tartrate. LVN 2 stated she should check and verify Resident 64's pulse rate prior to administering the Metoprolol Tartrate to prevent low blood pressure and low pulse rate. LVN 2 stated she should follow the physician's order to prevent negative outcomes such as heart failure to Resident 64. During a review of Resident 64's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 4/10/26, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnosis of essential (primary) hypertension. During a review of Resident 64's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 3/10/26, the MDS section C indicated Resident 64 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 6 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 64's cognition was severely impaired. During an interview on 4/10/26 at 3:09 p.m. with the Interim Director of Nursing (IDON), the IDON (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated her expectation for the licensed nurses is to follow the P&P for administering medication and following physician's orders. The IDON stated LVN 2 should check and verify Resident 64's pulse rate prior to administering Metoprolol per physician's order to prevent a drop in pulse rate and blood pressure. The DON stated it is important to follow the P&P for medication administration to prevent negative outcome to residents including falls. During a review of facility's P&P titled, Administering Medication, dated 1/2018, the P&P indicated, Medications shall be administered in a safe and timely manner, ad as prescribed.3. Medications must be administered in accordance with the orders. 8. The following information must be checked/verified for each resident prior to administering medications: b. vital signs, if necessary. During a review of the facility's P&P titled, Physician Orders, dated 1/2018, the P&P indicated, .physician orders are obtained to provide a clear direction in the care of the resident. 3.During an observation on 4/9/26 at 5:05 p.m. with LVN 1, in Resident 59's room, LVN 1 wrapped the blood pressure cuff around Resident 59's left upper arm and got a blood pressure reading of 122/67. LVN 1 went to the medication cart parked outside Resident 59's room and started preparing Resident 59's p.m. medication. LVN 1 opened a bottle of Aspirin 81 mg Enteric Coated (orange and shiny tablet) and placed one pill inside the medication cup. LVN 1 continued to prepare two more medications for Resident 59. During an observation on 4/9/26 at 5:09 p.m. with LVN 1, in Resident 59's room, LVN 1 administered three medications including Aspirin 81 mg enteric coated to Resident 59. Resident 59 swallowed the three medications with a cup of water. During a concurrent observation and interview on 4/9/26 at 5:10 p.m. with LVN 1, in front of the medication cart parked outside Resident 59's room. LVN 1 was signing Resident 59's EMAR for Aspirin 81 mg Chewable tablet. LVN 1 stated she administered Aspirin 81 mg enteric coated to Resident 59. LVN 1 stated she will change the order for Aspirin 81 mg chewable to Aspirin 81 mg enteric coated. During a concurrent interview and record review on 4/10/26 at 9:18 a.m. with LVN 1, Resident 59's EMAR, dated 4/9/26 was reviewed. The EMAR indicated LVN 1's initials for Aspirin Oral Tablet Chewable 81 mg give 1 tablet by mouth in the evening related to Cerebral Infarction (damage to tissues in the brain due to a loss of oxygen to the area). LVN 1 stated she signed Resident 59's EMAR for Aspirin 81 mg chewable tablet but she administered Aspirin 81 mg enteric coated to Resident 59 yesterday (4/9/26). LVN 1 stated physicians order should be followed, and she should administer Aspirin 81 mg chewable tablet to Resident 59 as indicated in the EMAR. LVN 1 stated Aspirin enteric coated cannot be crushed and does not absorb quickly while Aspirin chewable absorbs quickly. LVN 1 stated she believed it was not a medication error because the name and dose of medication were the same and stated she will consult her supervisor. During an interview on 4/10/26 at 12:01 p.m. with the Pharmacy Consultant (PC), the PC stated Aspirin enteric coated and chewable have different formulations. The PC stated chewable are crushable with quick absorption while enteric coated are not crushable with delayed absorption. The PC stated it was considered a medication error when Aspirin enteric coated was administered instead of Aspirin chewable as ordered by the physician. The PC stated licensed nurses should contact the physician for the medication error. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/10/26 at 3:09 p.m. with the IDON, the IDON stated Aspirin chewable and enteric coated were not the same medication. The IDON stated Aspirin chewable dissolves faster while Aspirin enteric coated is long acting with slow absorption. The IDON stated it was a medication error when licensed nurse administered Aspirin 81 mg enteric coated with a physician's order of Aspirin 81 mg chewable tablet. The IDON stated she spoke with LVN 1 and change of condition was completed for Resident 59's medication error. The IDON stated it was her expectation for licensed nurses to follow the P&P for medication administration and following physician's orders to prevent medication error. During a review of Resident 59's AR, dated 4/14/26, the AR indicated Resident 1 was admitted to the facility on [DATE] with primary diagnosis of Cerebral Infarction. During a review of Resident 59's MDS, dated [DATE], the MDS section C indicated Resident 59's BIMS - was not conducted with a code of 0 indicating No (resident is rarely/never understood). Resident 59's BIMS Summary Score was blank. During a review of facility's P&P titled, Administering Medication, dated 1/2018, the P&P indicated, Medications shall be administered in a safe and timely manner, ad as prescribed.3. Medications must be administered in accordance with the orders. 7. The individual administering the medication must check the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. During a review of the facility's P&P titled, Physician Orders, dated 1/2018, the P&P indicated, .physician orders are obtained to provide a clear direction in the care of the resident. 4.During an observation on 4/9/26 at 12:19 p.m. with LVN 2 at the end of Station 1 hallway, LVN 2 left the computer screen open showing the EMAR of the residents and was pushing the medication cart with computer screen showing residents EMAR including residents' names and photos remained visible until reaching nursing station 1. LVN 2 needed to stop three times while passing by the hallway to give way for other facility's staff and family, the computer screen was kept open, and residents' information was visible. During an interview on 4/9/26 at 12:37 p.m. with LVN 2, LVN 2 stated medication cart's computer screen should be hidden and not visible for other staff, families and residents and stated, HIPPA (Health Insurance Portability and Accountability Act - applies to healthcare providers, insurers, and other organizations handling patient data, mandating safeguards to prevent unauthorized access or misuse of sensitive information) compliance. LVN 2 stated resident health information should be protected. LVN 2 stated when licensed nurses were away from their medication cart and in areas where other people can see residents' information like in the hallway, computer screen should be closed or hidden. LVN 2 stated Station 1 hallway was a high traffic area where staff, families and residents were constantly passing by. During an interview on 4/10/26 at 3:09 p.m. with the IDON, the IDON stated medication cart's computer screen should be closed when not in use. The IDON stated residents' EMAR contains personal health information and should not be visible to other residents, families, and unauthorized staff to protect residents' health information. During a review of the facility's P&P titled Confidentiality and Non-Disclosure Agreement, dated 1/2028, the P&P indicated, Users who are granted access to our facility's protected health and (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	financial information will be required to sign a confidentiality and non-disclosure agreement. 1. The purpose of this policy is to maintain an adequate level of security to protect residents and facility information from unauthorized access, use or disclosure. 2. Only authorized users are granted access to resident and facility information. During a review of professional reference retrieved from https://www.ncbi.nlm.nih.gov/books/NBK500019/ tilted Health Insurance Portability and Accountability Act (HIPAA) Compliance, dated, indicated, The US Health Insurance Portability and Accountability Act (HIPAA), enacted in 1996, was established to safeguard patient privacy and secure health information. HIPAA sets strict standards for managing, transmitting, and storing protected health information. HIPAA applies to healthcare providers, insurers, and other organizations handling patient data, mandating safeguards to prevent unauthorized access or misuse of sensitive information. 5. During an observation on 4/7/26 at 9:40 a.m. with Resident 1, in Resident 1's room, Resident 1 was lying in bed, asleep. Resident 1's body was covered by white sheets. During an observation on 4/8/26 at 5:00 p.m., Resident 1 was not in the room. During a review of Resident 1's electronic medical record titled, OSR, undated, indicated, Dialysis Days: (Monday, Wednesday and Friday) chair time: 5:15 p.m. During a concurrent interview and record review on 4/9/26 at 5:16 p.m. with LVN 5, Resident 1's weights, dated 10/11/25 – 4/30/26 were reviewed. The weights indicated, 04/02/2026 173 lbs. ((pounds-a unit of weight and mass) +10.0% change [Comparison Weight 10/06/2025, 145.0 lbs., +19.3%, +28.0 lbs.] +7.5 change [Comparison Weight 01/06/2026, 13.0 lbs., +13.1%, +20.0 lbs.] 03/02/2026 167 lbs. +10.0% change [Comparison Weight 09/22/2025, 150.0 lbs., +11.3%, +17.0 lbs.] +7.5% change [Comparison Weight 12/02/2025, 154.0 lbs., +8.4%, + 13.0 lbs.]. LVN 5 stated Resident 1 had a significant weight gain of 10% for six months and 7.5% for three months. LVN 5 stated Resident 1 was receiving dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), on fluid restriction of 1200 ml/day and had chronic bilateral lower extremities edema (swelling caused by fluid in your body's tissues. It usually occurs in the feet, ankles and legs, but it can involve your entire body). During a concurrent interview and record review on 4/9/26 at 5:19 p.m. with LVN 5, Resident 1's Nursing-SBAR (Situation Background Assessment Request) Communication Form and progress note, dated 3/2026 – 4/2026 were reviewed. LVN 5 indicated and stated there was no change of condition SBAR completed for Resident 1's significant weight gain of 10% for 6 months and 7.5% for three months. LVN 5 stated a significant weight gain was considered a change of condition. LVN 5 stated licensed nurses should assess Resident 1 for a change of condition SBAR for the month of March and April 2026 to monitor Resident 1 for fluid retention and overload. During a review of Resident 1's AR, dated 4/14/26, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnosis of type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), essential (primary) hypertension (abnormally high blood pressure [the amount of force the heart uses to pump blood through the arteries] that is not the result of a medical condition), dysphagia (difficulty swallowing), and edema. Resident 1's diagnosis information did not indicate diagnosis of kidney failure, Resident 1 was receiving dialysis. