

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555446	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Rossmoor Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1226 Rossmoor Parkway Walnut Creek, CA 94595	
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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain essential mechanical equipment in safe operating condition when The facility did not ensure four of four facility ice machines were cleaned, sanitized, and maintained according to manufacturer instructions. This deficient practice could expose residents to contaminated ice and increase their risk of infection, illness, hospitalization, or other adverse health outcomes for 151 of 151 residents who were residing in the facility and potentially use ice form ice machines. During a concurrent observation and interview on 7/7/26 at 10:20 a.m., with the Facilities Director (FD), FD stated he cleaned each facility ice machine every four months. The FD stated the facility has two Hoshizaki (brand name) ice machines and two Scotsman (brand name) ice machines located in the Legacy Nursing Unit, Westbridge Nursing Station, MedBridge Nursing Unit, and the Resident Dining Hall. The FD stated the facility did not maintain a yearly cleaning log for the Hoshizaki machines. During an observation on 7/7/26 at 11:05 a.m., of the MedBridge nursing unit Scotsman ice machine with the FD, black specks were observed inside the interior ice bin. During an observation on 7/8/26 at 1:52 p.m., of the Legacy nursing unit Scotsman ice machine with the FD, black sludge was observed inside the ice holding bin and on upper interior surfaces. During an observation on 7/9/26 at 10:29 a.m., of the Westbridge nursing station Hoshizaki ice machine with FD, black specks and black residue were observed inside the interior ice bin, including the top interior surface. During interview on 7/8/26 at 10:10 a.m., the FD stated he had not been aware that the Hoshizaki ice machine required cleaning of interior panels and the internal ice bin until the former Facilities Director informed him on 7/7/26. FD stated he was unsure when the Hoshizaki machines were last cleaned due to the absence of yearly cleaning logs. During an interview on 07/08/26 at 4:10 PM, with Certified Nurse Assistant (CNA) 2, CNA 2 stated ice used for resident drinking water is obtained from the Legacy nursing unit ice machine. During an interview on 7/8/26 at 4:15 p.m., with CNA 3, CNA 3 stated ice used for resident's water pitchers is obtained for the nourishment room ice machine behind the Legacy nursing unit. During an interview on 7/8/26 at 4:20 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated nursing station ice machines are used to provide ice for resident drinking water, beverages, and ice packs. During an interview on 7/9/26 at 10:10 a.m., with Infection Preventionist/Director of Staff Development (IP/DSD) , IP/DSD stated she reviewed photographs taken prior to cleaning and confirmed sludge and residue were present inside the Scotsman ice machine. She stated ice produced in a contaminated machine can expose residents to bacterial illness or water contamination related illness. IP/DSD furthermore stated moisture and biofilm inside ice machines can support microbial growth including Legionella. IP/DSD stated the machines must remain out of service until cleaned, disinfected, re-inspected, and documented according to manufacturer instructions. During a record review of the Hoshizaki DB200H (brand name) Ice Dispensing Bin (storage container designed to hold freshly made ice and allow users to access it without scooping manually) manual showed the (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure respiratory therapy equipment was changed weekly for two of five sampled residents (Residents 70 and 161) who received oxygen therapy. This failure had the potential to contribute to the increased risk of infection and dry nasal passages, which could cause extreme discomfort for Resident 70 and 161. 1. During the initial tour on July 6, 2026, at 10:17 a.m., Resident 70 was receiving oxygen from an oxygen concentrator ((an oxygen concentrator is a medical device that pulls in the surrounding room air and delivers concentrated, pure oxygen) at 2 liters per minute (LPM-measures the flow rate or volume of supplemental oxygen delivered to a patient per minute) via nasal cannula (a lightweight, flexible plastic device used to deliver supplemental oxygen directly into the nose) attached to an oxygen humidifier bottle (oxygen humidifier bottle is a plastic bottle that adds moisture to the oxygen before the resident breathes it in, keeping the resident's nose and throat from becoming painfully dry, scratchy, or prone to nosebleeds). The humidifier which was labeled with an open date of 6/28/26, was observed to be completely empty. During a concurrent observation and interview in Resident 70's room on 7/06/26 at 10:26 a.m., Licensed Vocational Nurse (LVN) 5, described the humidifier bottle as empty. LVN 5 also stated, the bottle should not be empty, as it increases the risk of nosebleeds and infection. LVN5 Furthermore stated that the humidifier bottle should have been changed on 7/5/26, adhering to the weekly replacement schedule. A review of Resident 70's Face-sheet indicated, Resident 70 was admitted to the facility on [DATE] with diagnoses of asthma (a condition in which the airways narrow and swell and may produce extra mucus. This can make breathing difficult). A