STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555456	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Antelope Valley Care Center	44567 North 15th St. West Lancaster, CA 93534

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure self-administration of lidocaine (a topical adhesive patch that delivers a local anesthetic to a specific area of the body to relieve pain) was evaluated and considered safe by the interdisciplinary team (IDT-a multidiscipline group of healthcare professionals involved in periodically meeting and planning care for individual residents) for one of five sampled residents (Resident 51) reviewed during pain management. This deficient practice had the potential to result in increased risk of Resident 51 administering lidocaine patches to the wrong location due to lack of technique resulting in medical complications such as uncontrolled pain. Findings: During a review of Resident 51's admission Record (AR), the AR indicated that the facility originally admitted the resident on 8/14/2024 and readmitted on [DATE] with diagnoses including cauda equina syndrome (a condition where the nerve roots at the bottom of the spinal cord [cauda equina] are compressed, leading to damage and dysfunction), generalized muscle weakness, polyosteoarthritis (a condition where multiple joints experience inflammation and degeneration of cartilage) unspecified (exact cause or type of polyosteoarthritis is unknown). During a review of Resident 51's History and Physical (H&P), dated 8/16/2024, the H&P indicated that the resident has the capacity to make decisions. During a review of Resident 51's Minimum Data Set (MDS - a resident assessment tool), dated 6/7/2025, the MDS indicated the resident has clear speech, makes self understood, and has the ability to understand others. The MDS indicated the resident as cognitively intact (a person's thinking, learning, and memory abilities are functioning normally and are not impaired). The MDS indicated the resident required assistance from staff with ADLs including shower/bathing, upper and lower body dressing, putting on/taking off footwear, personal hygiene, and toileting hygiene. The MDS indicated the resident required assistance with mobility including sit to lying on the bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, and walking. During a review of Resident 51's Care Plan (CP) focus on musculoskeletal disorder, dated 10/21/2024, the CP indicated the resident's pain will be managed to a tolerable level with interventions including to observe for signs and symptoms of joint stiffness, fracture, change in function, or increased report of pain and notify physician of abnormal findings; to monitor pain level every shift and as needed; and to administer medication as ordered and monitor effectiveness. During a review of Resident 51's Order Audit Report (OAR), dated 8/27/2025, the OAR indicated the order summary: lidocaine External Patch four percent (% -a unit of measurement), apply to bilateral (both) shoulders topically one time a day for pain on 12 hours (hrs - a unit of measurement) and off 12 hours and remove per schedule. The OAR indicated lidocaine was administered by unsupervised self-administration with the directions to apply to bilateral shoulders topically one time a day for pain unsupervised self-administration on 12 hrs off 12 hrs and remove per schedule. During an interview on 8/25/2025 at 9:52 a.m. with Resident 51, Resident 51 stated she (Resident 51) has an order for a patch for her (Resident 51) left shoulder pain, and no facility staff has given the patch to her (Resident 51) since 8/24/2025. Resident 51 stated she (Resident 51) does not have a patch on her (Resident 51) left shoulder currently. Resident 51 stated she (Resident 51) told one of the medication nurses a few days ago that she (Resident 51) has pain on her (Resident 51) left shoulder and she (Resident 51) could not raise it higher because of the pain. During a concurrent observation and interview on 8/25/2025 at 9:54 a.m. with Licensed Vocational Nurse (LVN) 1 at Nursing Station 2, LVN 1 confirmed medication cart A contained 10 lidocaine external patch four %. LVN 1 stated the 10 lidocaine external patches were delivered 8/24/2025. LVN 1 stated she (LVN 1) was assigned to Resident 51 and finished administered Resident 51's morning medications. During a concurrent interview and record review on 8/25/2025 at 9:57 a.m. with LVN 1, Resident 51's physician orders, self-administration of medication assessment, and electronic Medication Administration Record (eMAR) for the month of 8/2025 were reviewed. LVN 1 stated she (LVN 1) has not applied the lidocaine patch. LVN 1 stated on 8/24/2025 and 8/25/2025, Resident 51's eMAR indicated the lidocaine patch was initialed U-SA. LVN 1 stated U-SA means supervised self-administration. LVN 1 stated on her (LVN 1) screen, the screen shows green and the green means the medication was administered. LVN 1 stated she (LVN 1) does not know why the medication was signed when she (LVN 1) has not clicked it. LVN 1 stated the eMAR would show her (LVN 1) initials that she (LVN 1) had given the lidocaine patch. LVN 1 stated when a resident self-administers a medication a self-administration of medication assessment is completed. LVN 1 stated a self-administration of medication assessment for Resident 51 was not done. LVN

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of resident needs and preferences by failing to ensure the call light (an alerting device for nurses or other nursing personnel to assist a patient when in need) was within reach for one (1) of one (1) sampled resident (Resident 42) reviewed under the call devices in reach care area. This deficient practice had the potential to result in a delay of care and services and possible injury to Resident 42 when the resident was unable to call for assistance. Findings: During a review of Resident 42's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility admitted the resident on 8/15/2023, with diagnoses including generalized anxiety disorder (a mental health condition where excessive fear and worry interfere with daily life, causing significant distress), post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 42's History and Physical (H&P) dated 10/16/2024, the H&P did not indicate Resident 42's capacity to understand and make decisions. During a review of Resident 42's Minimum Data Set (MDS, a resident assessment tool), dated 7/11/2025, the MDS indicated Resident 42 had severely impaired cognition (mental action or process of acquiring knowledge and understanding), and was unable to understand and make her needs known. The MDS further indicated Resident 42 required set-up or clean-up assistance with eating, substantial/maximal assistance with oral hygiene, upper and lower body dressing, and personal hygiene, and total assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 42's fall risk assessments dated 1/17/2025, 4/15/2025, and 7/11/2025, the fall risk assessments indicated Resident 42 was at a high risk for falls. During a review of Resident 42's care plan (CP) on risk for falls initiated on 8/15/2024, and last revised on 8/12/2024, the CP indicated to keep call light within easy reach, and provide verbal reminders or cues to ask for assistance as needed as a few of the interventions to minimize the risk for falls. During an observation 8/25/2025 at 10:54 a.m. inside Resident 42's room, observed Resident 42 lying in bed, awake, alert, and responds inappropriately. Observed Resident 42's call light hanging on the side of the right upper side rail almost touching the floor and not within Resident 42's reach. During a concurrent observation and interview on 8/25/2025 at 11:25 a.m. inside Resident 42's room, with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 42's call light was hanging on the side of the right upper side rail and away from the resident's reach. CNA 1 stated they usually do not give Resident 42 the call light as the resident had an ongoing behavior of putting things in their mouth and biting on them. During a concurrent observation and interview on 8/26/2025 at 10:00 a.m. inside Resident 42 with CNA 2, CNA 2 stated Resident 42's call light was hanging on the side of the right upper side rail and away from the resident's reach. CNA 2 stated they usually do not give Resident 42 the call light as the resident had a behavior of putting things in their mouth and biting on them. During a concurrent observation and interview on 8/27/2025 at 9:53 a.m. inside Resident 42's room with MDS Nurse (MDSN) 1, MDSN 1 stated Resident 42's call light was hanging on the side of the right upper side rail and away from the resident's reach. MDSN 1 stated even if a resident has a tendency to put things in their mouth and bite, the call light should still be placed within their reach. However, it will require frequent monitoring by staff to ensure the resident's safety. MDSN 1 stated the call light should have been within Resident 42's reach so the resident can call for assistance when needed as it placed the resident at risk for a delay in attending to and meeting Resident 42's needs. During an interview on 8/29/2025 at 12:30 p.m. with the Director of Nursing (DON), the DON stated staff are required to ensure that the call lights are placed within the residents' reach after providing care and prior to leaving the room regardless of if they have a behavior of putting things in their mouth. The DON stated the staff are required to monitor the resident more frequently to ensure their safety. The DON stated Resident 42's call light should have been placed within reach as the resident was unable to see where the call light was and reach for it. The DON stated if the call light was not within Resident 42's reach, the resident would not be able to call for assistance when needed and there could be a delay in providing assistance and meeting Resident 42's needs. During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light, last reviewed on 5/30/2025, the P&P indicated a purpose to ensure timely responses to the resident's requests and needs. The P&P further indicated to ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure residents rights to formulate an Advance Directive (AD, a legal document that outlines an individual's wishes regarding medical care in the event they become incapacitated and unable to communicate their preferences) was respected for one of eight sampled residents (Resident 134) reviewed under the AD care area by failing to provide written information concerning the right to formulate an AD. This deficient practice had the potential to violate the resident's right to have their wishes honored regarding health care decisions. Findings: During a review of Resident 134's admission Record (AR), the AR indicated the facility originally admitted the resident on 11/12/2024, and most recently re-admitted the resident on 6/28/2025, with diagnoses that included cirrhosis of liver (permanent scarring that damages the organ that removes toxins from the body's blood supply), ankylosing spondylitis (a chronic inflammatory disease that primarily affects the spine) of the lumbar region (lower back), and diverticulitis (a condition where small pouches in the wall of the colon become inflamed or infected). During a review of Resident 134's Minimum Data Set (MDS - resident assessment tool) dated 7/5/2025, the MDS indicated the resident was able to understand others and was able to make himself understood and required partial / moderate assistance with bathing, dressing, personal hygiene, and mobility. During a review of Resident 134's Advance Directive Acknowledgement form, dated 7/11/2025, the form indicated the resident did not wish to complete an AD. During a concurrent interview and record review on 8/28/2025 at 2:42 p.m. with Minimum Data Set Nurse (MDSN) 1, MDSN 1 reviewed Resident 134's Advance Directive Acknowledgement form, dated 7/11/2025. MDSN 1 stated the Advance Directive Acknowledgement form did not indicate that the AD was discussed or that written information was provided regarding formulating an AD to the resident or resident representative (RP). During a concurrent interview and record review on 8/28/2025 at 2:44 p.m. with Social Services Designee 1 (SS Designee) 1, SS Designee 1 reviewed Resident 134's Advance Directive Acknowledgement form, dated 7/11/2025. SS Designee 1 stated the AD is a document that gives information on a resident's wishes regarding medical decisions. SS Designee 1 stated the facility AD process is to speak with the resident or RP upon admission and ask if the resident has an AD or if the resident would like to formulate an AD. SS Designee 1 stated SS Designee 1 only explains the AD and does not provide anything in writing regarding the AD. During a concurrent interview and record review on 8/28/2025 at 2:55 p.m. with the Admissions Director (ADMD), the ADMD reviewed Resident 134's Advance Directive Acknowledgement form, dated 7/11/2025. The ADMD stated the ADMD provided the admissions packet to Resident 134. The ADMD stated the AD form does not indicate that the resident was provided with written information regarding the AD. The ADMD stated upon admission that the ADMD gives the residents an idea about what the AD is, but the social services department explains the AD in better detail. During a follow up concurrent interview and record review on 8/28/2025 at 3:05 p.m. with MDSN 1, MDSN 1 reviewed the facility policy and procedure (P&P) regarding ADs. MDSN 1 stated the P&P indicated residents are provided with written information concerning the resident's right to formulate an AD and the written information includes a description of the facilities policies to implement ADs and applicable state law. MDSN 1 stated there was no documented evidence that Resident 134 was provided with written information regarding the AD. During a concurrent interview and record review on 8/29/2025 at 8:44 a.m. with the Director of Nursing (DON), the DON reviewed the facility P&P regarding AD. The DON stated the AD is where a resident plans out their wishes for when they become unable to verbalize them. The DON stated it is the resident's right to know that they may formulate an AD and have their plan for care followed. The DON stated it is an issue of respect. The DON stated the DON recently identified the staff was not providing written AD information in a format that was easily understood by the resident. The DON stated the facility is now handing out a pamphlet that explains the AD, but the staff must have missed Resident 134. The DON stated when Resident 134 was not provided written information regarding the AD, the facility P&P was not followed with the potential that the facility staff may not be aware of the resident's wishes regarding care and their wishes would not be followed. During a review of the facility provided P&P titled, Advance Directives, last reviewed 5/30/2025, the P&P indicated the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. Advance care planning is a process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions. The Advance

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to immediately notify the primary physician, responsible party (RP), and Registered Dietician (RD) of a significant change in condition (COC - a significant shift or worsening in someone's health or well-being, often requiring attention or intervention) for one of four sampled residents (Resident 13) reviewed during the Nutrition care area by failing to notify per the facility policy and procedure (P&P) when the resident had significant unplanned weight loss (a loss of five [5] percent [%] of body weight in 30 days, 7.5% in 90 days, or 10% in 180 days) on 8/1/2025. This deficient practice had the potential to result in further weight loss and malnutrition (a serious condition that happens when your diet does not contain the right amount of nutrients) in Resident 13. Cross Reference F693 Findings: During a review of Resident 13's admission Record (AR), the AR indicated the facility originally admitted the resident on 10/27/2024, and most recently re-admitted the resident on 3/8/2025, with diagnoses that included End Stage Renal Disease (ESRD -irreversible kidney failure), dependence on hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), dysphagia (difficulty eating) following cerebral infarction (CVA-stroke, loss of blood flow to a part of the brain), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 13's Minimum Data Set (MDS - resident assessment tool) dated 7/14/2025, the MDS indicated the resident sometimes was able to understand others and sometimes was able to make themself understood. The MDS further indicated the resident required setup assistance with eating and required substantial / maximal assistance with bathing, toileting, dressing, oral and personal hygiene, and transfers from the bed/chair. During a review of Resident 13's Care Plan (CP) titled, Malnutrition: (Resident 13) is at risk for malnutrition due to.DM, ESRD., initiated 10/27/2024, the CP indicated a goal that the resident would not have significant weight loss to the extent possible. The CP indicated interventions that included monitor for acute changes in condition which may contribute to risk for malnutrition and notify the physician if observed, observe for signs and symptoms of weight loss, monthly weights if stable, and notify the physician of significant weight loss. During a review of Resident 13's Weight and Vitals record, dated 8/27/2025, the Weights and Vitals record indicated on 07/01/2025, the resident's Post HD Dry Weight (a patient's weight when all of the excess fluid is removed at the end of HD treatment) was 115 lbs. and on 08/01/2025, the resident's Post HD Dry Weight was 105 lbs. which was an 8.7 % loss from the prior month. During an observation on 8/26/2025 at 11:26 a.m., observed Resident 13 sitting on a gurney at Nursing Station 1. Observed Resident 13 stated Resident 13 needed food. Observed the Assistant Director of Nursing (ADON) stated to Resident 13 that the nurse would provide a sack lunch for the resident to take to the resident's HD appointment. During a concurrent interview and record review on 8/27/2025 at 11:15 a.m. with Minimum Data Set Nurse (MDSN) 2, MDSN 2 reviewed Resident 13's Weights and Vitals record, Weight Variance assessment dated [DATE], and Change of Condition Evaluation forms for 8/2025. MDSN 2 stated the facility process is the Restorative Nurse Aide (RNA) weighs the residents monthly and reports to the licensed nurse (LN). MDSN 2 stated that significant weight loss of greater than 5% is a COC and requires immediate notification to the physician and RP. MDSN 2 stated Resident 13 had significant weight loss on 8/1/2025. MDSN 2 stated there was no documented evidence that a COC was completed with notification to the physician and RP. MDSN 2 stated the importance of reporting significant weight loss is to make sure the reason for the weight loss is addressed, begin treatment, and prevent malnutrition in the resident. MDSN 2 stated the Quality Assurance Nurse (QAN) nurse reports any significant weight loss COC's. During a concurrent interview and record review on 8/27/2025 at 11:38 a.m. with QAN 2, QAN 2 reviewed Resident 13's Weights and Vitals record, Weight Variance assessment dated [DATE], and Change of Condition Evaluation forms for 8/2025. QAN 2 stated QAN 2 is responsible for entering resident weights in the computer, determining if there is significant weight loss, and reporting significant weight loss COCs the family and physician. QAN 2 stated it was important to notify the family and physician regarding a weight loss COC to ensure the family knows what is happening and the resident is monitored for continued weight loss and further weight loss is prevented. QAN 2 stated on 8/1/2025 Resident 13 had significant weight loss and was a COC. QAN 2 stated there was no documented evidence that the physician or RP were notified of Resident 13's COC. QAN 2 stated QAN 2 did not remember what happened or why QAN 2 did not notify the physician or RP regarding the COC, but the COC was not reported. QAN 2 stated when QAN 2 did not