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's MDS, dated [DATE], the MDS section C indicated Resident 1 had a BIMS score of 11, which indicated Resident 1's cognition was moderately impaired. During a concurrent interview and record review on 4/10/26 at 9:18 a.m. with LVN 1, Resident 1's Nursing Weekly Summary Notes, dated 4/8/26 was reviewed. The Nursing Weekly Summary Notes indicated, . Cardiac (relating to heart)/circulation.edema present.location +3 edema to bilateral lower extremities. pitting 3+pit edema (a medical sign of moderate-to-deep fluid retention (swelling), indicating a 5–6 mm [millimeters -unit of measurement] indentation (pit) that remains for 15 to 60 seconds after pressure is removed) .dependent extremity swollen. LVN 1 stated Resident 1 had no edema to bilateral lower extremities. LVN 1 stated she worked yesterday (4/9/26) a.m. and p.m. shift and did not notice edema to bilateral lower extremities. LVN 1 stated night shift license nurses were responsible in assessing residents to complete the Nursing Weekly Summary Notes. During concurrent observation and interview on 4/10/26 at 9:36 a.m. with LVN 1, in Resident 1's room with CNA 2 as interpreter (Resident 1 was speaking in Spanish), LVN 1 assessed Resident 1's bilateral lower extremities and stated there was no edema to bilateral lower extremities. LVN 1 stated Resident 1's +3 edema to bilateral lower extremities were resolved. During a concurrent interview and record review on 4/10/26 at 9:40 a.m. with LVN 1, Resident 1's weights and SBAR were reviewed. The weights indicated, 04/02/2026 173 lbs. (Dialysis Weight) and 03/02/2026 167 lbs. (Dialysis Weight). LVN 1 stated Resident 1 has a weight gain of 6 lbs. in a month and had a significant weight gain 10% in six months and 7.5% in three months for the months of March and April 2026. LVN 1 stated there was no change of condition SBAR done for Resident 1's significant weight gain. LVN 1 stated Resident 1 should be assessed for a change of condition SBAR due to significant weight gain to monitor Resident 1 for 72 hours and identify the cause of significant weight gain. During an interview on 4/10/26 at 3:09 p.m. with the IDON, the IDON stated it was her expectation for licensed nurses to complete a change of condition SBAR for significant weight changes. The IDON stated that a significant weight change applies to loss and gain of 5% in one month, 7.5% in three months, and 10% for 180 days or six months. The IDON stated licensed nurses should accurately assess residents with significant weight changes to identify the root cause and to prevent a delay in implementation of appropriate and necessary interventions and services to prevent further weight loss/gain. During a review of the facility's P&P titled Change in a Resident's Condition, dated 1/2018, the P&P indicated, Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status. 3. Prior to notifying the Physician or healthcare provider, the nurse will make observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the SBAR Communication Form. During a review of Nursing World.org Professional Reference titled, The American Nurses Association-Nursing: Scope and Standards of Practice, Third Edition, dated July 2015, (found at https://www.nursingworld.org/~4af71a/globalassets/catalog/book-toc/nssp3e-sample-chapter.pdf) the reference indicated, .The Standards of Practice describe a competent level of nursing care as demonstrated by the critical thinking model known as the nursing process. The nursing process includes the components of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. Accordingly, the nursing process encompasses significant actions taken by registered (continued on next page)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were stored in accordance with accepted professional standards of practice for one of eight sampled residents (Resident 21) and other residents when: Resident 21 stored over the counter (OTC) medications (medicines you can get without a prescription) of two jars of expired medicated vapor rub (an OTC medicated topical ointment used to temporarily relieve coughs, nasal congestion, and minor aches/pains using medicated vapors) without physician's order and four colored tablets of Calcium Carbonate (an OTC antacid used to treat heartburn, acid indigestion, and sour stomach) in a medication cup at her bedside table. Resident 21 had no physician's order for self-administration of medications stored at her bedside. This failure placed Resident 21 at an increased risk of improper self-administration of medications which could result in medication errors (any preventable event causing inappropriate medication used or patient harm) and side effects (undesirable effects of drugs), and had the potential for other residents, staff and visitors accessing medications stored at bedside. 2. The medication cart parked at station 1 hallway was not locked and unattended by authorized staff.This failure had the potential to result in unauthorized access and drug diversion (occurs when a medication is taken for use by someone other than whom it is prescribed or for an indication other than what is prescribed) of medications.1. During a concurrent observation and interview on [DATE] at 9:06 a.m. with Resident 21, in Resident 21's room, Resident 21 was sitting in the middle of her bed, alert and oriented x 4 (name, time, place and situation). Resident 21's primary language was Spanish and she was able to understand and speak English. Resident 21's bedside table had a blue basket containing multiple personal belongings and one jar of brand name vapor rub with expiration date of 9/2025. Resident 21 had a basket container on top of her cabinet containing one jar of medicated chest rub with expiration date of 9/2025. Resident 21 stated she had been applying the vapor rub into her nose when she needed it. Resident 21 stated she had used it last week for flu (also called influenza-an infection of the nose, throat and lungs). Resident 21 stated she was not aware of the expiration date and that it had been expired. During a concurrent observation and interview on [DATE] at 9:36 a.m. with Resident 21, in Resident 21's room, Resident 21was self-propelling her wheelchair. Resident 21 had four round tablets (three yellow and one orange color) in a medication cup on top of her bedside table. Resident 21 stated the brand name of the medication, and she was taking it for her stomach pain.During an observation and interview on [DATE] at 9:38 a.m. with Licensed Vocational Nurse (LVN) 3, in Resident 21's room, LVN 3 was talking to Resident 21 in Spanish l about the four tablets of antacid medication in a medication cup at her bedside table. LVN 3 stated that antacid medications were stored at her bedside for two days as indicated by Resident 21. LVN 3 stated he administered an antacid medication to Resident 21 this morning and she took it. LVN 3 stated he was not aware that Resident 21 was keeping antacid medications in her bedside table and taking it when she needed it. During a concurrent interview and record review on [DATE] at 9:40 a.m. with LVN 3, Resident 21's Electronic Medical Records (EMR - a digital version of a patient's paper chart) titled, Order Summary Report, undated, and Nursing admission Assessment, dated 6/2023 were reviewed. The Order Summary Report indicated, . Calcium Carbonate (Antacids) Oral tablet chewable. give 2 tablets by mouth three times a day related to Epigastric pain (a discomfort in the upper abdomen, just below the ribs). LVN 3 stated there was no physician's order for vapor rub or to perform self-administration of her medications. The Nursing admission Assessment indicated, self-administration: No. LVN 3 stated Resident 21 cannot perform self-administration and should not be self-administering her OTC medications at bedside without physician's orders. LVN 3 stated Resident 21 was alert oriented but forgetful. LVN 3 stated Resident 21 should not be storing and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	self-administering OTCs due to safety concerns. LVN 3 stated medications should not be left and stored at bedside. LVN 3 stated licensed nurses were responsible for administering Resident 21's medications and should ensure medications were taken in front of them to prevent potential risk of medication errors. LVN 3 stated Resident 21 could double the dose or not take the medications on time. During a concurrent interview and record review on [DATE] at 9:46 a.m. with Registered Nurse (RN) 4, Resident 21's care plan report, undated, was reviewed. The care plan report indicated, there was no care plan for self-administration of medications. RN 3 stated Resident 21's OTC medications should not be left and stored at bedside without a physician's order and self-administration assessment. RN 3 stated Resident 21's improper storage of OTC medications at bedside had a potential risk of medication errors and access to OTC medications by other residents and staff.During a review of Resident 21's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated [DATE], the AR indicated Resident 21 was admitted to the facility on [DATE] with acute upper respiratory infection (a short-term, contagious illness affecting the nose, throat, or airways, typically caused by viruses like the common cold or influenza).During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated [DATE], the MDS section C indicated Resident 21 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 21 was cognitively intact.During an interview on [DATE] at 3:09 p.m. with the Interim Director of Nursing (IDON), the IDON stated it was her expectation for the licensed nurses to follow the facility's Policy and Procedure (P&P) for proper medication storage. The IDON stated OTC medications should not be left and stored at bedside to prevent access to the medications by other residents. The IDON stated other residents can walk into the room and access the medications which could cause side effects and medication errors. The IDON stated OTC medications require a physician order. The IDON stated Resident 21 should not perform self-administration of OTC medications at bedside without physician's order and assessments. During a review of facility's P&P titled, Storage of Medications, dated 1/2018, the P&P indicated, The facility stores all drugs and biologicals in a safe, secure, and orderly manner. 1. Drugs and biologicals used in the facility are stored in locked compartments. Only persons authorized to prepare and administer medications have access to locked medications. 