review of Resident 70's MDS (Minimum Data Set- a standardized, federally mandated clinical assessment tool used in Medicare and Medicaid-certified nursing homes and skilled nursing facilities) , dated 6/9/26 indicated Resident 70's brief interview for mental status (BIMS-screening tool used by clinicians and social workers to assess a patient's basic cognitive function) score was 7 (means severe cognitive impairment). Review of Resident 70's monthly physician order, dated 7/9/26, indicated an order to start oxygen at two (2) liters if oxygen saturation was less than 91 % (oxygen saturation is a measure of how much oxygen your blood cells are carrying, measurement of 95% &ndash; 100% is considered normal, 92% &ndash; 94 % requires close monitoring and below 92%: may require medical intervention or supplemental oxygen) every shift. During an interview on 7/9/26 at 10:53 a.m., with the Assistant Director of Nursing (ADON), ADON stated that the oxygen humidifiers should be replaced before running empty to prevent nasal dryness in residents. 2. During a review of Resident 161's admission Record, dated 7/9/26, the record indicated, Resident (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	161 was re-admitted to the facility in 2022. During a review of Resident 161's MDS, dated [DATE], indicated Resident 161 had multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD, a progressive lung disease) and respiratory failure (when lungs cannot properly get enough oxygen into your blood or remove enough carbon dioxide from it). MDS also indicated, Resident 161 had a Brief Interview for BIMS score of 7, meaning Resident 161 had severe cognitive impairment. During a concurrent observation and interview on 7/6/26 at 10:37 a.m., with LVN 2, in Resident 161's room, Resident 161's oxygen was running at 2.5 LPM. The humidifier bottle dated 6/28/26 attached to Resident 161's oxygen was completely empty. LVN 2 stated, she was not aware the humidifier bottle was empty because she did not check it. During a follow up interview on 7/6/26 at 11:05 a.m., with LVN 2, LVN 2 stated, a humidifier was important to prevent Resident 161's mucus membranes from drying. LVN 2 also stated, without water in humidifier bottle, oxygen therapy can cause Resident 161's nasal irritation. LVN 2 stated there was risk of infection when Resident 161's humidifier was not changed per facility policy. LVN 2 furthermore stated, the humidifier bottle should be changed weekly with the oxygen tubing. During an interview on 7/8/26 at 11:30 a.m., with the Assistant Director of Nursing (ADON), ADON stated, the humidifier bottle should be changed weekly with the tubing per facility policy. ADON stated the expectation was for the licensed nurse to label the humidifier bottle and tubing with initial and the date it was replaced. ADON furthermore stated, humidifier must be kept filled with water to prevent dryness of nasal passages and prevent discomfort, and there was risk for bleeding. g inside Resident 161's nose when oxygen was being delivered without humidifier. During a review of Resident 161's Order Summary Report, dated 7/6/26, indicated a physician treatment order for oxygen at 2.5 LPM via nasal cannula continuous per concentrator/tank. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated 10/2010, indicated, the purpose of this procedure is to provide guidelines for safe oxygen administration. Under equipment and Supplies: indicated, the following equipment and supplies will be necessary when performing this procedure.3. Humidifier bottle; Under steps in the Procedure: .9. Check the mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened. Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through.11. Periodically re-check water level in humidifier bottle if in use. During a review of the facility's P&P titled, Oxygen Concentrator and Oxygen Storage dated 12/2022, indicated under Purpose: To administer oxygen for the treatment of certain diseases or conditions in a safe manner using oxygen concentrators or portable oxygen cylinders. Under Procedure: .2. Care of the Concentrator .c. Change humidifier bottle weekly, with tubing change or when water reaches minimal fill line.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 7) was free from unnecessary psychotropic drugs (medications that are capable of affecting the mind, emotions, and behavior) when Resident 7 had no rationale (reason) for continued use of PRN Lorazepam beyond 14 days (PRN or pro re nata [a Latin phrase], meaning as needed, or as necessary and Lorazepam is a psychotropic medication used to treat anxiety). These failures had the potential to not promote or maintain Resident 7's highest practicable mental, physical, and psychosocial well-being. During a review of Resident 7's Facesheet indicated that the resident was admitted to the facility on [DATE] with diagnoses which included dementia (a decline in mental ability severe enough to interfere with daily life). During an observation on 7/6/26 at 10:33 a.m., Resident 7 was resting in bed, calm and quiet. During a review of Resident 7's Minimum Data Set (MDS- an assessment screening tool to guide care), dated 5/8/26, under Section C, indicated Resident 7's cognition was severely impaired. During a review of Resident 7's Physician Order (PO) dated 7/9/26, the PO indicated an order of Lorazepam 0.5 milligram (mg. - a unit of measurement) by mouth every 4 hours PRN for anxiety with a start date of 5/27/26 and an end date of 8/1/26 (to be given PRN for a total of 66 days). During a review of Resident 7's all medical records, indicated no documentation by the Medical Doctor (MD) of a clinical rationale for the 66-day duration of the as-needed (PRN) lorazepam order. During an interview on 7/08/26 at 3:52 p.m., with the Consultant Pharmacist (CP), CP stated that the facility should adhere to the federal regulations for the stop date for PRN Lorazepam (federal regulations or government regulations). During an interview on 7/08/26 at 4:10 p.m., with MD, stated they (facility) will implement a 14-day discontinuation period for the PRN lorazepam moving forward. During an interview on 7/09/26 at 10:53 a.m., with Assistant Director of Nursing (ADON), ADON stated psychotropic PRN medications must have a stop date of 14 days. During a review of the facility's policy and procedures (P&P) titled, Psychotropic Medication Use, Revised February 2025, indicated, .PRN Medication:.3. PRN orders for psychotropic medications are limited to 14 days .		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a copy of the discharge notice was sent to the Long-Term Care (LTC) Ombudsman for one of three sampled residents (Resident 144). This failure had the potential for the LTC Ombudsman not to be able to advocate for the resident in protecting their rights from inappropriate transfer and discharge. During an interview on 7/8/26 at 12:00 p.m., with the LTC (Long Term Care) Ombudsman (a trained advocate who protects the rights, health, and quality of life for residents living in nursing homes, assisted living facilities), LTC ombudsman stated the facility did not notify them about Resident 144's discharge or the new location on 7/2/26, . LTC Ombudsman stated they learned about the resident's discharge from another source rather than from the facility.A review of Resident 144's Face-sheet (a summary document, typically acting as the cover page of a patient's medical record) indicated Resident 144 was admitted to the facility on [DATE], and was discharged on 7/2/26.During an interview on 7/8/26 at 12:59 p.m., with the Case Manager (CM), CM stated, Resident 144 was discharged on 7/2/26 to a respite home (a temporary care facility or service where a person with special needs, a disability, or an aging condition stays for a short time). CM furthermore stated they were not sure if the LTC Ombudsman was informed. During an interview on 7/8/26 at 4:02 p.m., with the Administrator (ADM), ADM stated they could not find documentation showing that the LTC Ombudsman was notified of Resident 144's discharge.During a review of the facility's policy and procedure (P&P) Transfer or Discharge Notices, revised March 2025, indicated, .Policy Statement: Residents (or resident representatives) are notified of an impending transfer or discharge.A copy of the notice is sent to the Office of the State Long- Term Care Ombudsman.		

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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, facility failed to provide timely nursing assessment and evaluation to one of three sampled residents (Resident 150) after an unwitnessed fall on 3/21/26. This failure had the potential to result in delayed identification of changes in condition, delayed nursing interventions and treatment, worsening conditions, hospitalization and decline in Resident 150's health status. During a review of Resident 150's admission record indicated Resident 150 was admitted to the facility on [DATE] with diagnoses of history of falls and difficulty in walking. During a review of Resident 150's Minimum Data Set (MDS- a standardized, federally mandated clinical assessment tool used in all Medicare- and Medicaid-certified nursing homes and skilled nursing facilities) dated 6/12/26, the assessment indicated Resident 150's Brief Interview for Mental Status (BIMS- a standardized screening tool used by clinicians and social workers to assess a patient's cognitive function) score was 15 out of 15 (normal thinking and memory). During an interview on 7/6/26 at 10:25 a.m., with Resident 150, Resident 150 stated, on 3/21/26, Resident 150 was standing beside, near bedside table when Resident 150 lost balance, fell, and hit the back of her head on the roommate's bed. Resident 150 stated the roommate had to call staff for help while Resident 150 remained on the floor. Resident 150 stated nursing staff, including Licensed Vocational Nurse (LVN 4), came into the room and assisted Resident 150 to get up, and LVN 4 did not assess for pain or injuries. Resident 150 stated, she experienced pain on their right wrist after the fall. During a concurrent interview and record review on 7/7/26 at 10:12 a.m., with LVN 4, Resident 150's progress notes dated 3/21/26 were reviewed. LVN 4 confirmed there was no documentation that indicated an assessment was completed on 3/21/26 after Resident 150's unwitnessed fall. LVN 4 stated, per protocol, the nurse should ask the resident after fall, what happened, perform a pain assessment, check the skin, and if resident can perform range of motion (ROM) to assess for injury, and inform the physician. LVN 4 stated these assessments must be documented in the progress notes and stated, If it is not documented, it didn't happen. During a record review of the facility's Policy and Procedure (P&P) titled, Charting and documentation, dated December 2024, 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 records should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.		