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, comfortable, and homelike environment for two of two sampled residents (Resident 201 and 157) reviewed under environment facility task by: 1. Failing to ensure the resident`s bilateral floor mats (a cushioned floor pad designed to help prevent injury should a person fall) did not have tears and were in disrepair for Resident 201. This deficient practice had the potential to negatively affect Resident 201's psychosocial well-being and make the resident feel uncomfortable in their living space. 2. Failing to ensure the resident's floor was not sticky with yellowish stains on the floor where the urinal bottle (is a portable container used to collect urine, often by people who cannot easily access a toilet) was placed for Resident 157. This deficient practice had violated the resident's right to a safe, clean, comfortable, and homelike environment. Findings: a. During a review of Resident 201’s admission Record (AR), the AR indicated the facility admitted the resident on 8/21/2025, with diagnoses including pneumonia (an infection/inflammation in the lungs), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and type two (2) diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 201’s History and Physical (H&P) dated 8/22/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 201’s Minimum Data Set (MDS-a resident assessment tool), dated 8/28/2025, the MDS indicated Resident 201 had an intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand others and make his needs known. The MDS further indicated Resident 201 required setup or clean up assistance with eating; partial/moderate assistance to substantial assistance with bed mobility and transfers; total assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 201 did not have an impairment of both upper and lower extremities. During a review of Resident 201’s Order Summary Report dated 8/29/2025, the Order Summary Report indicated a physician’s order dated 8/21/2025 for bilateral fall mats (floor mats) and may have low bed. During a concurrent observation and interview on 8/25/20205 at 9:54 a.m., inside Resident 201’s room, observed Resident 201 sitting up on the edge of the bed on the left side with fall mats on both sides of the bed. Observed Resident 201’s right floor mat with a tear on the right upper corner and multiple tears in the middle part of the left floor mat. Resident 201 stated that the fall mats are old and had tears and needed to be changed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 8/25/2025 at 10:01 a.m. inside Resident 201’s room with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 201’s right floor mat had a tear on the right upper corner, and the left floor mat had multiple tears in the middle. CNA 1 stated if the floor mats had tears, the staff were supposed to notify the maintenance department for replacement. CNA 1 stated the floor mat should be clean and not have tears as it does not look good and does not provide a homelike environment for the resident. During an interview on 8/29/2025 at 12:30 p.m. with the Director of Nursing (DON), the DON stated that the staff are required to notify the maintenance department as soon as possible if they observe any tears in the floor mats for replacement as the facility was not providing a homelike environment especially if the resident verbalized that the floor mats need to be replaced. The DON stated residents have the right to have a safe and clean environment. The DON stated the staff should have notified the maintenance department to change Resident 201’s floor mat. The DON if Resident 201’s floor mat in disrepair or with tears indicates that the facility is not providing a clean, and homelike environment to the resident which may affect his quality of life as the facility is considered the resident’s temporary home while recovering. During a review of the facility's recent policy and procedure (P&P) titled “Homelike Environment, ” last reviewed on 5/30/2025, the P&P indicated residents are provided with a safe, clean, comfortable, and homelike environment. The P&P further indicated: -The staff provides person-centered care that emphasizes the resident’s comfort, independence and personal needs and preferences. -The facility staff and management maximize the characteristics of the facility that reflect a personalized, homelike setting which includes a clean, sanitary, and orderly environment. b. During a review of Resident 157’s AR, the AR indicated the facility admitted the resident on 8/26/2024, and readmitted the resident on 5/22/2025, with diagnoses including enterocolitis due to clostridium difficile (C. diff, a highly contagious bacteria that causes severe diarrhea), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and hemiparesis (is a medical term for weakness on one side of the body). During a review of Resident 157’s H&P, dated 10/5/2024, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 157’s MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others, and had impaired vision. The MDS indicated the resident had intact cognition (is having a fully functioning and healthy mind) and required moderate to set up or clean-up assistance on mobility and ADLs. During a review of Resident 157’s Care Plan (CP) Report titled “Resident has individualized preferences to keep urinals on bedside table and not have the room cleaned until 2 p.m. or later, last revised on 7/30/2025, the CP indicated an intervention to manage environment to optimize comfort and monitor for safety and facility guidelines regarding personal preferences. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 8/25/2025, at 9:39 a.m., with Treatment Nurse (TN) 1, inside Resident 157’s room, observed Resident 157’s urinal hanging at the right upper side rail (is a metal or plastic bar that can be raised or lowered along the side of a resident's bed) of the bed and beneath the urinal had yellowish sticky substance on the floor. TN 1 stated the floor is sticky and there were yellowish sticky marks beneath the urinal possibly urine that spilled on the floor. TN 1 stated it was the responsibility of all staff to ensure the resident’s room is clean and homelike. TN 1 stated the failure of the facility to keep the floor clean could lead to resident getting upset and could predispose the resident to accidents such as slips and falls. During an interview on 8/28/2025, at 3:20 p.m., with the DON, the DON stated Resident 157`s floor should be clean, and free of any sticky, yellow stains. The DON stated the failure of the staff to keep the resident’s floor clean does not promote a homelike environment for the resident and could make the resident miss their home. During a review of the facility’s recent P&P titled “Homelike Environment,” last reviewed on 5/30/2025, the P&P indicated residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Policy Interpretation and Implementation 2. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect personalized, homelike setting. These characteristics include: a. safe, sanitary and orderly environment.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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: 1.Ensure two antidepressant medications, Celexa and Wellbutrin, (medications used to treat mental illness) were not used concurrently without a documented clinical rationale in one of five residents sampled for unnecessary medications (Resident 8.) 2.Ensure two antipsychotic medications, Seroquel and Abilify, (medications used to treat mental illness) were not used concurrently without a documented clinical rationale in one of five residents sampled for unnecessary medications (Resident 6.) 3.Monitor the use of Wellbutrin for adverse effects (unwanted or dangerous medication-related side effects) in the Medication Administration Record (MAR - a record of medications administered, and regular monitoring completed for a resident) for one of five residents sampled for unnecessary medications (Resident 8.) 4.Ensure the behavior manifestations for the use of buspirone (also known as Buspar, a medication used to treat general anxiety) and clonazepam (also known as Klonopin, a medication used to treat panic attacks and control seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] by slowing down the overexcited brain) were measurable and specific in one sampled resident (Resident 101). These deficient practices of using two psychotropic medications (medications that affect brain activities associated with mental processes and behavior) of the same class concurrently without documented clinical rationale, failing to monitor for adverse effects of Wellbutrin, and failing to define specific, measurable behaviors for the use of buspirone and clonazepam increased the risk that Residents 6, 8, and 101 could have experienced adverse effects related to psychotropic medication therapy, such as drowsiness, dizziness, constipation, or increased risk of fall, possibly leading to impairment or decline in their mental or physical condition or functional or psychosocial status. Cross-reference F656 Findings: a.During a review of Resident 8’s admission Record (a record containing diagnostic and demographic resident information), dated 8/28/2025, the admission record indicated the facility originally admitted the resident on 8/18/2023 and most recently readmitted on [DATE], with diagnoses including major depressive disorder (a mental illness characterized by depressed mood, difficulty sleeping, social withdrawal, or lack of interest in usually enjoyable activities) During a review of Resident 8’s History and Physical (H&P-a record of a physician’s comprehensive medical examination), dated 11/2/2024, the H&P did not indicate whether the resident had the capacity to understand and make medical decisions. During a review of Resident 8’s Order Summary Report (a summary of all active physician’s orders), dated 8/28/2025, the order summary report indicated the resident was receiving the following antidepressant medications: 1.Wellbutrin XL 150 milligrams (mg – a unit of measure for mass) by mouth once daily for “depression manifested by tearful episodes.” 2.Celexa 10 mg by mouth once daily for “depression manifested by sadness related to feeling of loss of independence.” (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 8’s available care plans (resident-specific plans of care created to address a resident’s needs), last revised 8/5/2025, there was no care plan for depression which specified the use of Wellbutrin XL 150 mg as a targeted intervention and no care plan to monitor the use of Wellbutrin for efficacy or adverse effects. During a review of Resident 8’s MAR for August 2025, the MAR indicated facility staff were not monitoring the use of Wellbutrin XL 150 mg for adverse effects. During a review of Resident 8’s clinical record and psychiatric progress notes (a record of a comprehensive psychiatric examination from a psychiatric care provider) authored by the psychiatric nurse practitioner (NP 1), dated 5/29/2025, 6/9/2025, and 7/10/2025, the notes did not contain any documented rationale or discussion of a clinical need to use both Celexa and Wellbutrin simultaneously. b.During a review of Resident 6’s admission Record, dated 8/28/2025, the admission record indicated the facility originally admitted the resident on 9/9/2017 and most recently readmitted on [DATE], with diagnoses including schizoaffective disorder (a mental illness characterized by hearing or seeing things that are not there, disorganized behavior or speech, and mood swings or depressed mood). During a review of Resident 6’s History and Physical, dated 9/26/2024, the H&P did not indicate whether the resident had the capacity to understand and make medical decisions. During a review of Resident 6’s Order Summary Report, dated 8/28/2025, the order summary report indicated the resident was receiving the following antipsychotic medications: 1.Abilify 10 mg by mouth once daily for “schizoaffective disorder manifested by incoherent and irrational thoughts as evidenced by episodes of screaming.” 2.Seroquel 100 mg by mouth every 12 hours for “schizoaffective disorder manifested by disorganized thought process as evidenced by verbal outbursts.” During a review of Resident 6’s clinical record and psychiatric progress note (a record of a comprehensive psychiatric examination from a psychiatric care provider) authored by the psychiatric nurse practitioner (NP 1), dated 7/24/2025, the notes did not contain any documented rationale or discussion of a clinical need to use both Abilify and Seroquel simultaneously. c. During a review of Resident 101’s admission Record, the admission Record indicated the facility originally admitted the resident on 5/27/2025 and readmitted in the facility on 6/7/2025, with diagnoses including generalized anxiety disorder (a mental health condition where excessive fear and worry interfere with daily life, causing significant distress), generalized muscle weakness, and difficulty walking. During a review of Resident 101’s History and Physical (H&P), dated 6/7/2025, the H&P indicated the resident had the capacity to understand and make decisions. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 101’s Minimum Data Set (MDS, a resident assessment tool), dated 6/14/2025, the MDS indicated the resident had the ability to understand others and make his needs known and had moderately impaired cognition (normal mental abilities that allow someone to effectively handle the day-to-day demands of life). The MDS indicated the resident received antianxiety medications (a drug used to treat symptoms of anxiety, such as feelings of fear, dread, uneasiness, and muscle tightness, that may occur as a reaction to stress). During a review of Resident 101’s Order Summary Report dated 8/29/2025, the Order Summary Report indicated the following physician’s orders: - 5/27/2025 and revised on 6/17/2025: buspirone hydrochloride (Hcl)oral tablet five (5) milligrams (mg – a unit of measurement) give one (1) tablet by mouth two (2) times a day for anxiety manifested by feeling of anxiety. - 5/27/2025 and revised on 6/17/2025: clonazepam oral tablet one (1) mg give one (1) tablet by mouth every 12 hours every Monday, Wednesday, Friday, Sunday for anxiety manifested by restlessness as evidenced by negative vocalizations and give one (1) tablet by mouth every 12 hours every Tuesday, Thursday, Saturday. - 8/14/2025: For buspirone use, monitor number of episodes manifested by feeling of anxiety indicate the number of episodes of behavior every shift. - 8/14/2025: For clonazepam use: monitor number of behavior episodes for anxiety manifested by restlessness as evidenced by negative vocalizations every shift. During a review of Resident 101’s care plan (CP) on the use of antianxiety medications buspirone and clonazepam initiated on 5/28/2025 and last revised on 6/2/2025, the CP indicated to administer the medications are ordered, monitor/document/report as needed any adverse reactions to the therapy, and monitor/record occurrence of target behavior as a few of the interventions to keep resident free from adverse reactions, maintain resident’s functional status, and have less than ten (10) episodes of anxious behavior per week. During a telephone interview on 8/28/2025 at 8:28 a.m. with the psychiatric nurse practitioner (NP) 1, NP 1 stated she is a psychiatric care provider for Resident 6 and Resident 8 and sees the residents monthly to provide psychiatric care. NP 1 stated she is unaware of any clinical rationale, other than historical use, as to why Resident 6 is using Seroquel and Abilify concurrently and why Resident 8 is using Celexa and Wellbutrin concurrently. NP 1 stated that using two medications of the same class together is uncommon without the dose on either of them being optimized and may result in the resident experiencing more side effects related to their psychotropic therapy than they would from one medication alone. NP 1 stated sometimes practicing in a skilled nursing facility environment presents unique challenges as resident's care is split between multiple providers and facility types and may lead to issues with medication therapeutic duplication. NP 1 stated she needs to do a better job of identifying medication-related issues and documenting a rationale or resolution in the residents' progress notes. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/28/2025 at 8:59 a.m. with the Director of Nursing (DON), the DON stated the facility failed to create a care plan for Resident 8's use of Wellbutrin and failed to monitor the use of Wellbutrin for adverse effects in the MAR. The DON stated creating a resident-specific care plan including the specific medication as a targeted intervention is important to ensure the medication is monitored for adverse effects and efficacy. The DON stated if the medication is not monitored for adverse effects, the resident may be on the medication longer than necessary and may experience adverse effects like drowsiness, dizziness, etc . that may cause a decline in their quality of life. During a concurrent interview and record review on 8/28/2025 at 10:50 a.m., reviewed Resident 101’s physician’s order with Quality Assurance Nurse (QAN) 1. QAN 1 stated Resident 101 had a physician’s order for buspirone hydrochloride (Hcl) for anxiety manifested by feeling of anxiety and clonazepam for anxiety manifested by restlessness as evidenced by negative vocalization. QAN 1 stated that the behavior manifestations for the use of buspirone Hcl and clonazepam were not specific. QAN 1 stated behavior manifestations for the use of any psychotropics should be person-centered, specific, and measurable. QAN 1 stated Resident 101’s behavior manifestations for the use of buspirone and clonazepam should have been person-centered, specific, and measurable so the staff can properly monitor Resident 101’s episodes of specific behavior manifestations, ensure appropriateness of the use of the antianxiety medications, and prevent adverse side effects if the medication use is not appropriate. During a concurrent interview and record review on 8/28/2025 at 11:20 a.m., reviewed Resident 101’s physician’s order with the Assistant Director of Nursing (ADON). The ADON stated Resident 101 had a physician’s order for buspirone for anxiety manifested by feeling of anxiety and clonazepam for anxiety manifested by restlessness as evidenced by negative vocalization. The ADON stated that the behavior manifestations for the use of buspirone and clonazepam were not specific. The ADON stated that the behavior manifestations for the use of any psychotropics should be person-centered, specific, and measurable. The ADON stated Resident 101’s behavior manifestations for the use of buspirone and clonazepam should have been person-centered, specific, and measurable so Resident 101 can be properly monitored for episodes of specific behavior manifestations, ensure appropriateness of the use of the antianxiety medications, and prevent adverse side effects if the medication use is not appropriate. The ADON stated the behavior manifestations for the use of buspirone, and clonazepam should have been clarified by QAN 1 or the licensed nurses with the physician to ensure the behavior being monitored is specific and measurable. During a review of the facility’s undated policy “Psychoactive/Psychotropic Medication Use, ” the policy indicated “Residents who are admitted from the community or transferred from a hospital and who are already receiving psychotropic medication will be evaluated for the appropriateness and indications for use… Monitoring of a resident receiving psychotropic medication will include evaluation or the effectiveness of the medication, as well as an assessment for possible adverse consequences… Staff will monitor for potential adverse consequences , such as: General: anticholinergic effects which may include flushing, blurred vision, dry mouth, altered mental status, difficulty urinating, falls, excessive sedation, constipation…” (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility’s policy “Psychotropic Medication Use,” revised May 2025, the policy indicated “Psychotropic medication management is an interdisciplinary process that involves the resident, family, and/or the representative and includes… establishing appropriate dose (including duplicate therapy) and duration… Duplicate therapy (use of two or more medication of the same pharmacological class or category without a clear distinction of when one medication should be administered over another) is generally not indicated unless there is a documented clinical rationale for the use of multiple medication from the same class or with similar therapeutic effects…” During a review of the facility’s policy and procedure (P&P) titled, “Psychoactive/Psychotropic Medication Use,” last reviewed on 5/30/2025, the P&P indicated psychoactive (also known as psychotropic) medications may be administered following federal and state regulations if the medication is necessary to treat a specifically diagnosed condition and is appropriately documented in the medical record. The P&P further indicated: - The attending physician (AP) will identify, evaluate, and document, with input from other disciplines and consultants as needed, medical symptoms that may warrant the use of psychotropic medications. - The AP and other staff, as possible, will identify acute psychiatric episodes, and will differentiate them from enduring psychiatric conditions. During a review of the facility’s P&P titled, “Psychotropic Medication Use,” last reviewed on 5/30/2025, the P&P indicated that the residents do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record. The P&P further indicated: - Psychotropic medication management is an interdisciplinary process that involves the resident, family, and/or the representative and includes determining adequate indication for use. - “Adequate indication for use” refers to the identified, documented clinical rationale for administering medication based on assessment of the resident’s condition and manufacturer’s recommendations, clinical practice guidelines, clinical standards of practice, medication references, clinical studies, or evidence-based review articles that support the use of the medication.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on observation, interview, and record review, the facility failed to develop and implement a baseline care plan (is an initial, temporary care document that is developed within 48 hours of a resident's admission, providing essential, person-centered care instructions to staff to ensure safety and continuity of care while a more comprehensive plan is developed) on the use of urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) with appropriate indication for one of three sampled residents (Resident 199) reviewed for urinary catheter. The deficient practice had a potential for delays in the delivery of necessary care and services and development of urinary tract infection (UTI, an infection in the bladder/urinary tract) in Resident 199. Findings: During a review of Resident 199's admission Record (AR), the AR indicated the facility admitted the resident on 8/23/2025, with diagnoses including muscle weakness, difficulty walking, and acute kidney failure (when the kidneys suddenly stop working properly, usually over hours or days). During a review of Resident 199's History and Physical (H&P), dated 8/16/2025, the H&P indicated the resident was alert and interactive with normal affect (means that a person's outward emotional expression is considered typical, healthy, and appropriate for a given situation). During a review of Resident 199's Order Summary Report (OSR), dated 8/24/2025, the OSR indicated an order for Foley (a brand of urinary catheter) catheter size: 16 French (F, is a sizing system for catheters and other medical tubes that measures the outer diameter)/10 cubic centimeters (cc, a unit of volume that measures the space an object occupies or the amount of liquid a container holds). The OSR did not have any indication for the Foley catheter. During a concurrent observation, interview, and record review on 8/26/2025 at 11:42 a.m., with Licensed Vocational Nurse (LVN) 6, inside Resident 199's room, observed Resident 199 with Foley catheter on. Reviewed Resident 199's OSR and Care Plan. LVN 6 stated there was an order for Foley catheter for the resident. However, there was no indication for its use and there was no baseline care plan developed and implemented for its use. LVN 6 stated the resident was admitted to the facility with the Foley catheter on 8/23/2025. LVN 6 stated it was important to have an indication for its use and a baseline care plan to ensure its safe use. During an interview on 8/28/2025 at 3:20 p.m., with the Director of Nursing (DON), the DON stated the licensed staff should have developed and implemented a baseline care plan on the use of urinary catheter of Resident 199 within 48 hours. The DON stated the care plan contains the goals and interventions the resident needs to achieve from the therapy. The DON stated the failure of the licensed staff to develop and implement a care plan on the use of the urinary catheter can delay the care and services necessary for the resident's health and well-being. During a review of the facility's recent policy and procedure (P&P) titled Care Plans- Baseline, last reviewed on 5/30/2025, the P&P indicated a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. Policy Interpretation and Implementation 1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: a. initial goals based on admission orders and discussion with the resident/representative; b. Physician orders; c. Dietary orders; d. Therapy services; e. Social services; and f. PASARR recommendation, if applicable.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan (is a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) by failing to: 1. Develop and implement a comprehensive care plan on the use of bilateral cushion boots (are padded, boot-like medical devices worn on both feet (bilateral) to protect and support them) per the physician's order for one of two sampled residents (Resident 93) reviewed for pressure ulcer/injury (localized damage to the skin and/or underlying tissue usually over a bony prominence). This deficient practice had potential to result in a delay in the delivery of the necessary care and services and development of a pressure injury on Resident 93's heels. 2. Develop and implement a care plan timely addressing the resident's behavior of putting things in their mouth for one (1) of two (2) sampled residents (Resident 42) reviewed under the behavior-emotional care area. 3. Develop and implement a care plan for the use of cefdinir (an antibiotic used to treat bacterial infections in the ear, sinus, throat, lungs, and skin) for one of six (6) sampled residents (Resident 12) reviewed for antibiotic (a medicine that stops the growth of bacteria that causes infections) use. These failures had the potential to result in a delay in the delivery of the necessary care and services the residents need. 4. Develop and implement a care plan for the resident's new onset of pain on bilateral shoulders for one of five sampled residents (Resident 51) reviewed during the pain management care area. Cross-reference F697 5. Implement a care plan for the resident's left heel deep tissue injury (DTI- a stage of pressure injury characterized by intact skin that is purple or maroon in color) for one of five sampled residents (Resident 189) reviewed under pressure injury (localized damage to the skin and/or underlying tissue usually over a bony prominence). Cross-reference F686 These deficient practices had the potential to result in miscommunication among interdisciplinary staff, residents, and resident representatives resulting in a delay in necessary care and services. 6. Develop and implement a care plan for the use of Wellbutrin (a medication used to treat mental illness) for one of five residents sampled residents (Resident 8) reviewed for unnecessary medications. The deficient practice increased the risk that Resident 8 could have experienced adverse effects related to psychotropic medication therapy, such as drowsiness, dizziness, constipation, or increased risk of fall, possibly leading to impairment or decline in their mental or physical condition or functional or psychosocial status. 7. Ensure the care plan intervention indicated the frequency of monitoring neurological checks (NC - a rapid assessment of a person's nervous system function) and vital signs (VS - essential measurements that indicate a person's basic physiological functions) for Resident 19 regarding a fall that happened on 6/25/2025, for one of three sampled residents (Resident 19) reviewed for falls. This deficient practice had the potential to result in a delay in the care of Resident 19. 8. Develop and implement a care plan for weight loss for one of four sample Residents (Resident 13) reviewed for nutrition. This deficient practice had the potential to result in further weight loss and malnutrition for Resident 13. Cross-reference F692 9. Implement a care plan for monitoring antibiotics (medication used to treat infection) for its side effects (effect of a drug that occurs alongside its desired effect) or adverse effects (response to a medication that is harmful) for three of five sampled residents (Residents 10, 106, and 202). These failures had the potential to result in a delay in the delivery of necessary care and services. Findings: 1. During a review of Resident 93’s admission Record (AR), the AR indicated the facility admitted the resident on 6/10/2025, and readmitted the resident on 8/8/2025, with diagnoses including pressure ulcer of sacral region stage 3 (a deep sore in the tailbone area where the full thickness of the skin has been lost, and the wound extends into the underlying fat tissue), muscle weakness, and difficulty of walking. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 93’s History and Physical (H&P), dated 8/9/2025, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 93’s Order Summary Report (OSR), dated 8/9/2025, the OSR indicated an order for may have bilateral cushion boot s when in bed for wound management/wound prevention every shift. During a review of Resident 93’s Minimum Data Set (MDS, a resident assessment tool), dated 8/15/2025, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (is a serious decline in a person's ability to think, reason, and remember that significantly impacts their daily life and independence). The MDS indicated the resident was dependent and needed partial assistance in mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting, that a person performs daily). The MDS indicated the resident was at risk for developing pressure injuries and currently had a Stage 3 pressure ulcer. The MDS indicated the resident was on pressure ulcer/injury care. During a review of Resident 93’s Braden Scale (BS) for Predicting Pressure Sore Risk, dated 8/16/2025, the BS indicated the resident was at high risk for developing pressure sore/injury. During a review of Resident 93’s Care Plan (CP) Report titled “Resident has a pressure ulcer to sacral coccyx Stage 3 and at risk for further breakdown and/or slow, delayed healing,” last revised on 8/9/2025, the CP indicated an intervention to administer treatment as ordered. During a concurrent observation, interview, and record review, on 8/25/2025, at 10:04 a.m., with the Assistant Director of Nursing (ADON), while inside Resident 93’s room, Resident 93’s bilateral cushion boot was observed to not be applied to the resident. The bilateral cushion boot was still in a plastic bag lying on top of the resident’s bedside drawer. The ADON stated the bilateral cushion boot should be on the resident’s feet to protect the heels from developing pressure sores/ulcer/injury. The ADON reviewed the OSR, Care Plan, and the BS of the resident. The ADON stated there was an order for Resident 93 to have the bilateral cushion boots on while in bed for wound management/prevention. The ADON stated the failure of the staff to apply the bilateral cushion boots on the resident can result in the development of pressure injury on the resident’s heels. The ADON also stated there was no care plan for the use of the bilateral cushion boots of Resident 93. The ADON stated the failure of the staff to develop and implement a care plan for the use of bilateral cushion boots had the potential for a delay in the care and services for the resident. During an interview on 8/28/2025, at 3:20 p.m., with the Director of Nursing (DON), the DON stated the staff should have applied the bilateral cushion boots on Resident 93 per the physician’s order and developed and implemented a care plan for its use to prevent pressure injuries from developing on the resident’s heels and to ensure its safe use. The DON stated the licensed staff should ensure the physician’s orders are followed and should be checked at least every shift and the care plan developed to prevent the delay of the care and services necessary for the resident’s care in particular to skin management and prevention. During a review of the facility's most recent policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, last reviewed on 5/30/2025, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Interpretation and Implementation 1. The interdisciplinary team (IDT, is a group of people from different fields of expertise who work together and coordinate their efforts to solve a complex problem or reach a common goal), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive. person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 2. During a review of Resident 42’s admission Record, the admission Record indicated the facility admitted the resident on 8/15/2023 with diagnoses including generalized anxiety disorder (a mental health condition where excessive fear and worry interfere with daily life, causing significant distress), post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 42’s History and Physical (H&P) dated 10/16/2024, the H&P did not indicate Resident 42’s capacity to understand and make decisions. During a review of Resident 42’s Order Summary Report dated 8/29/2025, the Order Summary Report indicated a physician’ order dated 5/6/2025 for Ativan (a fast-acting medication used for conditions like severe anxiety, panic attacks, and seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness)]) oral tablet give one tablet by mouth one time a day every Tuesday, Friday for anxiety 30 minutes prior to ADL care/showering due to fear of being transferred becoming aggressive with staff. During a review of Resident 42’s Minimum Data Set (MDS, a resident assessment tool), dated 7/11/2025, the MDS indicated Resident 42 had severe cognition (mental action or process of acquiring knowledge and understanding) and was unable to understand and make her needs known. The MDS further indicated Resident 42 required set-up or clean-up assistance with eating, substantial/maximal assistance with oral hygiene, upper and lower body dressing, and personal hygiene, and total assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a concurrent observation and interview on 8/25/2025 at 11:25 a.m. while inside Resident 42’s room with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 42’s call light was hanging on the side of the right upper side rail and away from the resident’s reach. CNA 1 stated they usually do not give Resident 42 the call light as the resident had an ongoing behavior of putting things in their mouth and biting on them but unsure of how long. During an interview on 8/26/2025 at 9:45 a.m. with Licensed Vocational Nurse (LVN) 8, LVN 8 stated that Resident 42 had the behavior of putting things in the mouth and biting for at least one year now and she was not sure if there was a care plan addressing the specific behavior. LVN 8 stated Resident 42 had an order for an Ativan tablet during shower days as the resident had the tendency to be combative and aggressive towards staff when touch or transferred. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/27/2025 at 8:10 a.m., Resident 42’s physician’s order and care plan was reviewed with MDS Nurse (MDSN) 1, MDSN 1 stated Resident 42 had a physician’s order to administer Ativan tablets on Tuesdays and Fridays 30 minutes prior to ADL care or shower days due to the resident being aggressive during transfers on shower days. MDSN 1 stated she was just made aware of Resident 42’s behavior of putting things in the mouth and biting on 8/25/2025 and just developed the care plan addressing the behavior on 8/25/2025. MDSN 1 stated there was no care plan developed prior to 8/25/2025. MDSN 1 stated the licensed nurses are required to develop and implement a care plan if they identified behavior issues of the resident to ensure the resident is getting the proper interventions to address the specific behavior issues, such as non-pharmacological interventions and notify the physician if ineffective, to prevent delay in meeting the needs of the resident. MDSN 1 stated the care plan addressing Resident 42’s putting things in the mouth should have been developed and implemented timely to ensure proper interventions were implemented such as more frequent monitoring of Resident 42 for putting things in the mouth and notifying the physician timely if the interventions were ineffective. MDSN 1 stated if the staff did not give the call light to Resident 42 due to behavior putting things in the mouth and it was not addressed with a care plan, it placed Resident 42 at risk for a delay in meeting the necessary care and services Resident 42 needs. During an interview on 8/29/2025 at 12:30 p.m. with the Director of Nursing (DON), the DON stated the CP should be developed and implemented addressing an issue, such as behaviors with a resident, as soon as the behavior is identified to be able to identify the interventions needed and provide the necessary care the resident needed. The DON stated the CP addressing Resident 12’s behavior of putting things in the mouth was not developed timely. The DON stated the CP addressing Resident 12’s behavior of putting things in the mouth should have been developed timely by the interdisciplinary team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the patients) to identify the proper interventions and services to be provided to Resident 12 which may lead to a delay in the delivery of care. During a review of the facility’s policy and procedure (P&P) titled, “Care Plans, Comprehensive Person-Centered,” last reviewed on 5/30/2025, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident’s physical, psychosocial, and functional needs is developed and implemented for each resident. The P&P further indicated: The comprehensive person-centered care plan: Includes measurable objectives and timeframes Describes the services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being, including: (3) which professional services are responsible for each element of care When possible, interventions address the underlying source(s) of the problem are(s), not just symptoms or triggers. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 12’s admission Record, the admission Record indicated the facility admitted the resident on 7/2/2025 with diagnoses including urinary tract infection (UTI- an infection in the bladder/urinary tract), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and generalized muscle weakness. During a review of Resident 12’s History and Physical (H&P) dated 7/4/2025, the H&P indicated Resident 12 had the capacity to understand and make decisions. During a review of Resident 12’s Minimum Data Set (MDS, a resident assessment tool), dated 7/9/2025, the MDS indicated Resident 12 had intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand and make her needs known. The MDS further indicated Resident 12 required set-up or clean-up assistance with eating; partial/moderate assistance with oral hygiene; substantial/maximal assistance with upper body dressing, and bed mobility; and total assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 12’s Order Summary Report dated 8/29/2025, the Order Summary Report indicated a physician’s order dated 7/2/2025 to administer cefdinir oral capsule 300 milligrams (mg – a unit of measurement) one capsule by mouth every 12 hours for UTI for five (5) days. During a review of Resident 12’s care plans (CP), there was no documented evidence that a CP was developed and implemented for the use of cefdinir for UTI. During a concurrent interview and record review on 8/28/2025 at 11:52 a.m., Resident 12’s Order Summary Report, CP, and nurses’ notes were reviewed with Quality Assurance Nurse (QAN) 1. QAN 1 stated Resident 12 had a physician’s order for cefdinir dated 7/2/2025 for UTI upon admission from the hospital. QAN 1 stated there was no care plan developed and implemented for Resident 12’s use of cefdinir for UTI. QAN 1 stated the licensed nurses are required to initiate a care plan as soon as an antibiotic is ordered, as it was a short-term treatment to ensure proper interventions were implemented, and that the staff are aware of the current plan of care. QAN 1 stated Resident 12’s care plan for the use of cefdinir for UTI should have been developed and implemented timely so the staff would be aware of the proper interventions needed to meet Resident 12’s needs timely, as it placed Resident 12 at risk of a delay in care. During an interview of 8/29/2025 at 12: 30 p.m. with the Director of Nursing (DON), the DON stated care plans for the use of antibiotics should be developed by the licensed nurse who received the order for the antibiotic so everyone involved in the resident’s care would be aware of the type of care and services the resident needs. The DON stated Resident 12’s care plan for the use of cefdinir to treat her UTI should have been developed and implemented on the day of admission so all the staff caring for Resident 12 would be aware of the proper interventions necessary to treat and help resolve the resident’s UTI and prevent delay in the care needed. During a review of the facility’s policy and procedure (P&P) titled, “Care Plans, Comprehensive Person-Centered,” last reviewed on 5/30/2025, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident’s physical, psychosocial, and functional needs is developed and implemented for each resident. The P&P further indicated: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive person-centered care plan: Includes measurable objectives and timeframes Describes the services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being, including: (3) which professional services are responsible for each element of care When possible, interventions address the underlying source(s) of the problem are(s), not just symptoms or triggers. 4. During a review of Resident 51’s admission Record (AR), the AR indicated that the facility originally admitted the resident on 8/14/2024 and readmitted on [DATE] with diagnoses including cauda equina syndrome (a condition where the nerve roots at the bottom of the spinal cord [cauda equina] are compressed, leading to damage and dysfunction), generalized muscle weakness, polyosteoarthritis (a condition where multiple joints experience inflammation and degeneration of cartilage) unspecified (exact cause or type of polyosteoarthritis is unknown). During a review of Resident 51’s History and Physical (H&P), dated 8/16/2024, the H&P indicated that the resident has the capacity to make decisions. During a review of Resident 51’s Care Plan (CP) focused on the resident’s musculoskeletal disorder, dated 10/21/2024, the CP indicated the resident’s pain will be managed to a tolerable level with interventions including to observe for signs and symptoms of joint stiffness, fracture, change in function, or increased report of pain and notify physician of abnormal findings; to monitor pain level every shift and as needed; and to administer medication as ordered and monitor effectiveness. During a review of Resident 51’s Minimum Data Set (MDS-a resident assessment tool), dated 6/7/2025, the MDS indicated the resident has clear speech, makes self-understood, and has the ability to understand others. The MDS indicated the resident was cognitively intact (a person's thinking, learning, and memory abilities are functioning normally and are not impaired). The MDS indicated that the resident required assistance from staff with ADLs including shower and bathing, upper and lower body dressing, putting on/taking off footwear, personal hygiene, and toileting hygiene. The MDS indicated the resident required assistance with mobility including sitting to lying on the bed, sitting to stand, chair/bed-to-chair transfer, toilet transfer, and walking. During a review of Resident 51’s Order Audit Report (OAR), dated 8/27/2025, the OAR indicated to apply lidocaine External Patch 4 percent (%-a unit of measurement), to bilateral shoulders topically one time a day for pain on 12 hours (hrs.-a unit of measurement) off 12 hours and remove per schedule. The OAR indicated the order details history for lidocaine indicated administered by unsupervised self-administration and the directions indicated to apply to bilateral shoulders topically one time a day for pain, unsupervised self-administration on 12 hrs. off 12 hrs. and remove per schedule. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/25/2025 at 9:52 a.m. with Resident 51, Resident 51 stated she has an order for a patch for her left shoulder pain, and no one has given it to her since yesterday. Resident 51 stated she does not have a patch on her left shoulder currently. Resident 51 stated she told one of the medication nurses a few days ago that she has pain in her left shoulder and could not raise it higher because of the pain. During a concurrent observation and interview on 8/25/2025 at 9:54 a.m. with Licensed Vocational Nurse (LVN) 1, medication cart A for Station 2 was inspected. LVN 1 stated she is the charge nurse for Resident 51 and has finished passing Resident 51’s morning medications. LVN 1 stated Resident 51’s lidocaine patch container has 10 patches inside. LVN 1 stated the 10 patches were delivered yesterday, 8/24/2025. During a concurrent interview and record review on 8/25/2025 at 9:57 a.m. with LVN 1, Resident 51’s physician orders, self-administration of medication assessment, and electronic Medication Administration Record (eMAR) for the month of 8/2025 was reviewed. LVN 1 stated she has not applied the lidocaine patch and will apply it now. LVN 1 stated on 8/24/2025 and 8/25/2025 indicated initialed and that U-SA means supervised self-administration and, on her screen, it shows green which means it was done but she does not know why it was signed when she has not clicked it. LVN 1 stated it would show her initials that she had given it. LVN 1 stated that when a resident self-administers medication a self-administration of medication assessment is completed. LVN 1 stated self-administration of medication assessment for Resident 51 was not done. LVN 1 stated it is done before the resident can self-administer a medication. During an interview on 8/27/2025 at 6:34 a.m. with LVN 1, LVN 1 stated when a self-administration of medications assessment is not completed, the resident could put the patch on the wrong body part and the resident’s pain management regimen would be off or ineffective. During a concurrent interview and record review on 8/27/2025 at 10:09 a.m. with the Medical Records Director (MRD), Resident 51’s Care Plans for the use of lidocaine and bilateral shoulder pain were reviewed. The MRD stated there was no care plan for the use of the lidocaine patches and the resident’s bilateral shoulder pain. During an interview on 8/27/2025 at 11:18 a.m. with LVN 5, LVN 5 stated he was the charge nurse who entered the order for Resident 51’s lidocaine patch. LVN 5 stated on 8/23/2025 the resident requested a lidocaine patch preference for her bilateral shoulder pain. LVN 5 stated the resident has an order for diclofenac (treats mild to moderate pain) for her knees and that she did not like the stickiness of it. LVN 5 stated he reached out to the doctor and asked for an order for the lidocaine patch. LVN 5 stated the resident did not request to self-administer the lidocaine patch he entered it in error. LVN 5 stated the medication nurses were to administer it. LVN 5 stated that when the order is entered incorrectly the medication would be administered incorrectly and show that the resident understands but does not understand. LVN 5 stated he did not complete a change in condition because the use of the lidocaine patch was a resident preference. LVN 5 stated communication with the doctor and the resident should have been documented. LVN 5 stated if he did not document it then he did not do it. LVN 5 stated care plan is developed to reflect the most updated treatment. LVN 5 stated he should have created a new care plan when he received the order for lidocaine. LVN 5 stated that when the care plan is not developed the residents could experience complications or adverse reactions and they have no way of knowing when it is not being monitored. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/27/2025 at 11:29 a.m. with the Assistant Director of Nursing (ADON), the DON stated the licensed nurse should have completed a change in condition for Resident 51 because that is uncontrolled pain and a new onset of pain on bilateral shoulders. The ADON stated Resident 51's mobility, ADLs, and activities, and level of participation can be affected when their pain is not monitored. The ADON stated it should show detailed documentation on what the licensed nurse did including pain assessment, doctor notification, and what the intervention was. The ADON stated the purpose of assessing the resident’s pain is to help them address the resident’s underlying pain and develop a care plan to manage the resident’s pain. During an interview on 8/27/2025 at 2:17 p.m. with the Director of Nursing (DON), the DON stated the physician should have been notified of Resident 51’s new onset of pain on a new site, bilateral shoulders. The DON stated that when a resident reports pain on a new site (location) the charge nurse should initiate a change in condition, notify the family and resident, carry out the order and monitor the resident’s pain. The DON stated assessing the resident’s pain is done for prompt monitoring and if current interventions are effective. The DON stated 72-hour monitoring is done and if the resident still verbalizes pain throughout review and any further interventions will be care planned. The DON stated the care plan should be initiated for a new pain site. The DON stated the care plan is for focused goal interventions and person-centered, new interventions are in place and if new interventions need to happen. The DON stated that when the resident’s care plan is not developed there is potential for the resident’s pain site to be unchecked, failure to communicate new plan of care for pain and to reassess the resident’s pain interventions. During a review of the facility’s policy and procedure (P&P) titled, “Pain Assessment and Management,” last reviewed 5/30/2025, the P&P indicated that the purpose of this procedure is to help the staff identify pain in the resident, develop interventions consistent with the resident’s goals and needs, and address the underlying causes of pain. The P&P indicated that pain management is a multidisciplinary process that included following: “e. Developing and implementing approaches to pain management based on accepted standards of practice. f. Monitoring for the effectiveness of interventions; and g. Modifying approaches as necessary.” The P&P indicated comprehensive pain assessments are conducted including when there is an onset of new pain or worsening of existing pain. The P&P indicated that the pain management interventions are consistent with the resident’s goals for treatment. The P&P indicated that the medication regimen is implemented as ordered and results of the interventions are documented and communicated directly to the provider when appropriate. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility’s P&P titled, “Care Plans, Comprehensive Person-Centered, ” last reviewed 5/30/2025, the P&P indicated a comprehensive, person-centered CP that includes measurable objectives and timetables to meet the resident’s physical, psychosocial and functional needs is developed and implemented for each resident. The P&P indicated CP interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The P&P indicated that CP includes measurable objectives and timeframes, describes services that are to be furnished, includes the resident’s stated goals, builds on the residents’ strengths, and reflects currently recognized standards of practice for problem areas and conditions. The P&P indicated that CP interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident’s problem areas and their causes, and relevant clinical decision making. The P&P indicated that assessments of residents is ongoing, and CPs are revised as information about the resident and the resident’s condition change. 5. During a review of Resident 189’s AR, the AR indicated the facility admitted the resident on 8/6/2025 with diagnoses including nondisplaced oblique fracture (a type of bone frac