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 6. Compartments (including, but not limited to drawers, cabinets, rooms, carts.) containing medications and biologicals are locked when not in used. 2.During an observation on [DATE] at 8:43 a.m. with LVN 2, at station 1 hallway, LVN 2 opened the medication cart and was looking for a disinfectant wipe. LVN 2 asked LVN 1 for a disinfectant wipe to clean the blood pressure monitor (a device used to measure blood pressure).During an observation on [DATE] at 8:44 a.m. with LVN 1, at nursing station 1, LVN 1 went to the medication cart parked in the hallway, opened the medication cart and took a container of the disinfectant wipe and handed it to LVN 2. LVN 1 closed the drawer of the medication cart and did not lock the medication cart. LVN 1 left and went back to the nursing station 1.During an observation on [DATE] at 9:00 a.m. at station 1 hallway, the medication cart remained unlocked and unattended. During a concurrent observation and interview on [DATE] at 9:09 a.m. with LVN 2, in front of the medication cart parked at the hallway, LVN 2 was cleaning the blood pressure monitor with the disinfectant wipes. LVN 2 went to another medication cart parked in the hallway, opened the bottom drawer and placed the blood pressure monitor in the drawer. LVN 2 stated the medication cart was not locked. During an interview on [DATE] at 9:13 a.m. LVN 2 stated LVN 1 forgot to lock the medication cart. LVN 2 stated medication cart should be locked when unattended because it contained medications. LVN 2 stated the medication cart was parked in the hallway where (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unauthorized staff (housekeeping and laundry, managers and certified nursing assistants), residents and families were constantly passing by. LVN 2 stated unauthorized staff, residents and families can access the medication cart when unlocked and had the potential to cause medication errors.During an interview on [DATE] at 9:16 a.m. with LVN 1 and LVN 2, LVN 2 validated and informed LVN 1 that her medication cart was not locked. LVN 1 stated medication cart should be locked at all times. LVN 1 stated licensed nurses should keep medication cart locked when unattended to prevent access to medications by unauthorized staff and residents. LVN 1 stated there will be an increased risk of accessing the medications when medication cart is unlocked and stated, anyone can open the med cart. get medicine, which could lead to medication errors and side effects.During an interview on [DATE] at 3:09 p.m. with the IDON, the IDON stated it was her expectation for the licensed nurses to follow the facility's P&P for proper medication storage by keeping medication cart locked when unattended. The IDON stated it was not an acceptable practice for licensed nurses not locking their medication carts when not in use and unattended. The IDON stated there was an increased risk of accessing the medication cart when unlocked by unauthorized staff, residents and visitors. The IDON stated residents can open the medication cart and get the medications which could cause side effects and medication errors. During a review of facility's P&P titled, Storage of Medications, dated 1/2018, the P&P indicated, The facility stores all drugs and biologicals in a safe, secure, and orderly manner. 1. Drugs and biologicals used in the facility are stored in locked compartments. Only persons authorized to prepare and administer medications have access to locked medications. 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 6. Compartments (including, but not limited to drawers, cabinets, rooms, carts.) containing medications and biologicals are locked when not in used. Unlocked medication carts are not left unattended.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food was stored, distributed, and served safely when the ice machine was observed with pale pink colored residue on the ice grate (a compartment within the ice machine that determines the size of the ice cubes that are produced).This failure resulted in the facility ice machine not being in a clean safe operating condition which can lead to the growth of microorganisms and result in foodborne illness for 69 out of 70 residents eating ice at the facility. During a concurrent observation and interview on 4/7/26 at 9:06 a.m. with the Maintenance Director (MND), the Kitchen Supervisor (KS), and the Registered Dietician (RD), the ice machine was observed in the kitchen. The MND was observed removing the ice grate cover. A pale pink colored residue was observed at the top of the ice grate. The MND was observed removing the pale pink residue with a white napkin. The KS stated the ice machine was expected to always be free from discoloration and/or residue.During a concurrent interview and record review on 4/9/26 at 11:42 a.m. with the KS, the kitchen documents titled, Maintenance Request Form (MRF), [Brand Name] Ice Machine Cleaning & Sanitation Log, and Ice Machine Sanitation Log undated, were reviewed. The KS stated on 1/7/26 the ice machine needed a new ice machine filter and was removed from service. The KS stated on 1/9/26 the MND ordered a new ice machine filter. The KS stated the kitchen documents did not indicate the exact date the ice machine was placed back into service, but the KS stated it was approximately the first week of 3/2026. The KS stated kitchen staff maintained a [Brand Name] Ice Machine Cleaning & Sanitation Log which indicated when the external portion of the ice machine was cleaned by kitchen staff. The KS stated kitchen staff maintained a Ice Machine Sanitation Log, posted on the ice machine, which indicated when the internal portion of the ice machine was cleaned by maintenance. The KS stated the Ice Machine Sanitation Log did not indicate the ice machine was cleaned before the ice machine was placed back into service. The KS stated the ice machine was expected to be cleaned internally before placing back into service to ensure it was clean and sanitized before use. The KS stated kitchen staff maintained the outside of the ice machine and the MND maintained the inside of the ice machine. The KS stated facility policy and procedure, and expectation was to clean the ice machine internally once a month. The KS stated the expectation for the ice machine was to inspect the internal components in between cleanings to ensure there was no discoloration and/or residue. The KS stated it was important to ensure the ice machine did not have any pale pink residue within the ice machine because it could lead to contamination of the ice. The KS stated if contaminated ice was consumed by residents it could result in food borne illness.During an interview on 4/9/26 at 11:50 a.m. with the RD, the RD stated the ice machine was removed from service on 1/7/2026 and was not placed back into service until 3/2026. The RD stated ice machine cleaning logs did not indicate the ice machine was internally cleaned before it was placed back into service during the first week of 3/2026. The RD stated if the ice machine internal cleaning was not documented, it could not be guaranteed it happened. The RD stated the ice machine was expected to be cleaned monthly and after periods of inactivity to ensure the internal components were free from contamination. The RD stated the ice machine was expected to always be clean and free from signs of discoloration and/or residue. The RD stated the pale peach colored discoloration on the ice grate was at risk of contaminating the ice. The RD stated if residents ate contaminated ice they were at risk for food borne illness. During an interview on 4/9/26 at 11:56 a.m. with the MND, the MND stated the ice machine was removed from service on 1/7/26 and placed back into service the first week of 3/2026. The MND stated maintenance did not maintain a separate internal ice machine sanitation log than the kitchen. The MND stated the internal ice machine cleaning log, Ice Machine Sanitation Log, was posted on the front of the ice machine. The MND stated the Ice Machine Sanitation Log, did not indicate the ice machine was internally cleaned before being placed back into service the first week of 3/2026.During an interview on 4/10/26 at 3:02 p.m. with the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interim Director of Nursing (IDON), the IDON stated ice was food and all food was expected, per policy, to be served under sanitary conditions. The IDON stated the ice machine was expected to be cleaned after periods of inactivity to ensure any potential contamination during service was removed before placing the ice machine back into use. The IDON stated the ice machine was expected to always be free from discoloration and/or debris to prevent contamination of ice which could result in foodborne illness if consumed.During a review of the facility's document titled, Diet Type Report, dated 4/9/26, the document indicated there were sixty-nine residents with diets. The document indicated one resident had a diet for nothing by mouth (NPO).During a review of the facility's policy and procedure (P&P) titled, Ice Machine Cleaning Procedures, dated 2023, the P&P indicated, .the ice machine needs to be cleaned and sanitized monthly.the internal components cleaned monthly or per manufacturer's recommendation, and the date recorded when cleaned.the maintenance supervisor can keep this record or it can be posted on the ice machine.During a review of the facility's ice machine manufacturer's guideline (MFG) titled, [Brand Name] Ice Machine Handbook & Maintenance Log, undated, the MFG indicated, .if the ice machine requires more frequent cleaning and sanitizing, consult a qualified service company.an extremely dirty ice machine must be taken apart for cleaning and sanitizing .removal from service/winterization.special precautions must be taken if the ice machine is to be removed from service for an extended period of time or exposed to an ambient temperature of 32 [Fahrenheit].