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, interview, and facility document review, the facility failed to ensure the person designated as the position responsible for the day-to-day management of the department was qualified per state regulations. This failure had the potential to negatively affect the health and well-being of 151 residents who received food prepared in the kitchen. State of California Title 22 Section 72333 describes dietetic service as a department that is organized, staffed and equipped to ensure food service to patients is safe, appetizing and provides for their nutritional needs. According to the California Code, Health and Safety Code - HSC S 1265.4, a licensed health facility shall employ a full-time, part-time, or consulting dietitian to supervise the provision of dietetic services. A health facility that employs a registered dietitian less than full time (on-site), shall also employ a full-time dietetic services supervisor who meets the requirements of subdivision (b) to supervise dietetic service operations. During an interview on 07/06/2026 at 9:30 AM with Registered Dietitian (RD), RD stated that she was responsible for the day-to-day oversight of the kitchen serving the skilled nursing facility. The RD stated that the kitchen supervisor was not qualified. The RD further stated that she is a full-time employee who works on-site two days a week and remotely three days per week. During an interview on 07/07/2026 at 9:40 AM with the Dietary Manager (DM), DM confirmed that RD was responsible for the day-to-day operations of the dietary department and worked on-site two days a week and remotely three days per week. During a concurrent interview and record review on 07/07/2026 at 1 PM with Human Resources (HR), the Registered Dietitian's (RD) Rossmoor Post Acute Offer Letter dated May 1, 2026, was reviewed. The offer letter indicated the RD's Position is full time, but the on-site (Facility) schedule will be as follows: On site hours will be around 12-16 hours per week, on average. HR confirmed that the RD worked on-site Mondays and Wednesdays. During a review of Job Description: Dietary Supervisor/ Manager, dated 02/2024, the job description indicated This position must provide supervision for the Dietary Department, ensuring quality food. The Dietary Supervisor will direct and assist the preparation and service of regular meals and therapeutic diets, order food and supplies, maintain area and equipment in sanitary condition, and assure the smooth operation with other nursing facilities departments. During a review of Job Description: Registered Dietitian, dated 02/2024, the job description indicated that RD is responsible for monitoring rather than day-to-day supervision of dietetic services. Examples include monitoring of nutrition, safety, sanitation and quality standards, as well as state and federal regulations. Monitoring food control systems such as food temperatures, portion control, preparation methods, garnishment and presentation of food to ensure that food is prepared and presented in an acceptable manner and inspecting diet trays for conformance to physician's diet orders prior to delivery. Review of the facility's documents for qualifications of the Dietary Supervisor/ Manager failed to show evidence she met the qualifications under the California Code, Health and Safety Code - HSC S 1265.4. During an interview on 07/07/2026 at 3:30 PM with Administrator (AD), AD acknowledged the above findings.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and facility document review, the facility failed to provide mechanically altered foods according to the menu for the Soft and Bite Sized (SB6) Diet (a diet designed for those who have difficulty chewing or swallowing but can safely eat soft foods). This failure had the potential to not meet the resident's nutritional needs for the 16 of 151 residents (Residents 15, 16, 18, 21, 48, 52, 57, 84, 87, 93, 110, 116, 120, 122, 151, 186) who received an SB6 diet. During an interview on 07/07/2026 at 11:00 AM with [NAME] 1 (CK1) in the kitchen during meal preparation of Beef Rib Bites with Teriyaki Sauce, [NAME] stated that he would be using the same sized beef for the Regular diet and the SB6 diet. During a concurrent observation and interview on 07/07/2026 at 11:50 AM during tray line (organized process in a healthcare food service operation where meal trays assembled, checked and prepared for delivery), a SB6 meal tray was prepared for Resident 186. The meal tray was delivered to nursing station two. At station two, Registered Nurse 4 (RN 4) confirmed that Resident 186 was receiving a SB6 meal tray according to the meal ticket. The meat pieces on the tray were one inch in size and were in thin gravy that was separated from the meat. RN 4 confirmed the above observation. During a concurrent observation, interview and facility document review on 07/07/2026 at 12:15 PM with Dietary Manager (DM) in the kitchen during tray line, the facility's document titled Diet Extensions, dated Tuesday (07/07/2026), and the Beef Rib Bites with Teriyaki Sauce recipe, undated were reviewed. DM confirmed that Diet Extensions indicated Soft and Bite Sized - SB6.meat should be 1/2 inch diced and tender cooked. Moisten with plenty of sauce thick enough to not let liquid and solids separate. When shown the beef rib bites in the steam table on tray line, DM stated that the pieces were too large and not 1/2 inch diced as the recipe