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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. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure the comprehensive care plan (is a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) is reviewed and revised by the interdisciplinary team (IDT, is a group of people from different fields of expertise who work together and coordinate their efforts to solve a complex problem or reach a common goal) for one of two sampled residents (Resident 93) by failing to resolve the care plan on stage three (3) sacral coccyx pressure injury (a deep wound affecting the skin and fatty tissue below it, where the fat layer is visible but the bone, tendon, or muscle is not exposed). This deficient practice had the potential to negatively affect the provision of care and services for Resident 93. Findings: During a review of Resident 93's admission Record (AR), the AR indicated the facility admitted the resident on 6/10/2025, and readmitted the resident on 8/8/2025, with diagnoses including pressure ulcer of sacral region stage three (3), muscle weakness, and difficulty of walking. During a review of Resident 93's History and Physical (H&P), dated 8/9/2025, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 93's Minimum Data Set (MDS, a resident assessment tool), dated 8/15/2025, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (is a major decline in a person's ability to think, remember, and make decisions that is significant enough to interfere with their daily life). The MDS indicated the resident was dependent to needing partial assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident was at risk for developing pressure injuries and currently had a stage three (3) pressure ulcer. The MDS indicated the resident was on pressure ulcer/injury care (relieving pressure on damaged skin by changing positions and using special cushions, keeping the wound clean and protected with appropriate dressings, ensuring proper nutrition and hydration, managing moisture on the skin from things like incontinence, and seeking professional help for deeper wounds or signs of infection). During a review of Resident 93's Order Summary Report (OSR), with a discontinued date of 8/9/2025, the OSR indicated an order for sacral coccyx stage three (3) ulcer: clean, with normal saline (NS, a mixture of water and salt), pat dry, apply zinc oxide cream (is a topical treatment that creates a protective barrier on the skin to shield it from moisture and irritants) on peri wound, apply purocol (is a special type of wound dressing made from collagen that helps difficult wounds heal faster) on wound bed and cover with Opti foam dressing (is a type of soft, highly absorbent foam bandage used to cover and protect wounds) every day shift for stage three (3) ulcer. During a review of Resident 93's Braden Scale (BS) for Predicting Pressure Sore Risk, dated 8/16/2025, the BS indicated the resident was at high risk for developing pressure sore/injury. During a review of Resident 93's Care Plan (CP) Report titled Resident has a pressure ulcer to sacral coccyx stage three (3) and at risk for further breakdown and/or slow, delayed healing, last revised on 8/9/2025, the CP indicated an intervention to administer treatment as ordered. During a review of Resident 93's Nursing-Comprehensive Skin Evaluation/Assessment (NCSE), dated 8/20/2025, the NCSE indicated Resident 93's sacral coccyx stage three (3) pressure injury was resolved. During a concurrent interview and record review on 8/27/2025, at 2:03 p.m., with the Assistant Director of Nursing (ADON), reviewed Resident 93's OSR, BS, NCSE, and CP. The ADON stated the order for sacral coccyx stage three (3) pressure ulcer was discontinued on 8/9/2025, and the NCSE dated 8/20/2025 indicated Resident 93's sacral coccyx stage three (3) pressure injury was resolved. The ADON stated the care plan for sacral coccyx stage three (3) is still active on the care plan list and was not revised or resolved. The ADON stated the licensed staff should have resolved the care plan to reflect the resident's current status. The ADON stated the failure of the staff to update/resolve the care plan can delay the necessary care and services needed for the resident's physical well-being. During an interview on 8/28/2025, at 3:20 p.m., with the Director of Nursing (DON), the DON stated the staff should have revised and reviewed the care plan for stage three (3) sacral coccyx pressure injury of Resident 93 to ensure an accurate picture of the resident and what active treatments are being provided to the resident to achieve the agreed upon goals set by the resident and the healthcare team. The DON stated the failure of the licensed staff to update/revise the care plan can lead to delays in care and services to the resident. During a review of the facility's recent policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, last reviewed on 5/30/2025, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy