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview and record review, the facility failed to follow professional standards of practice to ensure the Care Plan (CP) was reviewed and revised in a timely manner for one of six sampled residents (Resident 6) when the goals for Resident 6 were not reviewed and revised for right and left (bilateral) lower leg edema (swelling) for six months (since October 2025).This failure had the potential for Resident 6 to not receive the appropriate care for his bilateral lower limb edema and put Resident 6 at risk of adverse (harmful) effects from swelling such as skin breakdown, infection, hypertension (when the pressure in the blood vessels is too high), cardiovascular disease (heart disease) and death.Findings:During a concurrent observation and interview on 4/7/2026 at 12:34 p.m. with Resident 6 in Resident 6's room, Resident 6 was observed in bed, wearing a gown. Resident 6 had minimal verbalization and gestured with a thumbs up and nod that he was doing well and had no issues. Resident 6's legs were uncovered and were observed to have swelling in both lower limbs.During a review of Resident 6's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 4/9/26, the AR indicated Resident 6 was admitted to the facility from an acute care hospital on 8/5/24 with diagnoses of cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), hypertension, dysphagia (difficulty swallowing), localized edema, tubule-interstitial nephritis (kidney damage that occurs outside the structures that filter the blood), and pain in leg, unspecified.During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 2/4/26, the MDS section C indicated Resident 6 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 11 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 6 was moderately impaired. During a concurrent interview and record review on 4/8/2026 at 4:12 p.m. with Registered Nurse (RN) 3, Resident 6's Order Summary Report (OSR), undated, the OSR indicated, monitor +2 edema to the bilateral lower extremities for any signs and symptoms [s/s] of worsening. Notify physician [MD] if noted any. Every shift.order status.active.order date 10/27/2025.start date 10/27/25. RN 3 stated Resident 6 had bilateral leg swelling and staff was monitoring the swelling and would notify the physician if it worsened. RN 3 stated Resident 6 was not taking any medication for his swelling and was not receiving any treatment for his swelling except to elevate his right foot while in bed for foot pain.During a concurrent interview and record review on 4/08/2026 at 4:31 p.m. with RN 1, Resident 6's OSR, undated was reviewed. RN 1 stated Resident 6 was not receiving any medication for edema. RN 1 stated for a resident with any skin condition or any change of condition nurses completed an SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) and monitored the resident for 72 hours. RN 1 stated if there was no improvement, nurses notified the physician. RN 1 stated Resident 6 was being monitored for pain in his right foot, but not for his bilateral leg swelling. RN 1 stated Resident 6's physician should have been notified of his continued leg swelling. RN 1 stated it was important to notify the physician if there was no improvement in Resident 6's swelling, as the swelling could have been from fluid overload and Resident 6 might have needed a diuretic (a medication used to remove excess fluid from the body).During a concurrent interview and record review on 4/08/2026 at 4:31 p.m. with RN 1, Resident 6's Care Plan, undated was reviewed. The CP indicated, .resident has a +2 edema to the bilateral lower extremities.resident will maintain optimal fluid balance [stable weight, minimal edema].assess and document extent of edema.avoid prolonged standing or sitting.elevate affected extremities above heart level several (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times daily.[furosemide-a medication used to treat edema and hypertension] oral tablet 20milligrams [MG - a unit of measurement] give 1 tablet by mouth two times a day related to localized edema.for 2 weeks. RN 1 stated Resident 6 ?s CP was initiated on 10/27/25 for edema bilateral legs, and nurses were to assess and document his edema, elevate affected limbs, and monitor Resident 6's weight. RN 1 stated Resident 6 should have had a new assessment with new orders for fluids and medications, and his care plan revised. RN 1 stated Resident 6's continued leg swelling should have been caught by the nurses' weekly assessments.During an interview on 4/10/2026 at 12:30 p.m. with the Minimum Data Set Coordinator (MDS), the MDS stated she reviewed residents CPs, and Change of Condition (COC) assessments, and updated and revised the residents' CPs. The MDS stated the resident's CP should have had a time frame to see if the intervention was working. If the intervention was not working, the nurse should have reassessed the resident and notified the physician for new orders, evaluation and recommendations.During an interview on 4/10/2026 at 3:33 p.m. with the Interim Director of Nursing (IDON), the IDON stated if the resident had a COC, the nurse should have completed an SBAR, notified the physician, family or resident Responsible Party, received new orders and put on 72-hour monitoring. The IDON stated the resident's CP should have been revised with a time frame for the COC and intervention, which was usually seven days or two weeks to reassess the resident and see if the intervention was working. If there was no time frame for the intervention, the nurse should have asked the physician. If the intervention was resolved the residents' CP should have been revised to show the COC was resolved. The IDON stated monitoring Resident 6 for bilateral edema with no change or other intervention since October 2025 was not acceptable. The IDON stated staff should have followed up with Resident 6's physician. The IDON stated nursing, department managers, and the interdisciplinary team, which included the DON and the Director of Staff Development, should have looked at the 24-hour shift reports to see if Resident 6 continued with the COC. The IDON stated the nurses were ultimately responsible for not catching the continued swelling during the weekly assessments. The IDON stated Resident 6's CP should have been revised with an updated physician's order. The IDON stated resident's CPs should have been resident specific, since every resident was different.During a review of the facility's policy and procedure (P&P) titled, Care Planning - Interdisciplinary Team, dated 1/2018, the P&P indicated, .our facility's care planning/Interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident.the care plan is based on the resident's comprehensive assessment.During a review of the facility's P&P titled, Change in a Resident's Condition, dated 1/2018, the P&P indicated, .our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status.a significant change of condition is a major decline or improvement in the resident's status that.will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions.if a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted.During a review of the facility's P&P titled, Charting and Documentation, dated 1/2018, the P&P indicated, .all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.the following information is to be documented in the resident's medical record.changes in the resident's condition.progress toward or changes in the care plan goals and objectives.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure activities of daily living (Activities of Daily Living (ADLs- routine tasks/activities such as grooming, bathing, dressing and toileting a person performs daily to care for themselves) were not provided for two of eight sampled residents (Resident 79 and 17) when: 1.Resident 79's fingernails were long, jagged (sharp, uneven edges) and dirty with brownish to blackish dirt built up underneath the nails and toenails were long and thick.This failure had potential for Resident 79 in obtaining avoidable skin related injuries (including cuts (laceration), scrapes (abrasion), scratches, etc.) and infection (the invasion and growth of germs in the body).2. Resident 17's beard (the growth of hair on the chin and lower cheeks of a man's face) were silvery thick and long. Resident 17 stated he requested to be shaved two weeks ago.This failure had the potential for Resident 17 in harboring microorganisms (bacteria) in his beard that could cause infection.1.During a concurrent observation and interview on 4/7/26 at 8:51 a.m. with Resident 79, in Resident 79's room, Resident 79 was lying in bed with head of bed elevated. Resident 79 was alert and oriented and verbally responsive. Resident 79 had an indwelling foley catheter (a common type of indwelling catheter inserted into the bladder, used to drain urine) with a privacy bag. Resident 79's fingernails were long, and dirty with brownish to blackish dirt built up underneath the nails. Resident 79's left hand was shaking. Resident 79 stated no one cut and cleaned his fingernails. Resident 79 stated he bit his fingernails because they were long. Resident 79 stated he wanted his fingernails to be clean and trimmed. During a concurrent observation and interview on 4/8/26 at 10:56 a.m. with Licensed Vocational Nurse (LVN) 3, in Resident 79's room, LVN 3 checked Resident 79's fingernails and toenails. LVN 3 stated Resident 79's fingernails were long, uneven with sharp edges and dirty with brownish to blackish buildup underneath the nail bed, and toenails were long and thick. LVN 3 asked Resident 79 about biting his fingernails and Resident 79 stated he's been biting his fingernails because they were long. LVN 3 stated Resident 79 required assistance with his ADLs. LVN 3 stated he will inform the Social Services Director (SSD) to schedule a podiatrist (a doctor specializing in diagnosing and treating foot, ankle, and lower leg conditions) to trim his toenails. LVN 3 stated nail care should be provided by nursing staff and podiatrists to prevent infection and skin scratches. During an interview on 4/8/26 at 11:08 a.m. with the SSD, SSD stated Resident 79 had not seen or been evaluated by the podiatrist since admission. The SSD stated Resident 79 should be seen and evaluated by the podiatrist for toenail care. The SSD stated Resident 79 was not on the list for podiatrist visit because she did not receive a communication form from the licensed nurses for Resident 79's need of podiatry services. During an interview on 4/10/26 at 2:20 p.m. with the Director of Staff and Development (DSD), the DSD stated she was responsible for providing training with Certified Nursing Assistants (CNAs). The DSD stated it was her expectation for CNAs to provide nail care every Sunday and as needed if no restrictions. The DSD stated residents' fingernails and toenails should be checked by the CNAs during shower days twice a week. The DSD stated she conducts weekly checks to ensure residents are clean and well groomed. The DSD stated nails that were long and dirty could result in self-inflicted injuries like skin tears and scratches and harbor germs that could cause infection.During an interview on 4/10/26 at 3:09 p.m. with the Interim Director of Nursing (IDON), the IDON stated it was her expectation for staff to follow P&P for nail care by keeping residents' nails clean and trimmed and stated, nice and clean to prevent skin tears and infection. The IDON stated Resident 79 had an increased risk of getting infection related to biting his fingernails. The IDON stated new admit residents should receive necessary care and treatments including podiatrist care and services when needed.During a review of Resident 79's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 4/10/26, the AR indicated Resident 49 was admitted to the facility (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Postacute Care	1233 A Street Fresno, CA 93706