indicated. DM also stated that the liquid was too thin and was separate from the solid pieces of meat. DM confirmed that the beef rib bites for the SB6 diet were not prepared according to the recipe. During the lunch meal on 07/07/2026 at 1:45 PM, a SB6 test tray (a meal tray assembled as it would be served to a patient or resident and evaluated to verify that the tray meets quality, safety and accuracy standards) was removed from the tray cart. The food tested by the surveyor and the DM included Beef Rib Bites with Teriyaki Sauce, Mashed Potatoes and Soft and Bite Sized Carrots. A surveyor found the meat pieces to be large, tough and chewy. The DM stated that the meat looked tough and should be tender according to the SB6 recipe. The DM also stated that the liquid gravy had separated from the Beef Rib Bites. During a review of the facility's document titled Diet Extensions, dated Tuesday (07/07/2026), the diet spreadsheet indicated the SB6 diet served for lunch was chicken noodle soup (at ordered thickness), beef rib bites with teriyaki sauce (soft and bite sized), brown rice (moistened), soft and bite sized carrots, baked roll (pureed). During a review of the facility's diet manual (a reference guide that outlines a facility's approved therapeutic diets, food modifications, and nutritional standards for patient and resident meal service) titled, Grove Menus, undated, the manual indicated that the SB6 diet provides a texture modification of the regular diet. Foods must be soft, tender and moist, with no thin liquid separating from the food. Food piece size is controlled to minimize choking risk. The manual indicates that soft and bite sized foods are to be chopped in 1/2 inch pieces. On 07/07/2026 at 2:30 PM, the Registered Dietitian (RD) was informed and acknowledged the above findings.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 facility policy review, the facility failed to prepare, and serve food under sanitary conditions when, staff were observed using disposable face masks as hair coverings and facial hair coverings. These deficient practices had the potential to result in contamination of food, and compromised food service sanitation for all residents who were eating food, prepared by the facility's kitchen's staff. During observations on 07/07/26 at 10:15 a.m., saw kitchen staff using disposable face masks as facial hair coverings while working in food preparation areas. Hair was not fully restrained or covered. During interview on 07/07/26 at 10:24 a.m., the Dietary Manager stated staff had been observed using disposable face masks as facial hair coverings. The Dietary Manager stated this was not acceptable and stated hair not fully restrained in hairnets also did not meet facility requirements. During a phone interview on 07/07/26 at 4:15 p.m., with the Registered Dietician, Registered Dietician stated, disposable face masks were not allowed as hair coverings and did not meet hair restraint requirements. During a review of the facility policy and procedure Food Receiving and Storage dated 2001, indicated .food service areas are kept clean; refrigerated foods are covered, labeled, and dated; dry foods are stored to maintain packaging integrity. During a review of the facility's policy and procedure Sanitization dated 2001, indicated . kitchen areas are kept clean; utensils and equipment are maintained in good repair; cutting boards are washed and sanitized between uses; and dishwashing equipment is operated according to manufacturer sanitizing temperatures . During a review of the facility's policy and procedure Hairnet Use dated 2001, indicated . all staff entering food preparation areas wear approved hairnets that fully cover the hair, beards are covered with beard nets, and only approved hair restraint devices are used .		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary handling and consumption of food brought into the facility by family or visitors for one of three sample selected residents (Resident 139), when the facility did not provide instructions to Resident 139's visitors regarding safe food handling practices and did not ensure food brought from outside sources was managed safely in accordance with posted dietary precautions. This deficient practice could result in Resident 139 being exposed to foodborne illness or other preventable harm due to unsafe handling and consumption of food brought in by visitors. During observation of facility on 07/06/26 at 12:35 p.m., a sign was posted on the resident 139's door indicating neutropenic precautions (a set of strict infection prevention measures used to protect individuals with severely compromised immune systems and low white blood cell counts), including a pictogram (visual symbol) stating no raw fruits or vegetables. noted a family member brought salads and other food items from home for the resident. During an interview on 07/06/2026 at 12:38 p.m., with Resident 139's family member, the family member stated: He's had only one salad since he arrived, so I bring salads from home. I bring in some foods and drinks from home. They're in insulated containers with cold packs. Furthermore the family member stated, no staff member had provided instructions or guidelines about food safety, labeling, dating items, or guidance regarding what food was appropriate for the resident's neutropenic condition. During an interviews on 07/07/26 at 1:33 p.m., with Dietary manager, Dietary manager stated he was not aware of