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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 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. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's licensed nursing staff failed to provide care in accordance with professional standards to three of three sampled residents (Residents 157, 10, and 14) reviewed for insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (sq, beneath the skin) insulin administration sites. The deficient practice had the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat), and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross-reference F760. Findings: 1.During a review of Resident 157's admission Record (AR), the AR indicated the facility admitted the resident on 8/26/2024, and readmitted the resident on 5/22/2025, with diagnoses including type two (2) diabetes mellitus (DM 2, a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic neuropathy (is nerve damage caused by high blood sugar over a long period), diabetic polyneuropathy (is a type of multiple nerve damage caused by long-term high blood sugar levels in people with diabetes), and muscle weakness. During a review of Resident 157's History and Physical (H&P), dated 10/5/2024, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 157's Minimum Data Set (MDS, a resident assessment tool), dated 8/11/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (is a medical and psychological term that means a person's mental abilities are completely normal and not noticeably damaged or impaired). The MDS indicated the resident was taking hypoglycemic medication (a drug used primarily to lower high blood sugar levels in people with type two diabetes) which was considered a high risk drug class medication (a group of medications that pose a significantly elevated risk of causing harm to patients if used incorrectly or if errors occur during administration). During a review of Resident 157's Order Summary Report (OSR), dated 5/22/2025, the OSR indicated an order for: Insulin Regular Human Injection Solution 100 unit per milliliters (unit/ml, a measure of how concentrated insulin is, meaning there are 100 units of insulin in every 1 milliliter of liquid) (Insulin Regular Human). Inject as per sliding scale (is a simple chart that tells a person with diabetes how much fast-acting insulin to take, based on their current blood sugar level) subcutaneously before meals and at bedtime for DM 2: if 121 - 150 = 4 units; 151 - 200 = 5 units; 201 - 250 = 6 units; 251 - 300 = 8 units; 301 - 350 = 10 units; 351 - 400 = 12 units. Blood sugar (BS) greater than 400 give 14 units and notify the physician. If BS less than 70 notify the physician. Rotate Injection Sites. Insulin Glargine Subcutaneous Solution 100 unit/ml (Insulin Glargine). Inject 15 units subcutaneously at bedtime for Diabetes, rotate injection sites. During a review of Resident 157's Location of Administration (LOA) of insulin for 7/2025 to 8/2025, the LOA indicated: Insulin Regular Human Injection Solution 100 unit/ml was administered on, 7/10/2025 at 5:46 p.m. on the Abdomen - Left Upper Quadrant (LUQ) 7/10/2025 at 10:26 p.m. on the Abdomen - LUQ 7/14/2025 at 8:44 p.m. on the Abdomen - Right Lower Quadrant (RLQ) 7/15/2025 at 8:25 p.m. on the Abdomen - RLQ 7/19/2025 at 12:25 p.m. on the Arm - left 7/19/2025 at 8:48 p.m. on the Arm - left 7/20/2025 at 8:08 p.m. on the Abdomen - Left Lower Quadrant (LLQ) 7/21/2025 at 4:11 p.m. on the Abdomen - LLQ 7/22/2025 at 11:46 a.m. on the Abdomen - LUQ 7/23/2025 at 12:01 p.m. on the Abdomen - LUQ 7/25/2025 at 12:26 p.m. on the Abdomen - LLQ 7/25/2025 at 8:04 p.m. on the Abdomen - LLQ 7/26/2025 at 6:27 p.m. on the Abdomen - LLQ 7/26/2025 at 8:36 p.m. on the Abdomen - LLQ 7/27/2025 at 4:47 p.m. on the Abdomen - RLQ 7/27/2025 at 9:06 p.m. on the Abdomen - RLQ 8/2/2025 at 11:26 a.m. on the Abdomen - LUQ 8/2/2025 at 4:47 p.m. on the Abdomen - LUQ 8/5/2025 at 9:27 p.m. on the Abdomen - LLQ 8/6/2025 at 12:22 p.m. on the Abdomen - LLQ 8/12/2025 at 3:36 p.m. on the Abdomen - RLQ 8/13/2025 at 2:43 p.m. on the Abdomen - RLQ During a review of Resident 157's Care Plan (CP) Report regarding resident requiring hypoglycemic medication Metformin and insulin, last revised on 8/27/2024, the CP indicated an intervention to administer medication as ordered. During a concurrent interview and record review on 8/27/2025, at 1:38 p.m., with the Assistant Director of Nursing (ADON), reviewed Resident 157's OSR, LOA, and CP. The ADON stated there were multiple instances that the licensed staff did not rotate the insulin administration sites for Resident 157. The ADON stated the licensed staff should rotate insulin administration sites to prevent skin damage to the resident and lipodystrophy. The ADON stated the administration of insulin on sites of lipodystrophy can affect the absorption of the

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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 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. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to provide care and services necessary to maintain safe and good nutrition for one (1) of three (3) sampled resident (Resident 101) reviewed for activities of daily living (ADLs - routine/tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves) care area by failing to ensure Certified Nursing Assistant (CNA) 3 provided assistance to Resident 101 with meals as indicated in the meal ticket. This deficient practice placed Resident 101 at risk for weight loss, dehydration (a condition that occurs when the body loses more fluids than it takes in), or nutritional problems, and accidents such as choking. Findings: During a review of Resident 101's admission Record, the admission Record indicated the facility originally admitted the resident on 5/27/2025, and readmitted in the facility on 6/7/2025, with diagnoses including generalized anxiety disorder (a mental health condition where excessive fear and worry interfere with daily life, causing significant distress), generalized muscle weakness, and diabetes mellitus (DM 2-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 101's History and Physical (H&P), dated 6/7/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 101's Minimum Data Set (MDS, a resident assessment tool), dated 6/14/2025, the MDS indicated the resident had the ability to understand others and make his needs known and had moderately impaired cognition (normal mental abilities that allow someone to effectively handle the day-to-day demands of life). The MDS further indicated Resident 101 required supervision or touching assistance with eating; partial/moderate assistance with upper body dressing; substantial/maximal assistance with oral/toileting hygiene, personal hygiene, lower body dressing, and bed mobility; all other ADLs were not attempted due to medical condition or safety concerns. During a review of Resident 101's care plan (CP) on actual nutritional imbalance related to aspiration risk initiated on 5/28/2025 and last revised on 6/5/2025, the CP indicated Resident 101 required assistance with eating to observe for signs or symptoms of difficulty swallowing as evidenced by pocketing, coughing, choking, drooling, or holding food in the mouth as a few of the interventions for the resident not to exhibit signs and symptoms of malnutrition and to tolerate the current diet order with no signs and symptoms of chewing or swallowing difficulties. During a review of Resident 101's Order Summary Report dated 8/29/2025, the Order Summary Report indicated the following physician's orders: -5/27/2025 and revised on 6/18/2025: constant carbohydrate (CCHO - dietary plan designed to manage blood sugar levels providing consistent amount of carbohydrates), no added salt (NAS - low salt diet), renal diet (a special eating plan for people with kidney disease to reduce the amount of waste and fluids that build up in the body) pureed texture (blended or strained food until completely smooth, thick, and has no lumps), thickened liquid honey consistency (pours slowly in dollops, like honey) please provide plastic utensils, feeding assistance, aspiration precaution. -6/18/2025 and last revised on 7/14/2025: CCHO, NAS, Renal diet mechanical soft ground texture, thickened liquid nectar consistency (pours easily and freely, similar to fruit nectar), may also have ice chips. Please provide plastic utensils, feeding assistance, aspiration precaution. -7/14/2025 and last revised on 8/26/2026: CCHO, NAS, Renal diet mechanical soft texture, thickened liquid nectar consistency, may also have ice chips. Please provide plastic utensils, feeding assistance, aspiration precaution. During an observation on 8/25/2025 at 12:52 p.m. inside Resident 101's room during lunch meal service, Resident 101 was observed eating a peanut butter and jelly sandwich without assistance or supervision from the nursing staff. The lunch meal ticket indicated CCHO, NAS, Renal diet mechanical soft texture, thickened liquid nectar consistency, please provide plastic utensils, feeding assistance, aspiration precaution. During a concurrent observation and interview on 8/25/2025 at 12:59 p.m. inside Resident 101's room with CNA 3, CNA 3 stated when giving the meal trays to the residents, staff are required to offer the food to the residents and remove the covers from the food and liquids served. CNA 3 stated feeding assistance means that the staff has to stay with the resident, encourage them to eat the food and drink the liquids served with each meal to make sure the residents are eating and to monitor choking. CNA 3 stated she just removed the covers from Resident 101's peanut butter and jelly sandwich and drink served but did not stay with the resident as she was not aware Resident 101 required feeding assistance. CNA 3 stated she should have grabbed a chair and stayed with Resident 101 during lunch to ensure Resident 101 was able to consume the food and liquids served for lunch and/or offer alternatives if the resident refused what was served, and to make sure Resident 101 did not have signs and symptoms of difficulty swallowing or choking. During an interview on 8/26/2025 at 2:58 p.m. with CNA 4