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on [DATE] with primary diagnosis of cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area).During a review of Resident 79's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 3/6/26, the MDS section C indicated Resident 79 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 79 was cognitively intact.During a review of facility's policy and procedures (P&P) titled, Activities of Daily Living (ADLs), Supporting, dated 1/2028, the P&P indicated, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care) .During a review of facility's P&P titled, Fingernails/Toenails, Care of, dated 1/2018, the P&P indicated, The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections.1. Nail care includes cleaning and regular trimming during showers and/or as needed. 2. Proper nail care can aid in the prevention of skin problems around the nail bed. 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. 6. Stop and report to the nurse supervisor if there is evidence of. or if nails are too hard or too thick to cut with ease. During a review of facility's P&P titled, Foot Care, dated 1/20/28, the P&P indicated, Residents will receive appropriate care and treatment in order to maintain mobility and foot health. 1. Residents will be provided with foot care and treatment in accordance with professional standards of practice. 2. During a concurrent observation and interview 4/7/26 at 12:28 p.m. with Resident 17, in Resident 17's room, Resident 17 was self-propelling his wheelchair. Resident 17 was alert and oriented x 4 (name, time, place, event/situation). Resident 17 had a thick silvery beard. Resident 17 stated he'd been waiting for the staff to shave him and the last time he was shaved was two weeks ago. Resident 17 stated staff were aware that he needed a shave and informed them that he wanted to shave his beard. During a review of Resident 17's MDS, dated [DATE], the MDS section C indicated Resident 17 had a BIMS score of 15. Resident 17 was cognitively intact.During an interview on 4/8/26 at 11:13 a.m. with CNA 7, CNAs should provide shaving during showers and as needed if residents allow. CNA 7 stated shaving was part of providing good hygiene. CNA 7 residents should be shaved to look clean, presentable, and to prevent infection. CNA 7 stated he was not the CNA assigned to Resident 17 and he will look for his CNA.During a concurrent observation and interview on 4/8/26 at 11:16 a.m. with CNA 8, outside Resident 17's room, CNA 8 was talking to Resident 17 about shaving him today (4/8/26). Resident 17 stated he wanted to keep his mustache (a strip of hair left to grow above the upper lip). During an observation and interview on 4/8/26 at 2:55 p.m. with Resident 17, in Resident 17's room, Resident 17 was lying in bed with oxygen via nasal canula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen). Resident 17's beard remained thick and long. Resident 17 stated no one shaved him yet. Resident 17 stated he's been waiting to be shaved.During a concurrent observation and interview on 4/8/26 at 3:00 p.m. with CNA 8, in Resident 17's room, CNA 8 was talking to Resident 17 about scheduling his shaving tomorrow (4/9/26) because CNA 8 ran out of time. CNA 8 stated he got busy and could not shave Resident 17 today (4/8/26). CNA 8 stated he had no time to shave Resident 17 because he got busy with other residents. During an interview on 4/8/26 at 3:05 p.m. with Resident 17, in Resident 17's room, Resident 17 stated CNA 8 did not shave him today (4/8/26), and stated, I was puzzled.During an interview on 4/8/26 at 3:10 p.m. with the Infection Preventionist (IP), the IP stated she was working as charge nurse today (4/8/26) and Resident 17 was one of her residents. The IP stated Resident 17 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should be shaved today as requested by his CNA and it was not acceptable that he's been waiting for two weeks to be shaved. The IP stated Resident 17 should be shaved by CNA as needed to maintain cleanliness and prevent infection. The IP stated Resident 17 smokes and cigars ashes could potentially transfer to his beard that could cause infection.During an interview on 4/10/26 at 3:09 p.m. with the IDON, the IDON stated it was her expectation for CNAs to provide and maintain proper grooming including shaving to keep residents nice and clean. The IDON stated it was not acceptable for Resident 17 to wait for two weeks to be shaved. The IDON stated when residents requested to be shaved it should be done within the shift. The IDON stated residents should be shaved during shower days.During a review of facility's policy and procedures (P&P) titled, Activities of Daily Living (ADLs), Supporting, dated 1/2028, the P&P indicated, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and person and oral hygiene. 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care) .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice when Resident 54 received medication from unauthorized staff and was not monitored and assessed by Licensed Nurses for effective medication and treatment.This failure had the potential for Resident 54 not to receive necessary care, treatment, and services based on comprehensive assessment and comprehensive person-centered care plan.During a concurrent observation and interview on 4/7/26 at 9:46 a.m. with Resident 54, in Resident 54's room, Resident 54 was lying flat on low air loss mattress (a specialized medical surface that combines alternating pressure with a steady, low-volume airflow to treat or prevent pressure ulcers (bedsores) and manage moisture) in his bed. Resident 54 was awake, watching a program on television. Resident 54 was not verbally responsive and had no eye contact during conversation. Resident 54's forehead with creamy yellowish plaque (abnormal buildup or deposit, either a solid patch on the skin/organs) buildup and yellowish flakes in his hair. Resident 54 had bilateral lower extremities contractures (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff).During a concurrent observation and interview on 4/8/26 at 11:38 a.m. with CNA 7, in Resident 54's room, CNA 7 was cleaning Resident 54's forehead. CNA 7 stated Resident 54 had a thick and creamy yellowish buildup on his forehead and multiple dry yellow skin flakes on his hair like dandruff (a skin condition of scaly white or grayish flakes of dead skin of the scalp). CNA 7 stated Resident 54 was totally dependent on staff for his activities of daily living (Activities of Daily Living (ADLs- routine tasks/activities such as grooming, bathing, dressing and toileting a person performs daily to care for themselves). CNA 7 stated he will notify the license nurse to assess Resident 54's skin and scalp because it was difficult to remove.During a concurrent observation and interview on 4/8/26 at 11:39 a.m. with Licensed Vocational Nurse (LVN) 2, in Resident 54's room, LVN 2 checked Resident 54's head and forehead. LVN 2 stated Resident 54's forehead was red with buildup of thick yellowish plaques and skin flakes on his hair. LVN 2 stated Resident 54 was at risk for skin breakdown and licensed nurses should conduct skin assessments on shower days. LVN 2 stated she will notify the wound doctor to assess and evaluate Resident 54 skin condition.During a concurrent interview and record review on 4/8/26 at 11:40 p.m. with LVN 2, Resident 54's Nursing Weekly Summary Notes, dated 4/7/26 was reviewed. The Nursing Weekly Summary Notes indicated, L. Skin -Is skin clean and intact? Yes. LVN 2 stated the large amount of buildup of thick yellowish plaques on Resident 54's was not documented. LVN 2 stated Resident 54's skin assessment should reflect Resident 54's skin condition to evaluate if current interventions and treatment were effective.During an observation on 4/8/26 at 4:31 a.m. with CNA 5, in Station 1 hallway, CNA 5 informed CNA 6 that Resident 54 had a special shampoo and she would get it to the nurse.During an observation on 4/8/26 at 4:33 p.m. with Registered Nurse (RN) 3, in Station 1 hallway, RN 3 opened the treatment cart and handed a white bottle to CNA 5.During an interview on 4/8/26 at 4:45 p.m. with CNA 5, CNA 5 stated she assisted CNA 6 in providing a shower for Resident 54. CNA 5 stated she gave a bottle shampoo to CNA 6 and CNA 6 applied the shampoo to Resident 54's hair like a regular shampoo. CNA 5 stated CNAs were not authorized to apply a medicated shampoo to the residents and only licensed nurses can apply a medicated shampoo. During a concurrent interview and record review on 4/8/26 at 5:05 p.m. with RN 3, Resident 54's Electronic Medication Administration Record (EMAR- a digital version of daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 4/8/26 was reviewed. The EMAR indicated, .Ketoconazole External Shampoo 2% (Topical) Apply to scalp topically in the evening every Wednesday and Saturday for Seborrheic dermatitis (a common, chronic inflammatory skin condition causing itchy, flaky, greasy patches, often appearing as dandruff or rash on oily areas like the scalp, face, and chest) apply shampoo to scalp lather leave for 5 minutes and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Rinse -Start Date- 02/28/2026. RN 3 stated she signed the EMAR at 4:48 p.m. which indicated she administered the medicated shampoo to Resident 54's scalp. RN 3 stated she did not apply the medicated shampoo to Resident 54. RN 3 stated she should not allow CNA 5 and CNA 6 to apply the medicated shampoo because it contains medications. RN 3 stated she did not provide instructions and directions to CNAs on how to properly apply the medicated shampoo which could result in improper application of medicated shampoo. RN 3 stated incorrect application of medicated shampoo would not have a desired effectiveness and could result in worsening of his skin condition.During an interview on 4/8/26 at 5:13 p.m. with CNA 6, CNA 6 stated she was assigned to Resident 54. CNA 6 stated CNA 5 assisted her with Resident 54's transfers and showers. CNA 5 applied the shampoo to Resident 54's hair, on top of his hair. CNA 6 stated CNAs were not allowed and trained to administer medicated shampoo because it is a medication. CNA 6 stated licensed nurses were responsible in administering medicated shampoo. CNA 6 stated Resident 54 had a thick buildup of creamy, sticky and scaly plaques on the back of his head. CNA 6 stated the shower chair needed to be clean and sanitized by housekeepers due to presence of large amount of creamy, sticky and scaly flakes. CNA 6 stated Resident 54 should be provided with shower more than twice a week or needed a daily shower to clear the creamy, sticky and scaly plaques on the back of his head.During an interview on 4/9/26 at 9:34 a.m. with RN 4, RN 4 stated medicated shampoo should be administered by licensed nurses because it contains medication. RN 4 stated CNAs were not trained and authorized to administer medications. RN 4 stated licensed nurses should monitor and assess Resident 54 after each shower to evaluate if the medication was effective or not.During a concurrent interview and record review on 4/9/26 at 9:21 a.m. with LVN 1, Resident 54's bottle label of medicated shampoo was reviewed. The bottle label of medicated shampoo indicated, .Ketoconazole Shampoo 2% (Topical) Apply to scalp topically in the evening every Wednesday and Saturday for Seborrheic dermatitis apply shampoo to scalp lather leave for 5 minutes and Rinse Filled Date: 12/3/25. LVN 1 stated Resident 54 had been using the medicated shampoo since 12/3/25. LVN 1 stated licensed nurses were responsible in applying for the medicated shampoo because it contains medication and should follow the direction of application according to the physician's order. LVN 1 stated CNAs were not authorized and trained to apply medicated shampoo which could result in improper application. LVN 1 stated licensed nurses should assess Resident 54's skin and scalp during application of the