procedures for providing visitors with safe food handling information. Dietary manager was not able to identify who was responsible for communicating the policy to residents, families, or visitors. Dietary manager stated they had not been trained on assisting residents with food brought in by visitors or on applying dietary restrictions associated with neutropenic precautions. During a review of the facility's policy and procedure, dated 2001, titled Foods Brought by Family/Visitors indicated . Staff to explain safe food handling practices-including safe cooling and reheating, holding temperatures, preventing cross contamination with raw or undercooked foods, and hand hygiene-in a language and format families understand. Food brought by family/visitors to be labeled, dated, and stored in re-sealable containers with tight fitting lids .		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to ensure proper disposal and containment of refuse when the facility's outdoor garbage compactor was observed with a large mound of trash bags placed directly on the ground. The refuse was not contained in any waste receptacle and was not secured with a covered lid. The recycling dumpster was observed with lid not covering the container. Overflowing cardboard boxes and other recyclable materials were placed on the ground next to the recycling dumpster. These deficient practices had the potential to attract rodents and insects and create environmental contamination hazards in areas adjacent to residents care services. During the tour of the facility outdoor premises on 07/06/2026 at 3:24 p.m., with facility Administrator, a large mound of trash bags was observed placed directly on the ground in the trash disposal area. A strong sour odor was present. The garbage compactor located in the area was observed to be out of service. The trash bags were not contained in a dumpster or compactor with a secured lid. The recycling dumpster was observed with its lid not covering the container. Cardboard boxes and other recyclable materials were placed on the ground next to the recycling dumpster rather than inside the receptacle. During interview on 07/06/2026 at 3:29 p.m., with the Administrator, Administrator stated the trash compactor became inoperable earlier in the day 07/06/26, staff had no way to compact or contain the waste until temporary roll-off containers could be delivered by the contracted trash vendor. During record review of the facility's Policy and Procedure, titled Sanitization revised 2022, indicated .Garbage and refuse containers are in good condition, without leaks, and waste is properly contained in dumpsters/compactors with lids (or otherwise covered). Areas used for garbage disposal are free from odors and waste fats and maintained to prevent pests .		

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to report a right wrist fracture (broken bone) sustained by one of three sampled residents (Resident 150), to the State Agency as required, when Resident 150 was sent to the emergency department on 3/29/26 for evaluation of right wrist pain, where an x-ray confirmed fractures of the right radius (thumb side of the wrist) and ulna (pinkie side of the wrist). This failure could result in unaddressed causes of injury, missed corrective actions, and continued risk of harm to residents because required oversight, investigation, and prevention measures would not be initiated. Findings: During a review of Resident 150's admission record, indicated Resident 150 was admitted to the facility on [DATE]. During a review of Resident 150's Minimum Data Set (MDS, a resident assessment used to create individualized care plan) dated 6/12/26, the assessment indicated Resident 150's Brief Interview for Mental Status (BIMS, short-term memory screening tool), score was 15 out of 15, indicating normal thinking and memory. During an interview on 7/6/26 at 10:25 a.m., Resident 150 reported they developed persistent right wrist pain on 3/29/26, and requested to be sent to the emergency department. Resident 150 stated the hospital performed an x-ray, identified a fracture, and they returned to the facility later the same day (3/29/26). During a record review of Resident 150's Emergency Department (ED) Provider Notes, titled Diagnosis & Disposition, dated 3/29/26, the documentation indicated closed fractures of the right radius and right ulna. During an interview on 7/8/26 at 3:40 p.m., with Administrator (Adm), Adm stated that unusual occurrences, like a major injury such as a fracture must be investigated and reported by fax or email according to state requirements. Adm was unable to provide documentation that the incident had been reported. During an interview on 7/9/26 at 2:45 p.m., with Assistant Director of Nursing (ADON), ADON stated that fractures must be reported so the State Agency can review the care plan, visit the facility, investigate, and help improve care areas that the facility did not identify or catch. During a review of facility's Policy and Procedure (P&P) titled Unusual Occurrence Reporting dated March 2026 indicated As required by federal or state regulations, the facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of residents. Unusual occurrences are reported to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of an incident or as otherwise required by federal and state regulations. A written report detailing the incident and actions taken by the facility after the event will be submitted to the state agency (or other appropriate agencies) as required by federal and state regulations .		