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 to meet the resident's physical, mental, and psychosocial (relating to the interrelation of social factors and individual thoughts and behavior) for two of five sampled residents (Residents 16 and 10) needs by: 1. Failing to follow up with the physician timely when Resident 16 was complaining of pain on urination for one of two sampled residents (Resident 16) reviewed for change of condition (COC- significant change in a patient's health or functional abilities which requires medical attention or change in their care plan). This failure had the potential to result in the resident's pain on urination to be untreated timely and worsening of the pain which may lead to development of infection. 2. Failing to reconcile Resident 10's medication (formal process of creating the most accurate and complete list of a resident's medications and comparing it against the physician's current medication orders) upon admission to continue antibiotic order on 8/7/2025. This failure resulted in Resident 10 missing one dose of antibiotic on 8/7/2025 at 11 p.m. had the potential to place Resident 10 at further risk of infection. Findings: a. During a review of Resident 16’s admission Record (AR), the AR indicated the facility originally admitted Resident 16 on 11/19/2018, and readmitted in the facility on 7/11/2024, with diagnoses including End Stage Renal Disease (ESRD - irreversible kidney failure), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and type two diabetes mellitus (DM 2-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 16’s H&P dated 10/15/2024, the H&P indicated Resident 16 had the capacity to understand and make decisions. During a review of Resident 16’s Minimum Data Set (MDS-a resident assessment tool) dated 7/8/2025, the MDS indicated Resident 16 had an intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand and make her needs known. The MDS further indicated Resident 16 required set-up or clean up assistance with eating; supervision or touching assistance with oral hygiene; total assistance with transfers; substantial/maximal assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 16 had urinary tract infection (UTI- an infection in the bladder/urinary tract) in the last 30 days and received antibiotic therapy prior to admission and while in the facility. During a review of Resident 16’s eINTERACT Change of Condition Evaluation form (a communication tool used by healthcare workers when there is a change of condition among the residents) dated 8/2/2025 at 3:55 a.m., the eINTERACT Change of Condition Evaluation form indicated that Resident 16 complained of burning sensation when urinating. The eINTERACT Change of Condition Evaluation form further indicated that the physician was notified at 3:57 a.m. and was still awaiting a response back at 6:45 a.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 16’s Order Summary Report dated 8/29/2025, the Order Summary Report indicated a physician’s order dated 8/4/2025 for cephalexin oral tablet 250 milligram (mg-metric unit of measurement, used for medication dosage and/or amount) give one (1) tablet by mouth one time a day for presumptive (something is assumed to be true based on strong evidence or likelihood, but not yet fully confirmed) UTI for ten (10) days. The Order Summary Report did not indicate a physician’s order for any tests to confirm UTI. During a review of Resident 16’s progress notes from 8/2/2025 to 8/4/2025, there was no documentation in the progress notes that a follow up call was made by the licensed nurses to the physician regarding Resident 16’s complaint of burning pain on urination. During a concurrent interview and record review on 8/28/2025 at 9:59 a.m., with Infection Preventionist (IP) 2/Quality Assurance Nurse (QAN) 2, reviewed Resident 16’s eINTERACT Change of Condition Evaluation form, progress notes, and Order Summary Report. IP 2/QAN 2 stated the eINTERACT Change of Condition Evaluation form indicated the physician was notified of Resident 16’s COC on 8/2/2025 at 3:57 a.m. and there was another note in the COC that the nurse was still awaiting for the physician’s response at 6:45 a.m. IP 2/QAN 2 stated there was no documentation from nursing staff that follow up calls were made to the physician. IP 2/QAN 2 stated a physician order was obtained from the physician for the cephalexin on 8/4/2025 at 5:47 p.m. IP 2/QAN 2 stated COC’s are completed prior to end of shift and licensed nurses endorse to the next shift for the incoming nurse to follow up with the physician as soon as possible to address the resident’s issues and to be able to attend to their needs right away to prevent further complications. IP 2/QAN 2 stated the nurses should have made follow up calls with the physician regarding Resident 16’s complaint of burning pain on urination. IP 2/QAN 2 stated the nurse who obtained the physician order for cephalexin should have completed the COC on 8/4/2025 which was more than 24 hours after Resident 16’s complaint. IP 2/QAN 2 stated not following up with the physician and not addressing Resident 16’s complaints of burning pain upon urination timely placed Resident 16 at risk for continued burning pain upon urination which may lead to further complications such as UTI. During an interview on 8/29/2025 at 12:30 p.m. with the Director of Nursing (DON), the DON stated nurses are required to make follow up calls with the physician if a resident’s complaints have not been addressed and complete the eINTERACT Change of Condition Evaluation form upon receipt of orders from the physician for the facility to be able to attend the resident’s needs and prevent further complications. The DON stated he (DON) was made aware that Resident 16’s complaint of burning pain upon urination was not addressed timely as the order from the physician was not obtained until 8/4/2025 even though the eINTERACT Change of Condition Evaluation form was initiated on 8/2/2025. The DON stated that there were no nurses’ notes that the follow up calls were made to the physician for Resident 16`s complaint. The DON stated the nurses should have made follow up calls with the physician regarding Resident 16’s complaint and document in the nurses’ notes. The DON stated if Resident 16’s complaint of burning pain upon urination was not addressed timely, it placed Resident 16 at risk for continued burning pain affecting her quality of life which may lead to further complications such as UTI. During a review of the facility’s P&P titled, “Chane of Condition,” last reviewed on 5/30/2025, the P&P indicated the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident’s medical/mental condition and/or status. The P&P further indicated: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The nurse will notify the resident’s attending physician or physician on call when there has been a(an): d. significant change in the resident’s physical/emotional/mental condition i. specific instruction to notify the physician of changes in the resident’s condition -The nurse will record in the resident’s medical record information relative to changes in the resident’s medical/mental condition or status. During a review of the facility’s P&P titled, “Charting and Documentation,” last reviewed on 5/30/2025, 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 (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the patients) regarding the resident’s condition and response to care. b. During a review of Resident 10’s AR, the AR indicated the facility admitted Resident 10 on 8/7/2025, with diagnoses including other sequelae (disease related to a pre-existing one) of cerebral infarction (blood clot blocks an artery supplying the brain, starving brain cells of oxygen and causing them to die), generalized muscle weakness and unspecified (unconfirmed) organism lobar (section of a lungs) pneumonia (an infection/inflammation in the lungs). During a review of Resident 10’s General Acute Care Hospitals (GACH)’s Discharge Instruction, dated 8/7/2025, the Discharge Instruction indicated to continue amoxicillin-clavulanate (medication used to treat infection) 875-125 mg oral tablet via gastrostomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) two times a day for seven days. The Discharge Instruction indicated Resident 10 last received the antibiotic on 8/7/2025 at 11 a.m., and the next dose was scheduled on 8/7/2025 at 11 p.m. During a review of Resident 10’s medication administration record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 8/2025, the MAR indicated amoxicillin-clavulanate was started at the facility on 8/8/2025 at 9 a.m. During a review of Resident 10’s H&P, dated 8/9/2025, the H&P indicated Resident 10 had the capacity to understand and make decisions. During a review of Resident 10’s MDS, dated [DATE], the MDS indicated Resident 10’s cognitive skills for daily decisions were moderately impaired. The MDS indicated Resident 10 was on antibiotic. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/26/2025 at 8:38 a.m., with IP 2, Resident 10’s Discharge Instruction dated 8/7/2025, was reviewed. IP 2 stated the Discharge Instruction indicated Resident 10 last received the amoxicillin clavulanate on 8/7/2025 at 11 a.m., and the next dose should have been administered on 8/7/2025, at 11 p.m. IP 2 stated Resident 10 missed one dose of the antibiotic because it was not given on 8/7/2025 at 11 p.m. and was administered the following day of 8/8/2025 at 9 a.m. IP 2 stated the nurse failed to continue amoxicillin as ordered. During an interview on 8/27/2025, at 7:42 a.m., with Medical Records Director (MRD), the MRD stated the admitting nurse (LVN 3) should have transcribed the physician order for amoxicillin clavulanate to start on 8/7/2025 at 11 p.m. The MRD stated if the order is not correctly placed on the computer the start date of the medication automatically starts the following day. During an interview on 8/28/2025, at 11:26 a.m., with the Assistant Director of Nursing (ADON), the ADON stated amoxicillin- clavulanate should have been administered on 8/7/2025 at 11 p.m., because the facility had a stock of the medication in the emergency kit (e-kit, an emergency kit containing a small stock of medications and medical supplies for urgent situations. These kits are essential for ensuring quick access to critical drugs when a pharmacy is unavailable, such as after hour). The ADON stated Resident 10 missed one dose of antibiotic on 8/7/2025 at 11 p.m. The ADON stated missed antibiotic could delay the treatment, prolongs and may worsen Resident 10’s infection. During a concurrent observation, and interview on 8/28/2025, at 12:10 p.m., at Nursing Station 1 medication room, IP 2 showed e-kit with four tablets of amoxicillin-clavulanate 875-125 mg. IP 2 stated the antibiotic could have been given on 8/7/2025 at 11 p.m. because it was available. During a concurrent interview, and record review on 8/28/2025 at 3:19 p.m., with the DON, facility’s P&P titled, “Reconciliation of Medications on Admission” dated 5/2024, and last reviewed on 5/30/2025 was reviewed. The P&P indicated, “The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility. Preparation: 1. Gather the information needed to reconcile the medication list: a. Approved medication reconciliation form; b. Discharge summary from referring facility; c. admission order sheet; General Guidelines… Medication reconciliation helps to ensure that medications, routes and dosages have been accurately communicated to the Attending Physician and care team.” The DON stated LVN 3 should have verified with the physician and document if any orders were continued. The DON stated the importance of medication reconciliation was to avoid delay in treatment and treat current infection. The DON stated the potential effect of missing antibiotics could result in untreated and exacerbation of infection. The DON stated the facility’s policy was to start the antibiotic as physician order.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure residents with pressure ulcers/injury (a skin and tissue injury caused by prolonged pressure on the skin, often over bony areas) receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for three of three sampled residents (Resident 93, 189, and 36) by failing to: 1. Keep Resident 93's bilateral cushion boots (is a medical device worn on both feet and ankles to provide cushioning, support, and protection for various foot-related issues) on the resident while in bed per physician's order. The deficient practice had the potential for delay of necessary care and services and worsening of the resident`s pressure injury. 2.Obtain a physician order prior to applying wound dressing on Resident 189's right heel. 3. Follow Resident 189`s physician order for left heel deep tissue injury (DTI- a stage of pressure injury characterized by intact skin that is purple or maroon in color) wound treatment. 4. Specify in the wound treatment order the type of dressing used for left heel DTI wound for Resident 189. 5. Obtain a physician`s order for Resident 36 prior to applying the wound treatment on 8/24/2025 on the resident's sacrococcyx (fused sacrum [a shield-shaped bone located at the back of the pelvis] and coccyx [tailbone]) pressure ulcer/injury stage three (3) (thickness loss of skin. Dead and black tissue may be visible). These deficient practices had the potential to cause development of new pressure ulcers and the worsening of existing pressure ulcers in Residents 189 and 36. Findings: 1.During a review of Resident 93’s admission Record (AR), the AR indicated the facility admitted the resident on 6/10/2025, and readmitted the resident on 8/8/2025, with diagnoses including pressure ulcer of sacral region (is the triangular bone located at the very base of the spine) stage three (Full-thickness loss of skin. Dead and black tissue may be visible), muscle weakness, and difficulty of walking. During a review of Resident 93’s History and Physical (H&P), dated 8/9/2025, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 93’s Minimum Data Set (MDS, a resident assessment tool), dated 8/15/2025, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (means having very significant trouble with basic mental tasks like thinking, learning, remembering, and making decisions). The MDS indicated the resident was dependent to needing partial assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident was at risk for developing pressure injuries and currently had a stage three pressure ulcer. The MDS indicated the resident was on pressure ulcer/injury care (relieving pressure on damaged skin by changing positions and using special cushions, keeping the wound clean and protected with appropriate dressings, ensuring proper nutrition and hydration, managing moisture on the skin from things like incontinence, and seeking professional help for deeper wounds or signs of infection). During a review of Resident 93’s Order Summary Report (OSR), dated 8/9/2025, the OSR indicated an order for may have bilateral cushion boots when in bed for wound management/wound prevention every shift. During a review of Resident 93’s Braden Scale (BS) for Predicting Pressure Sore Risk, dated 8/16/2025, the BS indicated the resident was at high risk for developing pressure sore/injury. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 93’s Care Plan (CP) Report titled “Resident has a pressure ulcer to sacral coccyx stage three and at risk for further breakdown and/or slow, delayed healing,” last revised on 8/9/2025, the CP indicated an intervention to administer treatment as ordered. During a concurrent observation, interview, and record review on 8/25/2025 at 10:04 a.m., with the Assistant Director of Nursing (ADON), inside Resident 93’s room, Resident 93’s was observed without bilateral cushion boots applied. Bilateral cushion boots were still in a plastic bag placed on top of the resident’s bedside drawer. The ADON stated the bilateral cushion boots should be applied to the resident’s feet to protect the heels from developing pressure sores/injury/ulcer. The ADON reviewed the OSR, CP, and the BS of the resident. The ADON stated there was an order for Resident 93 to have bilateral cushion boots on while in bed for wound management/prevention. The ADON stated the failure of the staff to apply bilateral cushion boots on the resident can result in the development of pressure injury on the resident’s heels. During an interview on 8/28/2025, at 3:20 p.m., with the Director of Nursing (DON), the DON stated staff should have applied bilateral cushion boots on Resident 93 per physician’s order to prevent pressure injuries to develop on the resident’s heels. The DON stated licensed staff should ensure the physician’s orders are followed and should check compliance at least every shift. During a review of the facility's recent policy and procedure (P&P) titled Physician Orders, last reviewed on 5/30/2025, the P&P indicated the purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders. During a review of the facility's recent P&P titled Pressure Ulcers/Skin Breakdown- Clinical Protocol, last reviewed on 5/30/2025, the P&P indicated on Assessment and Recognition: 1. The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s). Treatment/Management 1.The physician will order pertinent wound assessments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.) and application of topical agents. 2. During a review of Resident 189’s admission Record (AR), the AR indicated the facility admitted the resident on 8/6/2025, with diagnoses including nondisplaced oblique fracture (a type of bone fracture where the bone breaks at an angle, but the broken pieces remain in their original position) of shaft of left tibia (shinbone), unspecified fracture of shaft of left fibula (the outer and usually smaller of the two bones between the knee and the ankle in humans, parallel with the tibia), pressure-induced deep tissue damage of sacral (a triangular bone at the base of the spine) region, and pressure-induced deep tissue damage of left heel. During a review of Resident 189’s History and Physical (H&P), dated 8/7/2025, the H&P indicated the resident had the capacity to understand and make decisions. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 189’s Minimum Data Set (MDS-a resident assessment tool), dated 8/13/2025, the MDS indicated the resident was able to make self understood and had the ability to understand others. The MDS indicated the resident was cognitively intact (a person's thinking, learning, and memory abilities are functioning normally and are not impaired). The MDS indicated that the resident required assistance from staff with ADLs including shower/bathing, upper and lower body dressing, putting on/taking off footwear, personal hygiene, and toileting hygiene. The MDS indicated the resident required assistance with mobility including rolling left and right, sit to lying, and lying to sitting on the side of bed. During a review of Resident 189’s Care Plan (CP) Report focused on impaired skin integrity, dated 8/7/2025, the CP indicated goals to prevent or delay deterioration of skin integrity with interventions including to administer treatments as ordered and to monitor for effectiveness. During a review of Resident 189’s Order Summary Report, the Order Summary Report indicated the following: -Sacral coccyx DTI, cleanse with soap and water, pat dry, apply zinc every three (3) days as needed (PRN) if soiled or dislodged, dated 8/7/2025. -Left heel DTI, cleanse with soap and water, pat dry, apply zinc every three days PRN if soiled or dislodged, every day shift every three days, dated 8/7/2025. During a review of Resident 189’s Braden Scale for Predicting Pressure Sore Risk, dated 8/20/2025, the Braden Scale indicated the resident was at moderate risk in developing pressure ulcer. During an observation on 8/26/2025 at 9:33 a.m. with Treatment Nurse (TN) 1, TN 1 prepared the following supplies: two (2) medicine cups, one container of sterile water, expiration date 5/2/2027. TN 1 poured sterile water into each of the medicine cups and placed gauze into each medicine cup. TN 1 used two tongue depressors and scooped out zinc oxide 20 percent (%-a unit of measurement) ointment then placed into two separate medicine cups. TN 1 placed one abdominal pad, one 22 centimeters (cm-a unit of measurement) x 25 cm bordered foam dressing, and one bandage roll dressing. During a concurrent observation and interview on 8/26/2025 at 9:42 a.m. with TN 1, at Resident 189’s bedside, Resident 189 was lying in bed on her right side. Observed Resident 189's left and right buttocks and sacrococcyx area with no discoloration and no open skin noted. TN 1 stated Resident 189 does not appear to have a sacrococcyx DTI and they are continuing this treatment for prevention. TN 1 cleansed Resident 189`s sacrococcyx area using a sterile water-soaked gauze and patted dry with a dry gauze. TN 1 applied zinc oxide using the tongue depressor and spread around the site. TN 1 applied the bordered gauze dressing to the resident’s sacrum. During an observation on 8/26/2025 at 9:48 a.m. with TN 1, at Resident 189’s bedside, TN 1 removed her gloves and washed her hands using soap and water. Observed Resident 189’s right heel with a bordered gauze dressing. TN 1 stated this dressing was applied as a preventative measure. TN 1 stated she believes the right heel dressing was placed yesterday. TN 1 continued wound treatment to the resident’s left heel. TN 1 dropped the medicine cup with soaked gauze in sterile water. TN 1 obtained new supply of soaked gauze in sterile water placed in a medicine cup. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 8/26/2025 at 9:52 a.m. with TN 1, at Resident 189’s bedside, TN 1 stated Resident 189’s left heel DTI measured 1.5 cm width and 1 cm length. TN 1 stated the resident's left heel DTI is black in color. TN 1 cleansed the resident’s left heel with gauze soaked in sterile water, patted dry with dry gauze, and applied zinc oxide. TN 1 covered the resident’s left heel with an abdominal pad and then wrapped with the bandage roll. During a concurrent interview and record review on 8/26/2025 at 3:08 p.m. with TN 1, reviewed Resident 189’s physician orders and treatment administration record for the month of 8/2025. TN 1 stated she should have clarified the order for the wound treatment on the resident’s left heel DTI before applying the sterile water and gauze dressing. TN 1 stated a physician order should have been obtained prior to the application of the wound dressing on Resident 189`s right heel. TN 1 stated the purpose of verifying the order and ensuring there is a physician order for the wound treatment is to ensure that it is the right treatment being provided to the resident. TN 1 stated the resident could potentially develop pressure ulcers. 3. During a review of Resident 36’s AR, the AR indicated that the facility originally admitted the resident on 12/17/2024, and readmitted on [DATE], with diagnoses including chronic respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood) with hypoxia (a condition in which the body does not have enough oxygen), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and generalized muscle weakness. During a review of Resident 36’s MDS, dated [DATE], the MDS indicated the resident made self understood and had the ability to understand others. The MDS indicated the resident was cognitively intact (a person's thinking, learning, and memory abilities are functioning normally and are not impaired). The MDS indicated the resident required assistance from staff with ADLs including shower/bathing, upper and lower body dressing, putting on/taking off footwear, personal hygiene, and toileting hygiene. The MDS indicated the resident required assistance with mobility including rolling left and right, sit to lying, and lying to sitting on the side of bed. During a review of Resident 36’s Braden Scale for Predicting Pressure Sore Risk, dated 8/22/2025, the Braden Scale indicated the resident was at high risk to develop pressure ulcer. During a review of Resident 36’s CP Report focused on sacral coccyx reoccurrence stage three pressure ulcer, dated 8/23/2025, the CP indicated the resident with goals of ulcer decreasing in size and healing without complications with interventions including to administer treatment as ordered. During a review of Resident 36’s Order Summary Report, the Order Summary Report indicated: -Sacral coccyx reoccurrence stage three pressure injury; cleanse with normal saline solution (nss), pat dry, apply Puracol (collagen-based wound dressing) sheet, cover with foam dressing as needed (PRN) if soiled or dislodged, PRN for wound care, dated 8/23/2025. -Sacral coccyx reoccurrence stage three pressure injury; cleanse with normal saline solution (nss), pat dry, apply Puracol (collagen-based wound dressing) sheet, cover with foam dressing as needed (PRN) if soiled or dislodged, every day shift for wound care, dated 8/23/2025. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 8/26/2025 11:02 a.m. with TN 1, at the treatment cart, TN 1 prepared wound treatment supplies for Resident 36’s sacral coccyx treatment: one medicine cup, poured nss into one medicine cup and placed gauze inside, one 6x6 inch (a unit of measurement) hydrocellular (a highly absorbent foam that protects wound from outside contaminants) dressing, one Puracol sheet, one nss container poured into the medicine cup. During a concurrent observation and interview on 8/26/2025 at 11:06 a.m. with TN 1, at Resident 36’s bedside, Resident 36 was observed lying in bed on her left side. TN 1 removed the old dressing and noted a white-colored ointment under the old dressing on the resident’s sacral coccyx area. TN 1 stated the white-colored ointment is zinc oxide. TN 1 stated she (TN 1) will clean the resident’s sacral coccyx wound with nss. TN 1 removed her gloves and applied alcohol-based hand sanitizer and measured Resident 36`s sacral coccyx wound. TN 1 stated the wound measured 3 cm length and 1.1 cm width, wound bed red, slough 20%, scant drainage. TN 1 applied Puracol sheet then the hydrocellular dressing on the resident’s sacral coccyx. TN 1 completed wound care for Resident 36. During a concurrent interview and record review on 8/26/2025 at 11:16 a.m. with TN 1, reviewed Resident 36’s physician orders. TN 1 stated the zinc oxide is not on the order for the resident’s sacral coccyx wound treatment. TN 1 stated she does not know who applied the zinc oxide. TN 1 stated she should have clarified the order yesterday, 8/25/2025 before she applied the resident’s sacral coccyx wound treatment. During a concurrent interview and record review on 8/26/2025 at 3:10 p.m. with TN 1, Resident 36’s physician orders and TAR for the month of 8/2025 were reviewed. TN 1 stated she (TN 1) applied the wound dressing after the zinc oxide was already applied to the resident yesterday, 8/25/2025. TN 1 stated she did not remove the zinc oxide ointment as it was already on the resident. TN stated she noted that the resident had maceration, so she (TN 1) spoke with the wound specialist and received a new order today, 8/26/2025. TN 1 stated she (TN 1) should have clarified Resident 36`s zinc oxide treatment when she (TN 1) saw it yesterday, 8/25/2025. TN 1 stated the resident’s wound could potentially get worse when the order is not clarified. TN 1 stated the wound treatment order should specify the treatment including the type of dressings used. During an interview on 8/27/2025 at 10:22 a.m. with the Assistant Director of Nursing (ADON), the ADON stated their protocol for wound treatment includes treatment nurse verifying the treatment orders. The ADON stated they prepare the medication and assemble supplies they need. The ADON stated the wound treatment order should specify the wound site, wound type, and the frequency of wound treatment. The ADON stated the purpose of verifying physician orders is to ensure an approved treatment by the doctor and this is the protocol of the facility. The ADON stated the purpose of the wound treatment order is to ensure a treatment order is in place and the wound is monitored/followed up on. The ADON stated the type of dressings, and the frequency and application should be specified in the physician`s wound orders. The ADON stated without an order they would not have accurate wound monitoring. The ADON stated that even if it is preventative wound treatment there should be an order. The ADON stated it is important to follow the treatment as ordered by the physician. The DON stated the potential outcome is that the resident's left heel DTI will not improve or heal. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/27/2025 at 2:30 p.m. with the Director of Nursing (DON), the DON stated the wound treatment should be followed as prescribed by the physician. The DON stated licensed staff are required to clarify wound orders prior to applying the treatment for optimal wound healing. The DON stated when the treatment is not followed and not clarified there is a possible delay in wound healing and potential for decline. During a review of the facility’s policy and procedure (P&P) titled, “Physician Orders,” last reviewed 5/30/2025, the P&P indicated the purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders. The P&P indicated that when recording treatment orders to specify the treatment, frequency and duration of the treatment. The P&P indicated an example: “Apply 4x4” duoderm with border to stage 1 ulcer on coccyx; change every 3 days and as needed per wound care protocol. During a review of the facility’s P&P titled, “Pressure Ulcers/Skin Breakdown,” last reviewed 5/30/2025, the P&P indicated that “The nursing staff and practitioner will assess and document an individual’s significant risk factors for developing pressure ulcers… The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing, and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents. During a review of the facility’s P&P titled, “Wound Care,” last reviewed 5/30/2025, the P&P indicated the purpose of this procedure is to provide guidelines for the care of wounds to promote healing. The P&P indicated during preparation the physician’s order is verified for this procedure. The P&P indicated and review the resident’s care plan to assessment for any special needs of the resident including as needed orders for pain medication prior to wound care and then to assemble the equipment and supplies as needed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment was free of accident hazards for four of four sampled residents (Residents 93, 199, 33, and 19) reviewed for accidents by failing to ensure: 1.Residents 93, 199, and 33's floor/fall mats (a cushioned floor pad designed to help prevent injury should a person fall) did not have equipment or furniture on top of them. 2.Conduct an interdisciplinary team (IDT-a collaborative group of healthcare professionals and staff, including the resident and their family, who work together to develop and implement a person-centered care plan) root cause analysis after Resident 19 fell on 6/25/2025. The deficient practices increased the risk of accidents such as falls with injuries on residents. Findings: 1.During a review of Resident 93’s admission Record (AR), the AR indicated the facility admitted the resident on 6/10/2025, and readmitted the resident on 8/8/2025, with diagnoses including history of falling, muscle weakness, and difficulty in walking. During a review of Resident 93’s History and Physical (H&P), dated 8/9/2025, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 93’s Minimum Data Set (MDS, a resident assessment tool), dated 8/15/2025, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (means a person has a very serious difficulty with thinking, remembering, learning, concentrating, and making decisions). The MDS indicated the resident was dependent to needing partial assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident had a fall without injury while a resident at the facility. During a review of Resident 93’s Order Summary Report (OSR), dated 8/8/2025, the OSR indicated an order for bilateral fall mats. During a review of Resident 93’s Fall Risk Observation/Assessment (FRO), dated 8/12/2025, the FRO indicated the resident was at high risk for falls. During a review of Resident 93’s Care Plan (CP) Report titled “Resident has a neurological disorder is at risk for complications,” last revised on 6/24/2025, the CP indicated an intervention to maintain a safe, hazard free environment. During a concurrent observation and interview on 8/25/2025, at 10:04 a.m., with the Assistant Director of Nursing (ADON), inside Resident 93’s room, observed bilateral floor mats were in place on both sides of Resident 93`s bed. There were a side table and a trash can on top of the left floor mat. The ADON stated there were a trash can and a side table on top of the resident’s left floor mat. The ADON stated there should be no furniture or equipment on top of the floor mats because it defeats the purpose of the floor mat to provide a safe landing space for the resident to fall. The ADON stated when a resident rolls out of the bed, they will hit the hard surfaces of the objects that was on top of the floor mat causing injuries to residents such as bruises, bumps, or even fractures (a break in bone). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/28/2025 at 3:20 p.m., with the Director of Nursing (DON), the DON stated there should be no furniture or equipment on top of the floor mat of Resident 93 to prevent injury to the resident. The DON stated he had read the manufacturer’s specification regarding the use of fall mat and it indicated not to place any heavy objects on top of the mat as it could damage the floor mat and form a permanent indentation on the fall mat reducing its ability to absorb the impact of the fall. During a review of the facility's recent policy and procedure (P&P) titled Safety and Supervision of Residents, last reviewed on 5/30/2025, the P&P indicated our facility strives to make the environment as free from accidents hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide priorities. Policy Interpretation and Implementation Facility-Oriented Approach to Safety 2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; quality assurance and performance improvement (QAPI) reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization. Resident Risks and Environmental Hazards 1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following: a. Bed Safety c. Falls. During a review of the facility's recent P&P titled Falls and Fall Risk, Managing, last reviewed on 5/30/2025, the P&P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Policy Interpretation and Implementation Fall Risk Factors 1. Environmental factors that contribute to the risk of falls include: a. wet floors; b. incorrect bed height or width; c. obstacles in the footpath. (continued on next page)