medicated shampoo to evaluate if the treatment is effective. LVN 1 stated there was no monitoring in Resident 54's EMR about the skin condition of his scalp-related diagnosis of Seborrheic dermatitis. LVN 1 stated physicians should be notified if medication or treatment was not effective. LVN 1 stated she was not aware of Resident's 54's buildup of yellowish plaques on his forehead.During an interview on 4/10/26 at 3:09 p.m. with the Interim Director of Nursing (IDON), the IDON stated her expectation for the licensed nurses to follow facility's policies and procedures to ensure medications were administered by authorized and trained staff. The IDON stated medicated shampoo contains medication and should be administered by licensed nurses and not by CNAs. The IDON stated it was not on CNAs scope of practice to administer medications. The IDON stated licensed nurses were responsible in administering medications including medicated shampoo to ensure it was applied correctly according to the physician's order. The IDON stated licensed nurses should monitor and properly assess resident for efficacy of medications and treatments and to notify the physician if the medications and treatments were not effective. The IDON stated licensed nurses should monitor residents for any adverse effects of medications. The IDON stated monitoring and assessment is important to identify and implement necessary care, treatment and services to the residents. During a review of Resident 54's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 4/10/26, the AR indicated Resident 54 was admitted to the facility on [DATE] with diagnosis of autistic disorder (a neurological and developmental disorder that affects how people interact with others, communicate, learn, and behave), and right and left lower leg (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contractures. Resident 54's diagnosis information did not indicate a diagnosis of Seborrheic dermatitis.During a review of Resident 54's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 1/7/26, the MDS section C indicated Resident 54 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) was not conducted with a code of 0 indicating No (resident is rarely/never understood). Resident 54's BIMS Summary Score was blank.During a review of Resident 54's shower sheet, dated 4/8/26, indicated, .visual check: reddened area, dryness, other.was blank.During a review of Resident 54's care plan report, undated, indicated, Focus. The resident has an ADL self-care performance deficit r/t total dependent with bed mobility, transfers, non-ambulatory.Interventions/Tasks. SKIN INSPECTION: Check SKIN with ADL care. Observe for redness, open areas, scratches, cuts, bruises and report changes to the Nurse.During a review of facility's lesson plan titled, Medication Administration, dated 8/12/25, indicated, .CNAs cannot administer any type of medicated creams, soaps, shampoos.Nurses must apply these items.During a review of facility's P&P titled, Administering Medication, dated 1/2018, the P&P indicated, Medications shall be administered in a safe and timely manner, ad as prescribed.3. Medications must be administered in accordance with the orders. 7. The individual administering the medication must check the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.During a review of the facility's P&P titled, Physician Orders, dated 1/2018, the P&P indicated, .physician orders are obtained to provide a clear direction in the care of the resident.During a review of the facility's P&P titled, Resident Examination and Assessment, dated 1/2018, the P&P indicated, The purpose of this procedure is to examine and assess the resident for any abnormalities in health status, which provides a basis for the care plan. 1. Review the resident's admission assessment and/or preliminary care plan to assess for any special situations regarding the resident's care. 7. Skin: a. intactness; b. moisture; c. color; d. texture; and e. presence of bruises, pressure sores, redness, edema, rashes. During a review of Nursing World.org Professional Reference titled, The American Nurses Association- Nursing: Scope and Standards of Practice, Third Edition, dated July 2015, (found at https://www.nursingworld.org/~4af71a/globalassets/catalog/book-toc/nssp3e-sample-chapter.pdf) the reference indicated, .The Standards of Practice describe a competent level of nursing care as demonstrated by the critical thinking model known as the nursing process. The nursing process includes the components of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. Accordingly, the nursing process encompasses significant actions taken by registered nurses and forms the foundation of the nurse's decision-making. Standard 1. Assessment The registered nurse collects pertinent data and information relative to the healthcare consumer's health or the situation.During a review of National Library of Medicine.org Professional Reference titled, Nursing Process, dated 4/10/23, (found at https://www.ncbi.nlm.nih.gov/books/NBK499937/) the reference indicated, . Planning: The planning stage is where goals and outcomes are formulated that directly impact patient care based on guidelines. These patient-specific goals and the attainment [the level of knowledge, skills, or qualifications a learner has acquired at a specific point in time] of such assist in ensuring a positive outcome. Nursing care plans are essential in this phase of goal setting. Care plans provide a course of direction for personalized care tailored to an individual's unique needs. Overall condition and comorbid conditions play a role in the construction of a care plan. Care plans enhance communication, documentation, reimbursement, and continuity of care across the healthcare continuum. vital to positive patient outcomes. the nursing process to guide care is clinically significant going forward in this dynamic, complex world of patient care. Aging populations carry with them a multitude of health problems and inherent risks of missed opportunities to spot a life-altering condition.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents' drug regimen must be free from unnecessary drugs for one of eight sampled residents (Resident 21) when Resident 21 was receiving an opioid (or narcotics, are potent substances derived from or mimicking the poppy plant) pain medication (used to treat moderate to severe pain) for excessive duration without adequate indication and monitoring.These failures placed Resident 21 at an increased risk of receiving unnecessary medications and had the potential to experience negative effects such as drug addiction, overdose, and fatal respiratory depression. During a concurrent observation and interview on 4/8/26 at 9:36 a.m. with Resident 21, in Resident 21's room, Resident 21 was self-propelling her wheelchair. Resident 21 had four round tablets (three yellow and one orange color) in a medication cup on top of her bedside table. Resident 21 stated the brand name of the medication, and she was taking it for her stomach pain.During a concurrent interview and record review on 4/8/26 at 9:40 a.m. with LVN 3, Resident 21's Electronic Medical Records (EMR - a digital version of a patient's paper chart) titled, Order Summary Report, undated, and Nursing admission Assessment, dated 6/2023 were reviewed. The Order Summary Report indicated, . Hydrocodone-Acetaminophen (a combination medication that contains hydrocodone [an opioid] and acetaminophen [an analgesic] used to manage moderate to severe pain) oral tablet 5-325 mg (milligrams -metric unit of measurement, used for medication dosage and/or amount) Give 1 tablet by mouth every 8 hours related to Epigastric pain (a discomfort in the upper abdomen, just below the ribs),.Tramadol (an opioid pain-relief medicine used for moderate to severe pain) oral tablet 50 mg Give 1 tablet by mouth two times a day related to other chronic pain, .Calcium Carbonate (Antacids - used to treat heartburn, acid indigestion, and sour stomach) Oral tablet chewable. give 2 tablets by mouth three times a day related to Epigastric pain. LVN 3 stated Resident 21 was receiving Hydrocodone-Acetaminophen as scheduled every 8 hours not for epigastric pain only and was given for other chronic pain such as generalized pain. LVN 3 stated Resident 21 was getting antacid medication due to epigastric pain. LVN 3 stated Resident 21 was receiving two strong pain medications for pain. LVN 3 stated Resident 21's physician order should be followed, and physicians should be notified of any changes in condition. During a concurrent interview and record review on 4/8/26 at 9:46 a.m. with Registered Nurse (RN) 4, Resident 21's care plan report, undated, was reviewed. The care plan report indicated, The resident is on brand name (Hydrocodone-Acetaminophen oral tablet 5-325 mg) related to epigastric pain.Interventions/Tasks-Evaluate the effectiveness of pain interventions Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results. Identify and record previous pain history and management of that pain. Monitor for adverse effects of opioid use: nausea, vomiting, and constipation. Monitor/document for probable cause of each pain episode. Monitor/record pain characteristics q (every) shift and PRN (as needed): Quality. RN 4 stated the care plan indicated that resident was receiving Hydrocodone-Acetaminophen oral tablet 5-325 mg related to epigastric pain and should not be given for other pain. RN 4 stated licensed nurses should assess and document the location, characteristics, and the root cause of the pain to administer appropriate medications. During a concurrent interview and record review on 4/8/26 at 9:55 a.m. with LVN 3, Resident 21's Electronic Medication Administration Record (EMAR- a digital version of daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 3/2026 and 4/2026. The EMAR indicated, .Hydrocodone-Acetaminophen oral tablet 5-325 mg Give 1 tablet by mouth every 8 hours related to Epigastric pain.Hours: 12:00 a.m. 8:00 a.m. and 4:00 p.m. 3/1/26 to 3/31/26 and 4/1/26 to 4/8/26 Pain level of 0 (zero). LVN 3 stated Resident 21's pain levels were 0s indicating no pain. LVN 3 stated Resident 21's narcotic pain medication should be evaluated by the physician for correct indication and should be changed.During a review of Resident 21's admission Record (AR - a summary of information regarding a patient which includes (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Postacute Care	1233 A Street Fresno, CA 93706