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on interview and record review, the facility did not ensure that the binding arbitration agreement was explained to and understood by either the resident or the resident's personal representative for Residents 26, 38,187,188.This deficient practice has the potential result in residents (Residents 26, 38,187,188.) and/or resident representatives not being aware of, or fully understanding, the implications of signing an arbitration agreement. During an observation on 7/9/26 at 8:55 a.m., Resident 26 was observed lying in bed with the resident's daughter present at the bedside. The daughter is Resident 26's personal representative. During a Resident 26's Minimum Data Set (MDS- It is a federally mandated, standardized clinical assessment tool used in Medicare and Medicaid-certified nursing homes and skilled nursing facilities) Resident 26 has a Brief Interview for Mental Status (BIMS- tools for assess a resident's cognitive function) 13 of 15, indicating the resident's assessed level of moderate cognitive function.During an interview on 7/9/26 at 8:55 a.m., with Resident 26, Resident 26 stated, I signed a bunch of things. I don't know what I signed. The gal just said sign here, here, and here on the electronic device. Resident 26 furthermore stated, No, I did not get a copy of what I signed. I wish I did. I don't know what arbitration is. What is that for? I'm here because I'm from the hospital.During an observation on 7/9/26 at 9:06 a.m., Resident 38 was observed sitting in a wheelchair with four visitors present at the bedside.During a record review (MDS), Resident 38 had a BIMS score of 12 of 15, indicating moderate cognitive ability to participate in an interview.During an interview on 7/9/26 at 9:06 a.m., asked Resident 38 if whether Resident 38 or the family member had signed the facility's binding arbitration agreement. Resident 38 stated yes and They had me sign on this tablet a bunch of stuff I don't know. Resident 38 stated the resident did not understand the meaning of arbitration and did not know there was a 30`day window to rescind the agreement.During a concurrent observation and interview on 7/9/26 at 9:23 a.m., Resident 187 was observed sitting in bed with the son and spouse, present at the bedside. Resident 187 stated, I do not remember signing an arbitration agreement. I don't know. I remember there was just a lot of commotion of people going in and out of the room. Resident 187 additionally stated, I would remember something like that if I signed something giving up my rights. During a record review (MDS) of Resident 187, Resident 187 has a BIMS score of 12 out of 15, indicating the resident was able to participate in a brief interview.During a concurrent observation and interview on 7/9/26 at 9:39 a.m., with Resident 188, Resident 188 was sitting in his bed watching Television . Resident 188 stated he vaguely remember signing documents but not a Arbitration agreement and do not recall for the 30 period to rescind . Resident 188 states I thought i have to sign all the documents to be admitted no one mention it was optional.During a record review (MDS) of Resident 187, Resident 187 had a BIMS score of 15 out of 15, indicating the resident was able to participate in a brief interview and cognitively intact.During an interview on 7/9/26 at 3:10 p.m., with Admissions Coordinator, admission Coordinator stated, she determines whether a resident or the resident's personal representative understands the arbitration agreement by asking the resident or their family member if they have any questions about the document. Admissions Coordinator stated this is the method she uses to gauge their understanding.		

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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 follow infection control prevention practices when: 1. Resident oxygen tubing (colorless, odorless, tasteless gas that is essential for effective breathing) for Resident 3 and Resident 72 was not secured and off the floor. 2. Visitors were allowed into Resident 72's room without wearing personal protective equipment (PPE- specialized gear and clothing worn by healthcare workers and residents to create a barrier against infections materials). 3. Resident 88's oxygen was stored in the bathroom. 4. Three pill crushers were dirty. These failures had the potential for cross contamination and spread of infections among for Residents who were residing in the facility. 1. During a concurrent observation and interview on 7/6/26 at 12:48 p.m., with Registered Nurse 1, (RN1), in Resident 3's room, the oxygen tubing was observed to be on the floor at Resident 3's bedside. RN1 stated oxygen tubing should be secured so that it does not touch the floor to prevent the resident from getting an infection. During a concurrent observation and interview with Certified Nursing Assistant 1, (CNA1), on 7/8/26 at 11:10 a.m., in Resident 3's room, the oxygen tubing was observed to be on the floor. CNA1 stated oxygen tubing should not be on the floor due to the risk of infection for the resident 2. During a concurrent observation and interview on 7/7/26 at 12:41 p.m., with RN2 in Resident 72's room, a visitor was observed at the bedside without PPE required on the neutropenic precautions (strict infection-control measures designed to protect patients with severely compromised immune systems and critically low white blood cell counts) posted outside Resident 72's room and when oxygen tubing was observed to be on the floor at the bedside. RN2 stated Resident 72 is on neutropenic precautions to protect Resident 72 from infection. RN2 stated individuals not wearing appropriate personal PPE present a risk to immuno-compromised individuals, (those with a weakened immune system that cannot properly fight infection), by spreading infection that may result in harm. RN2 stated oxygen tubing is contaminated once on the floor and should be replaced to prevent infection to the resident. 