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	555456	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Antelope Valley Care Center	44567 North 15th St. West Lancaster, CA 93534

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility-provided Floor Mat (FM) 1, undated, indicated when moving equipment across the mat ensure that the wheels are not locked as dragging wheels may damage the mat. Avoid sharp materials from contacting the mat. Never leave heavy materials on the mat for an extended amount of time and they may cause a permanent indentation. 2. During a review of Resident 199’s AR, the AR indicated the facility admitted the resident on 8/23/2025, with diagnoses including muscle weakness, difficulty in walking, and hypotension (low blood pressure). During a review of Resident 199’s H&P, dated 8/16/2025, the H&P indicated the resident was alert and interactive with normal affect (means that a person's outward expression of emotions is typical and healthy). During a review of Resident 199’s OSR, dated 8/23/2025, the OSR indicated an order for bilateral fall mats. During a review of Resident 199’s FRO, dated 8/23/2025, the FRO indicated the resident was at high risk for falls. During a review of Resident 199’s CP Report regarding the resident being at risk for falls with or without injury, last revised on 8/24/2025, the CP indicated a goal of minimizing risk for falls to extent possible. During a concurrent observation and interview on 8/25/2025, at 10:19 a.m., with Treatment Nurse (TN) 2, inside Resident 199’s room, observed Resident 199 had a floor mat at the left side of the bed with a side table on top of it. TN 2 stated there was a side table on top of Resident 199’s floor mat. TN 2 stated there should be no equipment or furniture on top of the fall mat to prevent injury to the resident. TN 2 stated when the resident rolls down from the bed, they will hit the hard surfaces of the object that is on top of the floor mat that can cause injury to the resident. TN 2 stated the resident can sustain bruising, bumps and even fractures from them. During an interview on 8/27/2025, at 1:10 p.m., with the ADON, the ADON stated there should be no equipment or furniture on top of Resident 199’s floor mat to prevent injury to the resident. The ADON stated placing heavy objects on top of the floor mat can cause permanent dent on the mat reducing the mat’s ability to lessen the impact of the fall. During an interview on 8/28/2025, at 3:20 p.m., with the DON, the DON stated the floor mats should be in good condition to prevent injury to the resident. The DON stated there should be no furniture or equipment on top of the floor mat of Resident 199 to prevent injury to the resident. The DON stated he had read the manufacturer’s specification regarding the use of fall mat and it indicated not to place heavy objects on top of the mat as it could damage the floor mat and form a permanent indentation to the fall mat reducing its ability to absorb the impact of the fall. During a review of the facility's recent P&P titled Safety and Supervision of Residents, last reviewed on 5/30/2025, the P&P indicated our facility strives to make the environment as free from accidents hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Interpretation and Implementation Facility-Oriented Approach to Safety 2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization. Resident Risks and Environmental Hazards 1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following: a. Bed Safety c. Falls. During a review of the facility's recent P&P titled Falls and Fall Risk, Managing, last reviewed on 5/30/2025, the P&P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Policy Interpretation and Implementation Fall Risk Factors 1. Environmental factors that contribute to the risk of falls include: a. wet floors; c. incorrect bed height or width; d. obstacles in the footpath. During a review of the facility-provided FM 1, undated, indicated when moving equipment across the mat ensure that the wheels are not locked as dragging wheels may damage the mat. Avoid sharp materials from contacting the mat. Never leave heavy materials on the mat for an extended amount of time and they may cause a permanent indentation. 3. During a review of Resident 33’s AR, the AR indicated the facility admitted the resident on 7/18/2025, with diagnoses including muscle weakness, difficulty in walking, and cerebral infarction (the medical term for an ischemic stroke, where a blockage in a blood vessel cuts off the oxygen supply to a part of the brain, causing brain cells in that area to die). During a review of Resident 33’s H&P, dated 7/19/2025, the H&P indicated the resident had the capacity to make decisions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 33’s MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (is a medical and psychological term that means a person's mental abilities are normal and functioning well). The MDS indicated the resident was dependent to needing setup assistance on mobility and ADLs. During a review of Resident 33’s FRO, dated 7/18/2025, the FRO indicated the resident was at high-risk for falls. During a review of Resident 33’s OSR, dated 7/21/2025, the OSR indicated an order for bilateral floor mats during every shift. During a concurrent observation and interview on 8/25/2025, at 11:46 a.m., with Licensed Vocational Nurse (LVN) 6, inside Resident 33’s room, observed bilateral floor mats were in place on both sides of Resident 33`s bed. A side table was placed on top of the floor mat on the right side. LVN 6 stated there should be no objects or equipment on top of the floor mat to prevent injury to residents. LVN 6 stated that if the resident falls on the floor mat, the resident will hit the hard surfaces on top of the floor mat instead of the soft surface of the mat that can cause injuries to residents. During an interview on 8/27/2025, at 1:10 p.m., with the ADON, the ADON stated there should be no equipment or furniture on top of Resident 33’s floor mat to prevent injury to the resident. The ADON stated placing heavy objects on top of the floor mat can cause permanent dent on the mat reducing the mat’s ability to lessen the impact of the fall. During an interview on 8/28/2025, at 3:20 p.m., with the DON, the DON stated the floor mats should be in good condition to prevent injury to the resident. The DON stated there should be no furniture or equipment on top of the floor mat of Resident 33 to prevent injury to the resident. The DON stated he had read the manufacturer’s specification regarding the use of fall mat and it indicated not to place heavy objects on top of the mat as it could damage the floor mat and form a permanent indentation to the fall mat reducing its ability to absorb the impact of the fall. During a review of the facility's recent P&P titled Safety and Supervision of Residents, last reviewed on 5/30/2025, the P&P indicated our facility strives to make the environment as free from accidents hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy Interpretation and Implementation Facility-Oriented Approach to Safety 2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization. Resident Risks and Environmental Hazards (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following: a. Bed Safety c. Falls. During a review of the facility's recent P&P titled Falls and Fall Risk, Managing, last reviewed on 5/30/2025, the P&P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Policy Interpretation and Implementation Fall Risk Factors 1. Environmental factors that contribute to the risk of falls include: a. wet floors; c. incorrect bed height or width; d. obstacles in the footpath. During a review of the facility-provided FM 1, undated, indicated when moving equipment across the mat ensure that the wheels are not locked as dragging wheels may damage the mat. Avoid sharp materials from contacting the mat. Never leave heavy materials on the mat for an extended amount of time and they may cause a permanent indentation. 4. During a review of Resident 19’s admission Record, the admission Record indicated the facility admitted the resident on 10/14/2024, with diagnoses including but not limited to Alzheimer’s disease (a progressive brain disorder that causes memory loss, confusion, and cognitive decline), hypokalemia (a condition in which the potassium levels in the blood are abnormally low) and heart failure (a condition where the heart muscle cannot pump blood effectively enough to meet the body's needs). During a review of Resident 19’s Minimum Data Set (MDS, a resident assessment tool), dated 8/12/2025, the MDS indicated Resident 19 had the ability to make self-understood and understand others. The MDS indicated Resident 19’s cognition was severely impaired (significant decline in a resident’s mental abilities that profoundly impacts their daily life and independence) and family participated in the assessment and goal setting of healthcare management. During a review of Resident 19’s Fall Risk Observation Assessment (evaluate a person's likelihood of falling), it indicated: 5/19/2025, Resident 19 was at high risk for fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 19’s Change of Condition Evaluation (COC), dated 6/25/2025, the COC indicated the Certified Nursing Assistant (CNA) reported Resident 19’s unwitnessed fall. The COC indicated that the CNA found Resident 19 sitting on landing mat by the foot of the bed. During a concurrent interview and record review on 8/28/2025 at 2:03 p.m., with the Assistant Director of Nursing (ADON), the facility’s IDT Conference Notes were reviewed. The ADON stated that there were no IDT post fall notes for Resident 19 `s fall on 6/25/2025. The ADON stated IDT conference should have been done to review the fall accident. The review was important to identify potential hazards and evaluate the risks for Resident 19. During an interview on 8/28/2025, at 4 p.m., with the Quality Assurance Nurse (QAN) 3, QAN 3 stated fall accidents require an IDT discussion. QAN 3 stated daily reports of COC are reviewed to ensure IDT attention and to determine if further intervention is needed. QAN 3 stated that the QA team missed reviewing COC of Resident 19 on 6/25/2025. QAN 3 stated Resident 19’s COC report should have been discussed with the IDT. QAN 3 stated IDT could have discussed what happened and what could be done better for Resident 19’ safety. QAN 3 stated failing to have a post fall IDT conference could lead to further falls and possible injury. During an interview on 8/29/2025 at11:55 a.m., with the Director of Nursing (DON), the DON stated post fall IDT meeting was not conducted after Resident 19’s fall accident on 6/25/2025. The DON stated IDT analyzed COC information within 48-72 hours and completed it in a timely manner to ensure intervention was in place. The DON stated that the IDT does root cause analysis of fall accidents. The DON stated it was important for Resident 19’s quality of care and safety. The DON stated IDT conference should have been done for Resident 19. The DON stated the failure to conduct IDT review of fall can potentially result in another fall. During a review of the facility's recent P&P titled “Safety and Supervision of Residents,” last reviewed on 5/30/2025, the P&P indicated: Policy Statement Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy Interpretation and Implementation Individualized, Resident-Centered Approach to Safety 1.Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. 2.The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. During a review of the facility's recent P&P titled “Interdisciplinary Team,” last reviewed on 5/30/2025, the P&P indicated: Purpose (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Every resident will have an Interdisciplinary Team (IDT) collaboration based on the individually assessed needs. Residents unable to participate due to cognitive or other conditions, representative or responsible party, conservator, legal guardian, etc. will participate. Policy Interpretation and Implementation 1.The IDT will be based on a resident's assessed physical, behavioral health, and psychosocial needs. 3.The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person centered care plan for each resident. 5. IDT for residents is conducted through Care Conferences. As part of an IDT, a plan of care will be established to address risk areas and manage the overall health condition of residents. During a review of the facility's recent P&P titled “Falls and Fall Risk Managing,” last reviewed on 5/30/2025, the P&P indicated: Policy Statement Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Policy Interpretation and Implementation A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder (a loss of control over when urinating, causing urine to leak out accidentally) received services and assistance for two of three sampled residents (Residents 157 and 188) reviewed for bladder and bowel incontinence by failing to label the urinal bottle (a container used to collect urine and is made for either male or female anatomy) of the residents with the name and room number. The deficient practices had the potential to cause cross-contamination (the physical movement or transfer of harmful bacteria from one person, object or place to to another) and increase the risk of urinary tract infection (UTI, an infection of the urinary system, which includes the kidneys, ureters, bladder, and urethra) due to the switching of urinals. Findings: 1.During a review of Resident 157's admission Record (AR), the AR indicated the facility admitted the resident on 8/26/2024, and readmitted the resident on 5/22/2025, with diagnoses including enterocolitis (a general term for inflammation affecting both the small intestine and the colon) due to clostridium difficile (a germ, or bacterium, that causes diarrhea and other intestinal problems, especially in people taking antibiotics), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and hemiparesis (weakness on one side of the body). During a review of Resident 157's History and Physical (H&P), dated 10/5/2024, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 157's Minimum Data Set (MDS, a resident assessment tool), dated 8/11/2025, the MDS indicated the resident had the ability to make self-understood and understand others, and had impaired vision. The MDS indicated that the resident had intact cognition (means that a person's thinking abilities are normal and healthy) and required moderate to set up or clean-up assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 157's Care Plan (CP) Report titled Resident has individualized preferences to keep urinals on bedside table and not have the room cleaned until 2 p.m. or later, last revised on 7/30/2025, the CP indicated an intervention to manage environment to optimize comfort and monitor for safety and facility guidelines regarding personal preferences. During a concurrent observation and interview on 8/25/2025, at 9:39 a.m., with Treatment Nurse (TN) 1, inside Resident 157's room, observed Resident 157's urinal bottle not labeled with the name and room number of the resident. TN 1 stated the staff should label each urinal bottle with the resident`s name and room number to prevent switching between residents which can lead to UTI. During an interview on 8/27/2025, at 2:12 p.m., with the Assistant Director of Nursing (ADON), the ADON stated the staff should have placed the room number or the last name of the resident on the urinal bottle to prevent exchanging of urinals among residents that can cause cross-contamination and UTI for the residents. During an interview on 8/28/2025, at 3:20 p.m., with the Director of Nursing (DON), the DON stated the urinal of Resident 157 should have been labeled with the resident`s room number, initials or the last name to prevent accidental switching of urinals among residents. The DON stated the staff`s failure to label the urinal had the potential to contribute to the development of UTI among residents. During a review of the facility's recent policy and procedure (P&P) titled Cleaning and Disinfection of Resident-Care Items and Equipment, last reviewed on 5/30/2025, the P&P indicated resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current Centers for Disease Control and Prevention (CDC) recommendations for disinfection and the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard. Policy Interpretation and Implementation b. Semi-critical items consist of items that may come in contact with mucous membranes or non-intact skin (e.g. respiratory therapy equipment). Such devices should be free from all microorganisms, although small numbers of bacterial spores are permissible. (Note: Some items that may come in contact with non-intact skin for a brief period of time [e.g., hydrotherapy tanks (a specially designed tank, tub, or pool that uses heated or cooled water, sometimes with jets or vibration, to provide therapeutic benefits for medical conditions, pain, and rehabilitation by relaxing muscles, increasing circulation, and reducing inflammation), bed side rails (a metal or plastic bar attached to the side of a bed that serves as a barrier to prevent falls or as an assist for mobility)] are usually considered non-critical surfaces and are disinfected with intermediate-level disinfectants.) 5. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). b. Single resident-use items are labeled with the residents' name and room. During a review of the facility's recent P&P titled Infection Prevention and Control Program, last

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents maintained acceptable parameters of nutritional status for one of four sampled residents (Resident 13) reviewed during the Nutrition care area by failing to: 1.Ensure a change of condition (COC - a significant shift or worsening in someone's health or well-being, often requiring attention or intervention) regarding significant unplanned weight loss (a loss of five [5] percent [%] of body weight in 30 days, 7.5% in 90 days, or 10% in 180 days) was reported to the physician, resident representative, and Registered Dietician (RD) per facility policy and procedure (P&P) on 8/1/2025. 2. Ensure the physician was notified of, and followed up on, Registered Dietician (RD) 1's recommendation for an appetite stimulant (medications that increase appetite) on 8/7/2025. 3.Ensure the interdisciplinary team met per the facility P&P following the resident's significant weight loss. 4. Develop and implement a care plan for weight loss. These deficient practices had the potential to result in further weight loss and malnutrition (a serious condition that happens when your diet does not contain the right amount of nutrients) in Resident 13. Cross-reference F580 Findings: During a review of Resident 13's admission Record (AR), the AR indicated the facility originally admitted the resident on 10/27/2024, and most recently re-admitted the resident on 3/8/2025, with diagnoses that included End Stage Renal Disease (ESRD -irreversible kidney failure), dependence on hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), dysphagia (difficulty eating) following cerebral infarction (CVA-stroke, loss of blood flow to a part of the brain), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 13's Minimum Data Set (MDS - resident assessment tool) dated 7/14/2025, the MDS indicated the resident sometimes was able to understand others and sometimes was able to make themself understood. The MDS further indicated the resident required setup assistance with eating and required substantial / maximal assistance with bathing, toileting, dressing, oral and personal hygiene, and transfers from the bed/chair. During a review of Resident 13's Care Plan (CP) titled, Malnutrition: (Resident 13) is at risk for malnutrition due to.DM, ESRD., initiated 10/27/2024, the CP indicated a goal that the resident would not have significant weight loss to the extent possible. The CP indicated interventions that included monitor for acute changes in condition which may contribute to risk for malnutrition and notify the physician if observed, observe for signs and symptoms of weight loss, monthly weights if stable, and notify the physician of significant weight loss. During a review of Resident 13's Weight and Vitals record, dated 8/27/2025, the Weights and Vitals record indicated on 07/01/2025, the resident's Post HD Dry Weight (a patient's weight when all of the excess fluid is removed at the end of HD treatment) was 115 lbs. and on 08/01/2025, the resident's Post HD Dry Weight was 105 lbs. which was an 8.7 % loss from the prior month. During an observation on 8/26/2025 at 11:26 a.m., observed Resident 13 sitting on a gurney at Nursing Station 1. Observed Resident 13 stated Resident 13 needed food. Observed the Assistant Director of Nursing (ADON) stated to Resident 13 that the nurse would provide a sack lunch for the resident to take to the resident's HD appointment. a.During a concurrent interview and record review on 8/27/2025 at 11:15 a.m. with Minimum Data Set Nurse (MDSN) 2, MDSN 2 reviewed Resident 13's Weights and Vitals record, Weight Variance assessment dated [DATE], Change of Condition Evaluation forms for 8/2025, and physician orders. MDSN 2 stated the facility process is the Restorative Nurse Aide (RNA) weighs the residents monthly and reports to the licensed nurse (LN). MDSN 2 stated that significant weight loss of greater than 5% is a COC and requires immediate notification to the physician and resident representative (RP). MDSN 2 stated Resident 13 had significant weight loss on 8/1/2025. MDSN 2 stated there was no documented evidence that a COC was completed with notification to the physician and RP. MDSN 2 stated the importance of reporting significant weight loss is to make sure the reason for the weight loss is addressed, to begin treatment, and prevent malnutrition in the resident. MDSN 2 stated the Quality Assurance Nurse (QAN) nurse reports any significant weight loss COC's. During a concurrent interview and record review on 8/27/2025 at 11:38 a.m. with QAN 2, QAN 2 reviewed Resident 13's Weights and Vitals record, Weight Variance assessment dated [DATE], and Change of Condition Evaluation forms for 8/2025. QAN 2 stated QAN 2 is responsible for entering resident weights in the computer, determining if there is significant weight loss, and reporting significant weight loss COCs to the family and physician. QAN 2 stated it was important to notify the family and physician regarding a weight loss COC to ensure the family knows what is happening and the resident is