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 4/10/26, the AR indicated Resident 21 was admitted to the facility on [DATE] with acute upper respiratory infection (a short-term, contagious illness affecting the nose, throat, or airways, typically caused by viruses like the common cold or influenza), migraine (a headache that can cause intense throbbing pain or a pulsing feeling, usually on one side of the head), and pain in leg. Resident 21's Diagnosis information did not indicate diagnosis of Epigastric pain and Other Chronic Pain. During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 4/1/26, the MDS section C indicated Resident 21 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 21 was cognitively intact.During a concurrent interview and record review on 4/9/26 at 9:39 a.m. with LVN 4, Resident 21's EMAR, dated 4/1/26 to 4/9/26. The EMAR indicated, Hydrocodone-Acetaminophen oral tablet 5-325 mg Give 1 tablet by mouth every 8 hours related to Epigastric pain.Hours: 12:00 a.m. 8:00 a.m. and 4:00 p.m. 4/1/26 to 4/9/26 Pain level of 0 (zero). LVN 4 stated he was assigned to Resident 21 on night shift, and he administered Hydrocodone-Acetaminophen for her headache and generalized body pain. LVN 4 stated he was not aware that Resident 21's Hydrocodone-Acetaminophen should be given for Epigastric pain. LVN 4 stated he administered antacid medication for her epigastric pain and not the Hydrocodone-Acetaminophen. LVN 4 stated he administered Hydrocodone-Acetaminophen because it was scheduled, she's been getting it routinely with pain level of zero. LVN 4 stated the EMAR was asking for the pain level and not the pain location. LVN 4 stated he should verify the pain medication order with physician. During an observation on 4/9/26 at 11:38 a.m. with LVN 3, in Resident 21, LVN 2 asked Resident 21 in Spanish about her pain, Resident 21 stated her head hurts a lot. LVN 2 assessed the pain level, Resident 21 stated eight out of 10. LVN 3 administered Tramadol 50 mg to Resident 21. During an interview on 4/9/26 at 11:52 a.m. with Resident 21, in Resident 21's room with LVN 3, Resident 21 stated she was getting Hydrocodone-Acetaminophen for her headache and not for stomach pain. Resident 21 stated she was getting Calcium Carbonate for her Epigastric pain. Resident 21 stated she had stomach pain when she was constipated (a problem with passing stool) and after she ate a lot of food. Resident 21 stated she had kidney stones 11 years ago. During a review of Resident 21's EMAR, dated 12/2025 to 3/2026. The EMAR indicated, Hydrocodone-Acetaminophen oral tablet 5-325 mg Give 1 tablet by mouth every 8 hours related to Epigastric pain.Hours: 12:00 a.m. 8:00 a.m. and 4:00 p.m. Pain level 0.During an interview on 4/10/26 at 11:42 a.m. with the Pharmacy Consultant (PC), the PC stated she's been the facility's PC since 2015 and was familiar with Resident 21. The PC stated she conducts a monthly drug regimen review and sends the report to the DON and Administrator. The PC indicated she reviewed resident's EMR including the EMAR, physicians' orders and laboratory results. The PC stated licensed nurses should follow the physician's order, if the pain medication was indicated for epigastric, it should be given for epigastric pain only and not for other chronic pain. The PC stated she had no recommendations for Resident 21's used of pain medications with a pain level of 0 from 12/2025 to 4/2026, and stated, I missed it. The PC stated if resident's EMAR documentation of pain level of 0 for two to three months which indicates no pain, pain is being controlled, or medication is working but it should trigger for a PC to send a recommendation for the physician to reassess the need of the pain medication. The PC stated there should be discussion with the physician to reduce or discontinue the pain medication to prevent unnecessary medication. The PC stated the goal was to decrease opioid use as much as possible, provide comfort, and not to over medicate the residents. The PC stated routine or scheduled pain medications could be changed to PRN and eventually discontinued. The PC stated Resident 21's epigastric pain could overlap other chronic pain. The PC stated Resident 21's other chronic pain should be assessed for the kind of chronic pain she had. The PC stated opioid medications can have (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	side effects such as stomach irritation and falls for elderly residents. During an interview on 4/10/26 at 3:09 p.m. with the Interim Director of Nursing (IDON), the IDON stated it was her expectation for the licensed nurses to follow the facility's Policy and Procedure (P&P) for pain assessment and management, and following physician's orders. The IDON stated licensed nurses should follow the physician's order for Resident 21's Hydrocodone-Acetaminophen related to epigastric pain. The IDON stated Resident 21's Hydrocodone-Acetaminophen should only be given specifically for epigastric pain and not other pain. The IDON stated licensed nurses should assess resident for pain including the pain location when giving pain medication regardless of if pain medication was routine. The IDON stated pain assessment of 0 for more than a month should require a re-evaluation from the physician to prevent unnecessary medications.During a review of facility's P&P titled, Administering Pain Medications, dated 1/2018, the P&P indicated, The purpose of this procedure is to provide guidelines for assessing the resident's level of pain prior to administering analgesic pain medication. 6. Administer pain medications as ordered.During a review of facility's P&P titled, Pain Assessment and Management, dated 1/2018, the P&P indicated, The purpose of this procedure is to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. 3. Pain management is a multidisciplinary care process that includes the following: c. Identifying the characteristics of pain; d. Addressing the underlying causes of the pain; e. Developing and implementing approaches to pain management; g. Monitoring for the effectiveness of interventions; and h. Modifying approaches as necessary. 6. For stable chronic pain the resident's pain and consequences of pain are assessed at least weekly. Assessing Pain: 1. During the comprehensive pain assessment gather the following information: b. Characteristics of pain: 1. Location of pain. Monitoring and Modifying Approaches: 5. If pain symptoms have resolved or there is no longer an indication for pain medication, the multidisciplinary team and physician shall try to discontinue or taper analgesic medications to the extent possible.During a review of facility's P&P titled, Pain-Clinical Protocol, dated 1/2028, the P&P indicated, Assessment and Recognition. 1. The physician and staff will identify individuals who have pain or who are at risk for having pain. a. This includes reviewing known diagnoses and conditions that commonly cause pain. 3. The staff and physician will identify the characteristics of pain such as location, intensity, frequency, pattern, and severity. Monitoring. 4.a. The physician will adjust or discontinue medications, accordingly, based on effectiveness and side effects.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an effective infection prevention and control program for two of six sampled residents (Resident 4 and Resident 69) when: 1. Resident 4 was not placed on Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce transmission of resistant organisms [bacteria that have become resistant to certain antibiotics] that requires gown and glove use during high contact resident care activities) for documented Methicillin Resistant Staphylococcus Aureus (MRSA-a type of bacteria that could cause an infection and was harder to treat because some antibiotics [medication used to treat infections] did not work against it).This failure placed Resident 4 at risk for cross-contamination (the process when germs are unintentionally transferred from one substance or object to another, which causes a harmful effect), and placed other residents at risk for exposure to MRSA.2. Resident 69 was not placed on EBP for her tracheostomy stoma (a surgically created hole in the front of the neck to allow a person to breathe) which required cleaning and dressing changes.This failure placed Resident 69 at risk for cross-contamination and infection (an invasion of the body by germs that cause disease).Findings:During a concurrent observation and interview on 4/7/2026 at 9:22 a.m. in Resident 4's room. No EBP signage was observed on Resident 4's room door. Resident 4 was observed in bed dressed and asleep, covered with her blanket and padded bed rails up at the head of her bed. Certified Nursing Assistant (CNA) 2 stated Resident 4 had amplified earphones to hear when spoken to and attempted to place them in Resident 4's ears. Resident 4 did not want to answer any questions and fell back to sleep. CNA 2 stated she tried to get Resident 4 up for activities, but Resident 4 liked to sleep and would get angry and yell. CNA 2 was observed to not be wearing a gown or gloves while attempting to wake Resident 4 and take her to activities via her wheelchair.During a review of Resident 4's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 4/10/26, the AR indicated Resident 4 was admitted to the facility from an acute care hospital on 8/6/25 with diagnoses of dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), seizures (a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements, behaviors, sensations, or states of awareness), hallucination (a sight, sound, smell, taste, or touch that a person believes to be real but is not real), neoplasm of the brain (abnormal masses of tissue that grow in the brain due to excessive overgrowth of brain cells), diabetes mellitus (when the blood sugar levels in the body are too high), artificial hip (surgery to remove damaged sections of the hip joint and replace them), arthritis (joint inflammation) due to other bacteria, right hip, and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities).During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 3/23/26, the MDS section C indicated Resident 4 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 5 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 4 was severely cognitively impaired.During a concurrent interview and record review on 4/8/2026 at 4:23 p.m. with Registered Nurse (RN) 2, Resident 4's Order Summary Report (OSR), undated was reviewed. The OSR indicated Resident 4 was taking doxycycline hyclate (a drug used to treat many types of bacterial infections)100mg 1 tablet by mouth two times a day for one year for MRSA. RN 2 stated Resident 4 was on antibiotics for a diagnosis of right hip arthritis from bacteremia (the presence of bacteria in the blood). RN 2 stated Resident 4 was to take doxycycline for one year for MRSA to her right hip. RN (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2 stated any resident who was on EBP required staff to wear appropriate personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments), which included gloves, gown, and to perform proper hand hygiene before and after providing care to the residents. RN 2 stated Resident 4 was not on EBP.During a concurrent interview and record review on 4/9/2026 at 11:05 a.m. with the Infection Preventionist (IP), Resident 4's OSR, undated was reviewed. The OSR indicated, .doxycycline Hyclate oral tablet 100 milligrams [mg - a unit of measurement] give 1 tablet by mouth two times a day for a year for MRSA to right hip. The IP stated residents were placed on EBP for indwelling medical devices and open wounds. The IP stated all staff should have been monitored for wearing appropriate PPE during patient care. The IP stated she discussed infection prevention with department supervisors, such as housekeeping, and the supervisors gave the in-services to their staff. The IP stated appropriate PPE was