3. During a review of Resident 88's admission record, dated 7/9/26, indicated Resident 88 was admitted to the facility on [DATE]. During a review of Resident 88's Minimum Data Set (MDS &ndash; a federally mandated resident assessment tool), dated 6/2/26, the MDS indicated Resident 88 had multiple diagnoses that included Systemic Inflammatory Response Syndrome (SIRS- when body is having a massive, system-wide inflammatory reaction to a major physical trauma or stress). During a review of Resident 88's Order Summary Report, dated 7/3/26, indicated Resident 88 had an order for O2 (oxygen supplement) at 2 LPM (liters per minute-measures the rate or volume of supplemental oxygen flowing from a tank or concentrator to a patient) via Nasal Cannula (NC, a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) PRN (as needed) for Shortness of Breath (SOB)/chest pain. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 7/6/26 at 10:06 a.m., with Infection Preventionist/Director of Staff Development (IP/DSD), inside Resident 88's bathroom, Resident 88's oxygen concentrator (a medical device that pulls in room air, filters out nitrogen, and delivers concentrated medical-grade oxygen) was stored next to the toilet with power cord on the floor and parts of oxygen tubing connected to the concentrator was inside garbage container. IP/DSD disconnected the oxygen tubing and power cord and stated, the oxygen concentrator was not supposed to be stored in the bathroom due to risk of infection for Resident 88. IP/DSD stated, Resident 88 required oxygen supplement as needed per doctor's order and oxygen concentrator must be kept at Resident 88's bedside or, when not in use or in the designated oxygen storage room. During an interview on 7/8/26 at 11:15 a.m., with the Assistant Director of Nursing (ADON), ADON stated, it was not acceptable practice to store oxygen concentrator in Resident 88's bathroom. ADON stated, oxygen concentrators must be stored in the designated storage unit after resident use. During an interview on 7/8/26 at 11:27 a.m., with ADON, ADON was asked what potential risks were, when oxygen concentrator being actively used, was stored in Resident 88's bathroom with tubing in garbage container, ADON stated, I don't think the oxygen is dirty. During an interview on 7/8/26 at 12:57 p.m., with House Keeping Supervisor (HKS), HKS stated, housekeeping staff will be notified if oxygen concentrator was not in use. HKS furthermore stated, housekeeping staff are supposed to clean, disinfect and then store the oxygen concentrator in the storage area. During a review of the facility's policy and procedure (P&P) titled, Oxygen Concentrator and Oxygen Storage, revised 12/2022, indicated it is the policy of this facility to provide a safe environment for residents, staff, and the public. This policy addresses the use and storage of oxygen and oxygen equipment. The P&P also indicated, under 3. Safety .u. Concentrators do not have to be stored in the oxygen storage location. They can be stored in a clean utility room. v. Keep concentrator turned off when set up for use in resident's room, but not actively in use . 4. During a concurrent observation and interview on 7/7/26 at 8:51 a.m., with Licensed Vocational Nurse (LVN) 3, in Medbridge unit, the silent knight pill crusher (a medical-grade device used to grind solid pills into a fine powder) on top of medication cart Purple had gray and white powder that has dried into a hardened, solid crust on its' surface and surrounding parts. LVN 3 stated, pill crusher was dirty and had the potential for contamination of medications being given to the residents. During a concurrent observation and interview on 7/7/26 at 9:27 a.m., with Registered Nurse (RN) 3, RN 3, in Legacy unit, the silent knight pill crusher on top of medication cart Blue was dirty with calcified white and gray residue on it's surrounding parts. RN 3 stated, the pill crusher was dirty. During a concurrent observation and interview on 7/7/26 at 9:31 a.m., with LVN 4, in Legacy unit, the silent knight pill crusher on top of medication cart Green had white and black solid crust on its surrounding surface. LVN 4 stated, the dirty pill crusher had the potential to cause infection to residents if dirty debris got in resident medications. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/7/26 at 10:15 a.m., with the Assistant Director of Nursing (ADON), ADON stated, pill crushers are shared equipment and should be cleaned thoroughly after each shift. During a review of facility's P&P titled Cleaning and Disinfection of Resident-Care Items and Equipment, dated 9/2022, under Policy Interpretation and Implementation, indicated .5. Reusable items are cleaned and disinfected or sterilized between residents. 6. Reusable resident care equipment is decontaminated and/or sterilized between residents.		