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Antelope Valley Care Center	44567 North 15th St. West Lancaster, CA 93534

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review the facility failed to ensure residents receiving enteral feeding (EF - also known as tube feeding, a method of supplying nutrients directly into the stomach) received appropriate care and services to prevent complications of EF for one (1) of two (2) sampled resident (Resident 18) reviewed for tube feeding by failing to ensure the EF was started timely as ordered by the physician. This deficient practice had the potential to result in altered nutritional status such as dehydration (a condition that occurs when the body loses more fluids than it takes in), malnutrition (lack of proper nutrition, caused by not having enough to eat or not eating enough of the right things), and complications associated with enteral feeding like gastrointestinal (GI) (relating to stomach and intestines) problems such as abdominal pain and diarrhea which may lead to weight loss. Findings: During a review of Resident 18's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility originally admitted the resident on 2/13/2025, and readmitted in the facility on 4/15/2025, with diagnoses including gastrostomy, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and generalized muscle weakness. During a review of Resident 18's History and Physical (H&P) dated 4/16/2025, the H&P indicated Resident 18 had the capacity to understand and make decisions. During a review of Resident 18's Minimum Data Set (MDS, a resident assessment tool), dated 6/30/2025, the MDS indicated Resident 181 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and was able to understand and make her needs known. The MDS further indicated Resident 18 received GT feeding and required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 18's care plan (CP) on risk for enteral nutritional complications initiated on 2/13/2025, and last revised on 7/17/2025, the CP indicated GT feeding as ordered as one of the interventions to maintain Resident 18's adequate nutritional and hydration status and prevent unplanned significant weight change. During a review of Resident 18's Order Summary Report dated 8/29/2025, the Order Summary Report indicated a physician's order for Tube Feeding Formula (TFF) 1 at 60 milliliters (ml - a unit of measurement) per hour for 20 hours to provide 1200 ml per 1800 kilocalories (kcal - a unit measurement) feeding pump to run from 1 p.m. to 9 a.m. or until the dose limit was met. During an observation on 8/25/2025 at 1:22 p.m. inside Resident 18's room, observed Resident 18 lying in bed awake. Resident 10 was mumbling. Observed a TF machine attached to a pole but there was no TFF hanging. During a concurrent observation and interview on 8/25/2025 at 2:29 p.m. inside Resident 18's room with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she was supposed to hang Resident 18's GT feeding at 1 p.m. However, she (LVN 1) forgot. LVN 1 stated she (LVN 1) should have started Resident 18's TF timely as ordered by the physician. During a follow up interview and record review on 8/27/2025 at 6:53 a.m. reviewed Resident 18's physician's order with LVN 1. LVN 1 stated Resident 18 had a physician's order for TFF 1 at 60 ml per hour for 20 hours to provide 1200 ml per 1800 kcal and to run the feeding pump from 1 p.m. to 9 a.m. or until the does is met. LVN 1 stated the purpose of turning off the pump from 9 a.m. to 1 p.m. was to give time for providing ADL care to the residents such as shower, bed bath, changing of incontinence briefs, and range of motion exercises. LVN 1 stated TF orders for the residents were calculated to ensure the residents were getting the correct and proper amount of nutrition and calories each resident need and can be started one (1) hour before and after the prescribed time by the physician. LVN 1 stated she (LVN 1) should have started Resident 18's TF timely. LVN 1 stated Resident 18's TF was started one (1) and half hours late and a late administration of TF placed Resident 18 at risk for complications such as weight loss due to inadequate amount of nutrition received. During an interview on 8/29/2025 at 12:30 p.m. with the Director of Nursing (DON), the DON stated that all resident TFs are supposed to be hanging between 1 p.m. and 9 a.m. everyday to allow time for provision of ADL care such as showers, bed bath, and changing of incontinent briefs as well as provision of range of motion exercises to the residents. The DON stated the standard of practice in hanging TF was that the TF can be started one (1) hour before and after the prescribed time by the physician to ensure the resident is receiving the correct amount of nutrition required to maintain their nutritional status. The DON stated LVN 1 started Resident 101's TF late. The DON stated LVN 1 should have started Resident 18's TF timely as ordered by the physician to ensure Resident 18 received the correct amount of nutrition the resident needed which may lead to weight loss. During a review of the facility's policy and procedure (P&P) titled, Enteral Feedings - Safety

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure parenteral fluids (liquids that are administered intravenously or by injection to bypass the digestive system) were administered consistent with professional standards of practice for one (1) of one (1) sampled resident (Resident 177) reviewed during a random observation by failing to ensure Registered Nurse (RN) 1 labeled the intravenous (IV - thru the vein) antibiotic (medication used to treat infection) bag with the date and time it was administered. This deficient practice placed Resident 177 at risk for developing complications such as inflammation of the vein and infection. Findings: During a review of Resident 177's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility originally admitted the resident on 4/14/2022 and readmitted in the facility on 7/21/2025, with diagnoses including chronic osteomyelitis (a bone infection not completely cured after treatment which can linger for months or years), incomplete paraplegia (paralysis of both sides of the body), and type two (2) diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 177's History and Physical (H&P) dated 7/22/2025, the H&P indicated Resident 177 was alert and oriented to time, place, person, and event. The H&P did not indicate Resident 177`s capacity to understand and make decisions. During a review of Resident 177's Minimum Data Set (MDS, a resident assessment tool), dated 7/28/2025, the MDS indicated Resident 177 had an intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand and make his needs known. The MDS further indicated Resident 177 received IV antibiotic medications and required set-up or clean up assistance with eating; supervision or touching assistance with upper body dressing; partial/moderate assistance with oral hygiene, bathing self, and rolling in bed left and right; substantial/maximal assistance to total assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 177's care plan (CP) on risk for complications and side effects of antibiotic use initiated on 7/22/2025 and last revised on 8/18/2025, the CP indicated an intervention to administer the medication as ordered for Resident 177 to exhibit the therapeutic effect of antibiotic use as evidenced by resolution of infection. During a review of Resident 177's Order Summary Report dated 8/29/2025, the Order Summary Report indicated a physician's order dated 7/21/2025 for IV Antibiotic (IV ATB) 1 IV solution use three (3) grams (gm - a unit of measurement) intravenously every six (6) hours for infected decubitus ulcer (also known as pressure ulcer/injury - localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) for six (6) weeks. During a concurrent observation and interview on 8/25/2025 at 12:50 p.m. inside Resident 177's room, observed RN 1 disconnecting Resident 177' IV ATB 1 bag from the resident's peripherally inserted central catheter (PICC - a thin, flexible tube inserted into a smaller vein in the arm used for long term IV treatment like antibiotics) on the right upper arm. Upon closer observation of the IV ATB 1 bag and interview with RN 1, RN 1 stated the date and time she (RN 1) administered IV ATB 1 was on the sticker she (RN 1) attached on the IV tubing. RN 1 stated she (RN 1) did not indicate the date and time on the IV ATB 1 bag. RN 1 stated the standard of practice is that the IV bag should be labeled with the date and time the medication was administered. RN 1 stated the IV ATB 1 should have been labeled with the date and time it was hung, not just the IV tubing. This ensures that the staff are aware of when the last dose of antibiotic was administered and helps prevent the resident from missing a dose. During an interview on 8/29/2025 at 12:30 p.m. with the Director of Nursing (DON), the DON stated the standards of practice during administration of IV antibiotics or IV fluids is that the licensed nurses are required to indicate the date and time the bag was hung not just on the IV tubing. The DON stated IV tubing, IV fluid bags ,and IV antibiotic bags have different times and dates to hang so it was important to indicate the start date and time in the bag to prevent confusion and ensure the staff are all aware that the bag or tubing was changed which may lead to complications such as infection if not changed at the correct time. The DON stated he was made aware by RN 1 that she did indicate the start date and time on Resident 177`s IV ATB 1. The DON stated RN 1 should have indicated the start date and time on IV ATB 1 bag to prevent confusion and ensure the staff are all aware that the bag or tubing was changed which may lead to complications such as infection if not changed at the correct time. During a review of the facility's policy and procedure titled, Antibiotic Infusion Guideline, last reviewed on 5/30/2025, the P&P indicated: -Nursing Responsibilities: -When an antibiotic is initiated in a facility, the infusion nurse shall administer medications ordered by the resident's physician. -All medication

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 care provided to residents was consistent with professional standards of practice for two of two sampled residents (Residents 173 and 52) reviewed for respiratory care by failing to ensure: 1.Resident 173's suction canister (is a container used with a medical suction machine to collect and store fluids removed from a patient's body) was changed every seven (7) days and labeled with the date it was last changed. 2.Resident 173's suction tubing (a flexible tube, typically for medical or industrial use, that connects a vacuum source to a device or catheter to remove fluids, secretions, or debris from a specific area) dated 3/18/2025 was discarded and changed every (7) days. 3.Resident 52's oxygen tubing had a label including the date and time of when it was last changed. The deficient practices had the potential for the residents to develop complications such as shortness of breath and desaturation (low levels of oxygen in the blood) and respiratory infections. Findings: 1.During a review of Resident 173’s admission Record (AR), the AR indicated the facility admitted the resident on 2/26/2023, with diagnoses including pericardial effusion (a condition where excessive fluid accumulates in the pericardium, the sac-like membrane that surrounds the heart), personal history of COVID-19 ([coronavirus disease 2019] is a disease caused by the SARS-CoV-2 virus), and dysphagia (difficulty swallowing). During a review of Resident 173’s Minimum Data Set (MDS, a resident assessment tool), dated 6/4/2025, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had moderately impaired vision. The MDS indicated the resident had severely impaired cognition (means experiencing noticeable difficulties with memory, thinking, and other cognitive functions, which are more severe than in mild impairment but do not significantly interfere with daily life) and was totally dependent on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 173’s Order Summary Report (OSR), dated 9/14/2024, the OSR indicated an order to suction the resident as needed for throat congestion. During a review of Resident 173’s Care Plan (CP) Report titled “Resident is at risk for infection related to exposure to group A strep (is a common type of bacteria that often lives harmlessly on a person's skin or in their nose and throat),” last revised on 3/31/2025, the CP indicated an intervention to educate on infection control prevention to the extent possible and infection control prevention practices (i.e., hand hygiene). During a concurrent observation and interview on 8/25/2025 at 10:28 a.m., with the Director of Staff Development (DSD), inside Resident 173’s room, observed Resident 173’s suction canister without the date it was last changed. Resident 173`s suction tubing was dated 3/18/2025. The DSD stated the suction canister was not labeled with the date it was last changed, and the suction tubing was dated 3/18/2025. The DSD stated she (DSD) does not know when to change the suction canister and the oxygen tubing. DSD stated she (DSD) will ask and will get back to the surveyor once she (DSD) finds out the answer. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 8/25/2025 at 10:35 a.m., with the Assistant Director of Nursing (ADON), inside Resident 173’s room, observed Resident 173’s suction canister not labeled with the date it was last changed, and the suction tubing was dated 3/18/2025. The ADON stated they label the suction canister with the date it was last changed, and the suction tubing was dated 3/18/2025 and should have been discarded and replaced. The DSD and the ADON present at Resident 173`s bed side both stated that respiratory supplies and tubing should be changed every seven (7) days on Fridays. The ADON and the DSD stated the suction canister, and the suction tubing should be dated to prevent using respiratory supplies for more than allowable time because bacteria and viruses can grow in them and can get the residents sick when used. During an interview on 8/28/2025 at 3:20 p.m., with the Director of Nursing (DON), the DON stated of Resident 173`s suction canister, and suction tubing should have been dated with the date it was last changed to prevent respiratory infection to resident. The DON stated the respiratory supplies are good for seven days only and should be replaced. The DON stated using respiratory supplies for a longer period of time can result to bacteria and viruses to grow on the tubing and canisters that can get the resident develop respiratory infection. During a review of the facility's recent policy and procedure (P&P) titled Changing of Suction Set-ups, last reviewed on 5/30/2025, the P&P indicated to minimize the risk for infection. Responsible Discipline: Registered Nurse (RN)/LVN/Certified Nursing Assistant (CNA) Policy: -All disposable suction canisters will be changed weekly or as needed when 3/4 full -All suction tubing will be changed weekly and as needed when soiled -All Yankauer (is a rigid suction tool, typically a plastic tube with a rounded tip, used to clear fluids from the mouth and throat) oral suction devices will be changed weekly and prn (as needed) 2. During a review of Resident 52’s admission Record, the admission Record indicated the facility admitted the resident on 5/7/2019, with diagnoses including but not limited to chronic respiratory failure (a condition where the lungs are unable to adequately exchange oxygen and carbon dioxide between the blood and the air.), dependence on supplemental oxygen and heart failure (a condition where the heart muscle cannot pump blood effectively enough to meet the body's needs). During a review of Resident 52’s History and Physical (H&P), dated 1/22/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 52’s MDS dated [DATE], the MDS indicated Resident 52 had the ability to make self-understood and understand others. The MDS indicated Resident 52’s cognition was intact (mental processes that enable people to think, understand, make decisions, and complete tasks) and participated in the assessment and goal setting of healthcare management. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 52’s care plan (CP), dated 6/4/2025, the CP indicated the resident uses oxygen due to chronic obstructive pulmonary disease (COPD- a condition of the lungs that cause long-term breathing difficulties). The CP goal was for the resident to remain free from shortness of breath and maintain oxygen saturation (a measurement of how much oxygen your blood is carrying compared to its maximum capacity-for healthy adults, normal oxygen saturation is between 95% and 100%) above 92 % daily. The intervention included administer oxygen as ordered. During an observation on 8/25/2025 at 11:15 a.m., inside Resident 52 rooms, Resident 52 was observed sleeping on her bed receiving oxygen at two (2) liters per minute via nasal canula (NC- a small plastic tube which fits into the person’s nostrils for providing supplemental oxygen). Resident 52’s oxygen tubing did not have a label including the date and time of when it was last changed. During a concurrent observation and interview on 8/28/2025 at 11:15 a.m. with the Director of Rehabilitation (DOR), inside Resident 52’s room, DOR stated that Resident 52’s oxygen tubing did not have a label with the date and time of when it was last changed. DOR went to the nurse’s station for assistance to label the oxygen tubing. DOR stated that the nurse assigned to the resident should have made rounds to ensure the tubing is labeled. DOR stated not changing the tubing can potentially cause respiratory infection to Resident 52. During an interview on 8/28/2025 at 1:34 p.m., with the Assistant Director of Nursing (ADON), the ADON stated licensed staff are required to conduct daily checks on oxygen tubing of residents on oxygen therapy. ADON stated that the licensed facility staff are required to change the humidifier and oxygen tubing once per week. ADON stated the potential outcome of not changing and labeling the oxygen tubing and humidifier is the increased risk of infection for the residents. During an interview on 8/29/2025 at11:55 a.m., with the Director of Nursing (DON), the DON stated that the morning shift licensed nurses are responsible for changing the tubing and humidifier weekly and labeling with the date it was changed. The DON stated licensed staff are also responsible for checking if oxygen labels are current. The DON stated that the oxygen tubing should have been labeled with a date it was last changed. The DON stated that the staff would have a reference date for weekly change if it was labeled with a date. The DON stated Resident 52 can potentially have increased risk of infection and respiratory complications. During a review of the facility’s policy and procedure (P&P) titled “Respiratory Therapy-Prevention of Infection,” last reviewed on 5//30/2025, the P&P indicated: Respiratory Therapy-Prevention of Infection Purpose The purpose of this procedure is to guide the prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. Steps in the Procedure Infection Control Considerations Related to Oxygen Administration (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Change the oxygen cannula and tubing every seven (7) days, or as needed.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pain management consistent with professional standards of practice and the residents' goals and preferences for two of five sampled residents (Resident 134 and 51) reviewed under the Pain care area and one resident present during the Resident Council task (Resident 89) by failing to: 1. Ensure the licensed nurse (LN) administered oxycodone (an opioid [also called a narcotic - powerful pain-reducing medication) per the facility policy and procedure (P&P) and the physician's order when the LN failed to assess and document the resident's pain level based on the numeric pain rating scale (a standard pain scale with zero being no pain and ten [10] as the worst pain one can imagine), assess and document the location of pain, and implement and document non-pharmacological interventions (any treatment or therapy that does not involve medication) for pain management for Resident 134. 2. Ensure as needed (PRN) oxycodone 10 milligrams (mg - a unit of measurement) was administered per the physician's orders for Resident 89. 3.Clarify the physician's order prior to administering PRN oxycodone five (5) mg when the moderate pain numeric scale indicated for pain seven (7) to 10 for Resident 89. 4. Assess Resident 51's new onset of bilateral (both) shoulder pain. 5. Administer lidocaine patch (a topical adhesive patch that delivers pain relief to a specific area of the body to relieve pain) on 8/25/2025 to treat Resident 51's bilateral shoulder pain. These deficient practices had the potential to result in the residents' underlying causes of pain going unchecked; side effects from unnecessary administration of narcotics including constipation; and mismanagement of resident pain resulting in limited resident participation in activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily), general activities, and mobility. Findings: a.During a review of Resident 134’s admission Record (AR), the AR indicated the facility originally admitted the resident on 11/12/2024 and most recently re-admitted the resident on 6/28/2025 with diagnoses that included cirrhosis of liver (permanent scarring that damages the organ that removes toxins from the body's blood supply), ankylosing spondylitis (a chronic inflammatory disease that primarily affects the spine) of the lumbar region (lower back), diverticulitis (a condition where small pouches in the wall of the colon become inflamed or infected), generalized abdominal pain, osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 134’s Minimum Data Set (MDS – resident assessment tool), dated 7/5/2025, the MDS indicated the resident was able to understand others and was able to make himself understood and required partial / moderate assistance with bathing, dressing, personal hygiene, and mobility. The MDS further indicated the resident had pain occasionally with a pain intensity of eight (8) on the numeric scale. The MDS indicated the resident was taking opioids. During a review of Resident 134’s Order Summary Report, the Order Summary Report indicated the following orders: - Oxycodone hydrochloride (Hcl) oral tablet 10 mg, give one (1) tablet by mouth every four hours as needed for pain management for moderate to severe pain (4 to 10/10 on the pain scale). Offer non-pharmacological interventions using the following codes: 0-not applicable, 1=HEAT/COLD COMPRESS, 2=POSITIONING, 3=MASSAGE, 4=RELAXATION TECHNIQUES, 5=MUSIC/TELEVISION, 6=REFER TO PROGRESS NOTES. Plus (+) indicates effective, negative (-) indicates ineffective, dated 7/8/2025. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Acetaminophen tablet 325 mg, give two (2) tablets by mouth every four hours as needed for mild pain (1 to 3/10 on the pain scale), dated 6/28/2025. During a review of Resident 134’s Care Plan (CP) titled, “Pain, (Resident 134) is at risk for acute and chronic pain or discomfort due to…cirrhosis, generalized abdominal pain,…,” initiated 6/28/2025, the CP indicated goals that pain will be relieved to a tolerable level and the resident will express pain relief after alternative comfort measures and / or administration of medication as needed. The CP indicated an intervention to assess pain as indicated and administer medication as ordered. During a review of Resident 134’s CP titled, “Pain, (Resident 134) is experiencing chronic pain…,” initiated 6/28/2025, the CP indicated to offer nonpharmacological interventions to relieve discomfort or pain. During a review of Resident 134’s CP titled, “Bowel, (Resident 134) is at risk for constipation due to…narcotic use…,” initiated 6/28/2025, the CP indicated to administer medications as ordered. During a concurrent observation and interview on 8/25/2025 at 10:40 a.m. with Resident 134, Resident 134 sat in a wheelchair at bedside and stated Resident 134 had pain in the abdominal area and the pain medication the facility provides does not work. During a concurrent interview and record review on 8/27/2025 at 8:22 a.m. with Minimum Data Set Nurse (MDSN) 2, Resident 134’s physician orders, Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), for 8/2025, and Progress Notes, for 8/2025, were reviewed. MDSN 2 stated the facility process for administering PRN pain medication is the LN will first assess the resident for the location of pain. MDSN 2 stated it is important to report any new or unusual pain to the physician. MDSN 2 stated the LN first offers non-pharmacologic interventions because overuse of narcotics may lead to dependence and pain medication may not be effective over time as a resident builds up a tolerance (more medication may be needed to achieve the same level of pain relief). MDSN 2 stated when non-pharmacologic interventions do not work, then the LN administers pain medication based on the numeric pain scale. MDSN 2 stated pain is subjective, and it is important to ask the pain level to determine the type of pain medication to offer a resident. MDSN 2 stated the LN documents the treatment provided including the location of pain, the number of pain on the pain scale reported, and the non-pharmacologic methods attempted. MDSN 2 stated if the LN does not document, then it was not done. MDSN 2 reviewed Resident 134’s MAR and progress notes and noted there was no documented evidence of the location of pain, a pain level, and/or non-pharmacological interventions on the following dates and times: -On 8/1/2025 at 8:57 a.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/2/2025 at 10:34 a.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/2/2025 at 4:01 p.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555456	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Antelope Valley Care Center	44567 North 15th St. West Lancaster, CA 93534