important for residents on EBP to prevent cross contamination of germs, which increased the risk of infection and superbugs (a strain of bacteria that has become resistant to antibiotic drugs).During an interview on 4/10/2026 at 9:32 a.m. with the Laundry Aide (LDA) , the LDA stated Staff used a separate container for soiled laundry of residents on isolation precautions and their clothes and linens were washed separately from residents not on isolation precautions. The LDA stated she asked questions if a resident was on isolation precautions, on what type of infection the resident had and what PPE was needed because she did not want to get germs on herself and take them to another resident or to her home.During an interview on 4/10/2026 at 10:15 a.m. with CNA 1, CNA 1 stated the CNAs brought resident's soiled linens out of their room and placed them in the bins in the hallway, and laundry staff picked up the bins. CNA 1 stated if a resident was on isolation precautions, the CNAs bagged their soiled linens and placed them in a bin inside the room. CNA 1 stated staff did not remove the bin from the room until the end of the day. CNA 1 stated staff bagged up all the soiled linen from the isolation precaution room and took it to a bin outside the laundry room. CNA 1 stated staff wore appropriate PPE for resident care and changing linens of residents on isolation precautions. CNA 1 stated residents in isolation had a sign on their door of the type of isolation precautions the resident was on and a cart with PPE outside the resident's room.During a concurrent interview and record review on 4/10/2026 at 11:47 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 4's OSR dated 4/10/26 was reviewed. The OSR indicated .doxycycline Hyclate oral tablet 100mg give 1 tablet by mouth two times a day for a year for MRSA to right hip. LVN 1 stated Resident 4 was not on any isolation precautions. LVN 1 stated Resident 4 was taking antibiotics for bacteria to her right hip for one year for MRSA. LVN 1 stated Resident 4 came to the facility with MRSA. LVN 1 stated EBP signs were no longer on Resident 4's door. LVN 1 stated she did not get notified when residents were no longer on isolation precautions.During a concurrent interview and record review on 4/10/2026 at 11:56 a.m. with the IP, Resident 4's Care Profile, undated was reviewed. The Care Profile indicated Resident 4 was ordered doxycycline hyclate 100 mg on 8/6/25 for staphylococcal (a type of bacteria that causes infection) arthritis in the right hip. The IP stated Resident 4 was admitted on antibiotics and was still receiving antibiotics. Resident 4's Progress Notes, dated 9/15/25 from the Infectious Diseases and Internal Medicine physician were reviewed. The Progress Notes indicated, .diagnosis [dx] periprosthetic joint infection [when bacteria or other microorganisms infect the area in and around a joint implant] of hip/MRSA.discontinue intravenous [I.V.-through the vein] antibiotic.start oral doxycycline. The IP stated if Resident 4 was colonized (the presence of bacteria on a body surface [like on the skin, mouth, intestines or airway] without causing disease in the person) she should have been placed on EBP.During an interview on 4/10/2026 at 3:39 p.m. with the Interim Director of Nursing (IDON), the IDON stated residents were placed on EBP if they had any implanted devices, open wounds with dressings or Multi-drug Resistant Organisms (MDROs such as MRSA). The IDON stated nursing and the IP determined who was placed on EBP. The IDON stated nurses should have been looking at the physician orders to see why Resident 4 was on antibiotics and should have notified the IP if Resident 4 was not on EBP. The IDON (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated all staff were trained on what conditions required EBP. The IDON stated wearing appropriate PPE was important so staff did not spread infections to other staff and residents and so the infection was contained. The IDON stated if a resident with infection was not placed on EBP and staff were not wearing the appropriate PPE while caring for the resident, there was a risk of spreading the infection to other residents and staff.During a review of the facility's policy and procedure (P&P), titled, Enhanced Barrier Precaution, dated 6/2022, the P&P indicated, .the purpose of this policy is to establish and provide guidelines for isolation precautions as well as prevent transmission of infectious agents in the facility.Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities.EBP may be indicated [when Contact Precautions do not otherwise apply] for residents with any of the following.wounds or indwelling medical devices, regardless of MDRO colonization status.infection or colonization with an MDRO.PPE used for these situations .dressing .bathing/showering . transferring.providing hygiene.changing linens.changing briefs or assisting . toileting .device care or use.wound care: any skin opening requiring a dressing.required PPE .gloves and gown prior to the high-contact care activity.change PPE before caring for another resident.position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room.post clear signage at the door or wall outside the resident room.2. During a concurrent observation and interview on 4/07/2026 at 9:10 a.m. in Resident 69's room, Resident 69 was observed in bed, wearing a gown, with a dressing over her tracheostomy stoma site. Resident 69 was unable to speak, but was able to makes sounds, and nodded yes when asked if she was doing ok.During a review of Resident 69's AR, dated 4/10/26, the AR indicated Resident 69 was admitted to the facility on [DATE] from an acute care hospital with diagnoses of hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body), dysphagia (difficulty swallowing), epilepsy (a seizure [a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements, behaviors, sensations, or states of awareness] disorder), and subarachnoid hemorrhage (bleeding in the space between the brain and the membrane that covers it).During a review of Resident 69's MDS, dated 2/9/26, the MDS section C - Cognitive Patterns indicated Resident 69 was unable to complete the interview. The MDS section O - Special Treatments, Procedures, and Programs indicated, .E.1 Tracheostomy care.while a resident.During an interview on 4/8/2026 at 11:42 a.m. with CNA 4, CNA 4, stated she had worked with Resident 69 and Resident 69 said yes and no to question and had a communication board that Resident 69 would point to the pictures for her needs. CNA 4 stated she checked Resident 69's tracheostomy dressing and if it was soiled, she let the nurse know.During a concurrent observation and interview on 4/8/2026 at 4:08 p.m. in Resident 69's room, with Resident 69, no EBP signage or Personal Protective Equipment (PPE- gowns, gloves, eye protection) cart was observed outside Resident 69's room. Resident motioned she used the paper with pictures posted on her wall to communicate with staff when she needed something.During a concurrent interview and record review on 4/8/2026 at 4:17 p.m. with RN 2, Resident 69's OSR, undated was reviewed. The OSR indicated, .cleanse trach stoma site with normal saline [n/s] pat dry apply dry dressing daily and as needed [prn] for wrinkle and soilage every day shift.order status.active.order date.10/26/2021. RN 2 stated every morning and evening the nurse cleaned and changed Resident 69's dressing. RN 2 stated Resident 69 should have been on EBP since she had an opening in her skin and to prevent infection. RN 2 stated Resident 69 could have obtained an infection. RN 2 stated residents should have been placed on EBP if they had a catheter (a type of indwelling catheter inserted into the bladder, used to drain urine), a gastrostomy (g-tube - the surgical formation of an opening through the abdominal wall into the stomach for nutritional support), or an open wound. RN 2 stated the nurse assessed the resident and if the resident had any opening, the nurse told the IP, and the IP set up carts, and put an (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EBP sign on the resident's room door. RN 2 stated the CNAs were notified of a resident on EBP by the door signs and education from the nurses. During an interview on 4/10/2026 at 3:39 p.m. with the IDON, the IDON stated residents were placed on EBP if they had any implanted devices, open wounds with dressings or Multi-drug Resistant Organisms (MDROs such as MRSA). The IDON stated nursing and the IP determined who was placed on EBP. The IDON stated all staff were trained on what conditions required EBP. The IDON stated wearing appropriate PPE was important so staff did not spread infections to other staff and residents and so the infection was contained. The IDON stated if staff did not wear the appropriate PPE while caring for residents requiring EBP, there was a risk of spreading the infection to the resident, other residents and staff.During a review of the facility's policy and procedure (P&P), titled, Enhanced Barrier Precaution, dated 6/2022, the P&P indicated, .the purpose of this policy is to establish and provide guidelines for isolation precautions as well as prevent transmission of infectious agents in the facility.Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities.EBP may be indicated [when Contact Precautions do not otherwise apply] for residents with any of the following.wounds or indwelling medical devices, regardless of MDRO colonization status.infection or colonization with an MDRO.PPE used for these situations.during high-contact resident care activities.dressing.bathing/showering.transferring .providing hygiene.changing linens.changing briefs or assisting . toileting .device care or use.tracheostomy/ventilator.wound care: any skin opening requiring a dressing.required PPE .gloves and gown prior to the high-contact care activity.change PPE before caring for another resident.position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room.post clear signage at the door or wall outside the resident room.During a review of professional reference (PR) titled, Implementation of Personal Protective Equipment [PPE] Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms [MDROs], dated 7/12/2022, retrieved from: https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, the PR indicated, .multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs.EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status.infection or colonization with an MDRO.residents in nursing homes are at increased risk of becoming colonized and developing infection with MDROs.more than 50% of nursing home residents may be colonized with an MDRO, nursing homes have been the setting for MDRO outbreaks, and when these MDROs result in resident infections, limited treatment options are available.focusing only on residents with active infection fails to address the continued risk of transmission from residents with MDRO colonization, who, by definition, have no symptoms of illness. MDRO colonization may persist for long periods of time.which contributes to the silent spread of MDROs. PPE used for these situations.device care or use.tracheostomy/ventilator.wound care: any skin opening requiring a dressing.