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 8/2/2025 at 8:01 p.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/3/2025 at 4:20 a.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/3/2025 at 9:59.m., no pain level documented. -On 8/4/2025 at 5:48 p.m., no pain level documented. -On 8/4/2025 at 10:02 p.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/5/2025 at 7:42 a.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/6/2025 at 9:28 a.m. - no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/7/2025 at 9:40 a.m. no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/7/2025 at 2:16 p.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/7/2025 at 7 p.m., no pain level documented. -On 8/8/2025 at 9:57 a.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/8/2025 at 2:14 p.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/8/2025 at 11:15 p.m.- no pain level or non-pharmacological interventions documented. -On 8/8/2025 at 6:40 p.m.- no pain level documented. -On 8/8/2025 at 11:15 p.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/9/2025 at 4 a.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/9/2025 at 9:27 a.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/9/2025 at 6:08 p.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 8/10/2025 at 4:41 a.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/10/2025 at 9 a.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/10/2025 at 10:35 p.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/11/2025 at 10:18 a.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/11/2025 at 4:41 p.m.- no non-pharmacological interventions documented. -On 8/11/2025 at 9:06 p.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/12/2025 at 10:05 a.m.- no location of pain, no pain level documented. -On 8/12/2025 at 6:10 p.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/13/2025 at 2:31 a.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/13/2025 at 8:03 p.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/14/2025 at 9:08 a.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/14/2025 at 1:31 p.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/15/2025 at 5:11 a.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/15/2025 at 9:28 p.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/16/2025 at 4:45 a.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/16/2025 at 7:14 p.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/17/2025 at 3:06 a.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 8/17/2025 at 9:23 a.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/19/2025 at 3:56 a.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/19/2025 at 8:27 a.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/20/2025 at 10:08 p.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/21/2025 at 4:39 a.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/21/2025 at 10:13 a.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/21/2025 at 5:30 p.m.- no pain level documented. -On 8/22/2025 at 9:05 a.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/22/2025 at 5:35 p a.m.- no pain level documented. -On 8/23/2025 at 4:25 a.m.- no non-pharmacological interventions documented. -On 8/23/2025 at 9:56 a.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/23/2025 at 6:17 p.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/24/2025 at 9:10 a.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/24/2025 at 3:01 p.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/25/2025 at 9:09 a.m.- no location of pain, no pain level, and non-pharmacological interventions were documented. -On 8/25/2025 at 6 p.m.- no pain level documented. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDSN 2 stated when there was no documented evidence of the location of Resident 134’s pain location, there was the potential to result in a delay of treatment for a resident’s change of condition. MDSN 2 stated when there was no documented evidence of the non-pharmacologic interventions provided, there was the potential that Resident 134 would receive oxycodone unnecessarily resulting in side effects. MDSN 2 stated when there was no documented evidence of the numeric pain scale there was the potential that Resident 134 did not receive the appropriate pain medication. MDSN 2 stated there was the potential that Resident 134’s pain was mismanaged resulting in a delay of care and services to the resident. During an interview on 8/27/2025 at 2:09 p.m. with the Director of Nursing (DON), the DON stated the DON was made aware that there was an issue regarding Resident 134’s PRN oxycodone. The DON stated upon review the DON identified the order was not entered correctly resulting in the LNs not documenting the resident’s pain scale, location of pain, and non-pharmacologic interventions. The DON stated the LNs should have clarified the order or made a note to indicate the resident’s location of pain, number of pain, and non-pharmacologic interventions, but they did not. The DON stated if it was not documented then it was not done. The DON stated it was important to assess and document the resident’s pain level, location of pain, and non-pharmacological interventions attempted to ensure the resident was provided with the proper pain management interventions and to minimize the use of narcotics that potentially lead to dependence and side effects like constipation. The DON stated the facility P&P was not followed. During a review of the facility provided P&P titled, “Pain Assessment and Management,” last reviewed 5/30/2025, the P&P indicated the purposes of the procedure is to help the staff identify pain in the resident, develop interventions consistent with the resident's goals and needs, and address the underlying causes of pain. Pain management is a multidisciplinary process that includes the following: identifying signs and symptoms of and assessing existing pain; identifying the underlying causes, intensity, duration, type, and characteristics of pain; and developing and implementing approaches to pain management based on accepted standards of practice. Monitor the resident for the presence (or worsening) of pain and the need for further assessment when there is a change of condition. Assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level. Pain management interventions are consistent with the resident's goals for treatment and reflect the sources, type, and severity of pain. Non-pharmacological interventions may be appropriate alone or in conjunction with medications. Pharmacological interventions (i.e., analgesics) may be prescribed to manage pain, however they do not usually address the cause of pain and can have adverse effects on the resident (e. g., drowsiness, increased risk of falling, loss of appetite). The medication regimen is implemented as ordered. If the resident is prescribed opioid analgesics, monitor for the following side effects: a.Tolerance, meaning more medication may be needed to achieve the same level of pain relief; b.Physical dependence which causes symptoms of withdrawal when opioid medication is stopped, or a dose is held or missed; c.Increased sensitivity to pain; d.Constipation; (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e.Nausea, vomiting, and dry mouth; f.Sleepiness, dizziness, and/or confusion; g.Depression; and h.Itching and sweating. Document the following in the resident's medical record: -Staff assessment and observations of the resident's current pain; -The resident's reported pain using a standardized pain scale; -The characteristics of the resident's pain (location, intensity, description, pattern and frequency); -Pain management interventions; and -Outcomes after interventions. During a review of the facility provided P&P titled, “Administering Pain Medication,” last reviewed 5/30/2025, the P&P indicated the purpose of the procedure is to provide guidelines for assessing the resident's level of pain prior to administering analgesic pain medication. The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. Conduct a pain assessment as indicated. The choice of pain scale will consider the resident's age, cognitive status, language, and cultural factors. Examples include: Numeric Rating Scale (0-10) for residents able to self-report verbally. Document the results of the pain assessment in the resident's medical record. Evaluate and document the effectiveness of non-pharmacologic interventions. Administer pain medications as ordered. Notify the supervisor if the resident refuses the procedure. b. 1.During a review of Resident 89’s AR, the AR indicated the facility admitted the resident on 7/6/2025 with diagnoses that included fusion of spine (surgery to connect bones in the back), lumbosacral region (lower back), pain due to internal orthopedic prosthetic devices (medical devices that are used to replace damaged or dysfunctional body parts such as joints, bones, or ligaments), rheumatoid arthritis (a disease that effects multiple joints, resulting in pain, swelling, and stiffness), and difficulty walking. During a review of Resident 89’s MDS dated [DATE], the MDS indicated the resident was able to understand others and was able to make himself understood and required substantial / maximal assistance with bathing, dressing, personal hygiene, and mobility. The MDS further indicated that the resident had pain occasionally with a pain intensity of eight on the numeric scale. During a review of Resident 89’s Order Summary Report, the Order Summary Report indicated the following orders: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Oxycodone HCl oral tablet 10 mg, give one tablet by mouth every four hours as needed for severe pain (7 to 10). Offer non-pharmacological interventions, dated 7/15/2025. - Oxycodone HCl oral tablet 5 mg, give one tablet by mouth every four hours as needed for moderate pain (7 to 10). Offer non-pharmacological interventions, dated 7/15/2025. - Acetaminophen tablet 325 mg, give 2 tablets by mouth every four hours as needed for mild pain (1 to 3/10 on the pain scale), dated 7/6/2025. During a review of Resident 89’s CP titled, “Analgesic / Opioid: oxycodone – potential for side effects, complications … related to use of drug… mental mood changes, severe abdominal pain, difficulty urinating,… fainting, … nausea, vomiting, diarrhea… respiratory arrest (stop breathing), … and substance abuse,…,” initiated 6/28/2025, the CP indicated goals that the benefit of the drug would outweigh risk/adverse effects with interventions that included to administer medications as ordered. During a review of Resident 89’s CP titled, “Pain, (Resident 89) is experiencing acute pain…,” initiated 7/13/2025, the CP indicated to administer pain medication as ordered. During a concurrent observation and interview on 8/28/2025 at 8:37 a.m., Resident 89 lay in bed and stated Resident 89 had pain and was usually administered oxycodone 10 mg for a pain level of 8. Resident 89 stated Resident 89 did not remember ever taking oxycodone five mg for pain. During a concurrent interview and record review on 8/28/2025 at 8:47 a.m. with Licensed Vocational Nurse (LVN) 9, LVN 9 reviewed Resident 89’s physician orders and MAR. LVN 9 stated PRN pain medication is given based on the pain rating scale to ensure the proper dosage of medication is administered for resident’s pain. LVN 9 stated it was important to not overmedicate a resident because a higher dosage of medication has the potential for more side effects like drowsiness resulting in resident falls. During a concurrent interview and record review on 8/28/2025 at 9 a.m. with MDSN 1, MDSN 1 reviewed Resident 89’s physician orders and MAR for 8/2025. MDSN 1 stated the facility process for administering PRN pain medication is to assess the resident’s numeric pain scale rating, review the physician’s orders for the correct dosage of pain medication to administer per the pain scale, administer the medication, and document in the MAR. MDSN 1 stated the numeric pain scale is a standardized scale with moderate pain being 4-6 and severe pain being 7-10. MDSN 1 reviewed Resident 89’s MAR and noted oxycodone 10 mg for severe pain of 7-10 was not administered per the physician’s orders on the following dates and times: -On 8/9/2025 at 9:01 p.m., oxycodone 10 mg was administered for a pain level of 5. -On 8/23/2025 at 9:57 p.m., oxycodone 10 mg was administered for a pain level of 6. MDSN 1 stated when oxycodone 10 mg was administered for a pain level below 7, there was the potential that the resident would be overmedicated potentially resulting in side effects like dependence or constipation. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/29/2025 at 8:44 a.m. with the DON, the facility’s P&P titled, “Pain Assessment and Management,” last reviewed 5/30/2025, and P&P titled, “Administering Pain Medication,” last reviewed 5/30/2025, were reviewed. The DON stated the pain medication should be administered per the physician’s order. The DON stated there is a standard pain scale that indicates severe pain is 7-10 and moderate pain is 4-6. The DON stated the goal is to administer the lowest effective dosage to minimize the potential side effects of narcotics like dependency and constipation. The DON stated that when a higher dosage of pain medication was administered to Resident 89 for a pain level below 7, it is considered an unnecessary administration of a PRN narcotic. The DON stated when the LNs did not follow the physician’s order for Resident 89, the facility P&P was not followed. During a review of the facility provided P&P titled, “Pain Assessment and Management,” last reviewed 5/30/2025, the P&P indicated the purposes of the procedure is to help the staff identify pain in the resident, develop interventions consistent with the resident's goals and needs, and address the underlying causes of pain. Pain management interventions are consistent with the resident's goals for treatment and reflect the sources, type, and severity of pain. The medication regimen is implemented as ordered. During a review of the facility provided P&P titled, “Administering Pain Medication,” last reviewed 5/30/2025, the P&P indicated the purpose of the procedure is to provide guidelines for assessing the resident's level of pain prior to administering analgesic pain medication. The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. Administer pain medications as ordered. During a review of the facility provided P&P titled, “Administering Medications,” last reviewed 5/30/2025, the P&P indicated only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so. The individual administering the medication checks the label THREE (3) times to verify the right dosage. b.2.During a concurrent interview and record review on 8/28/2025 at 8:47 a.m. with LVN 9, Resident 89’s physician orders and MAR were reviewed. LVN 9 stated PRN pain medication is given based on the pain rating scale to ensure the proper dosage of medication is administered for the level of the resident’s pain. LVN 9 stated it was important to not under medicate a resident because a lower dosage would not effectively treat their pain. LVN 9 stated Resident 89 had pain in the shoulder and back and LVN 9 administered oxycodone for pain management. LVN 9 reviewed Resident 89’s physician orders and stated Resident 89 had two dosages, 10 mgs and 5 mgs, of oxycodone both prescribed for a pain level of 7-10. LVN 9 stated the 5 mg dosage of oxycodone indicated moderate pain. LVN 9 stated moderate pain is 4-6, not 7-10. LVN 9 stated Resident 89’s orders for oxycodone had a discrepancy and should have been clarified with the physician prior to administration, but it wasn’t. During a concurrent interview and record review on 8/28/2025 at 9 a.m. with MDSN 1, Resident 89’s physician orders and MAR, for 8/2025, were reviewed. MDSN 1 stated Resident 89 had two different dosages of oxycodone ordered for a pain scale of 7-10. MDSN 1 stated the order for oxycodone 5 mg should have been clarified prior to administration because the order indicated a discrepancy. MDSN 1 reviewed Resident 89’s MAR and noted the oxycodone 5 mg for moderate pain was administered on the following dates: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 8/3/2025 at 10:07 p.m., for a pain level of 7. MDSN 1 stated 7 is not moderate pain and the order should have been clarified prior to administration, but it was not. -On 8/4/2025 at 11:50 a.m., for a pain level of 8. MDSN 1 stated 8 is not moderate pain and the order should have been clarified prior to administration, but it was not. -On 8/4/2025 at 10:18 p.m., for a pain level of 8. MDSN 1 stated 8 is not moderate pain and the order should have been clarified prior to administration, but it was not. -On 8/5/2025 at 6 a.m., for a pain level of 7. MDSN 1 stated 7 is not moderate pain and the order should have been clarified prior to administration, but it was not. -On 8/8/2025 at 2:19 p.m., for a pain level of 8. MDSN 1 stated 8 is not moderate pain and the order should have been clarified prior to administration, but it was not. -On 8/12/2025 at 10:26 a.m., for a pain level of 8. MDSN 1 stated 8 is not moderate pain and the order should have been clarified prior to administration, but it was not. -On 8/14/2025 at 10:08 p.m., for a pain level of 8. MDSN 1 stated 8 is not moderate pain and the order should have been clarified prior to administration, but it was not. -On 8/16/2025 at 4:43 a.m., for a pain level of 8. MDSN 1 stated 8 is not moderate pain a[TRUNCATED]

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, and record review, the facility failed to ensure that a resident who was receiving dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed) treatment, received services consistent with professional standards of practice for one (1) out of one (1) sampled resident (Resident 16) reviewed under the dialysis care area by failing to ensure the post dialysis assessment was completed on 8/23/2025. This deficient practice placed the resident at risk for unmonitored development of complications related to renal disease (a condition when the kidneys get damaged and unable to properly filter waste and extra fluid from the blood) like swelling, high blood pressure and shortness of breath. Findings: During a review of Resident 16's admission Record, the admission Record indicated the facility originally admitted the resident on 11/19/2018, and readmitted in the facility on 7/11/2024, with diagnoses including End Stage Renal Disease (ESRD - irreversible kidney failure), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 16's History and Physical (H&P) dated 10/15/2024, the H&P indicated Resident 16 had the capacity to understand and make decisions. During a review of Resident 16's Minimum Data Set (MDS, a resident assessment tool), dated 7/8/2025, the MDS indicated Resident 16 had an intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand and make her needs known. The MDS further indicated Resident 16 required set-up or clean up assistance with eating; supervision or touching assistance with oral hygiene; total assistance with transfers; substantial/maximal assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 16 received dialysis services. During a review of Resident 16's Order Summary Report dated 8/29/2025, the Order Summary Report indicated the following physician's order: -6/10/2024: Complete post hemodialysis in assessment tab on Tuesday, Thursday and Saturday after hemodialysis at bedtime. -10/3/2024: Complete pre-hemodialysis in assessment tab on Tuesday, Thursday and Saturday before hemodialysis every evening shift. During a review of Resident 16's post hemodialysis evaluation forms in the assessment tab, there was no documented evidence that the post hemodialysis evaluation form was completed on 8/23/2025. During a concurrent interview and record review on 8/28/2025 at 9:17 a.m., reviewed Resident 16's pre and post hemodialysis evaluation forms with Infection Preventionist (IP) 2/Quality Assurance Nurse (QAN) 2. IP 2/QAN 2 stated the post dialysis evaluation form was not completed by the charge nurse on 8/23/2025 after Resident 16 returned from hemodialysis treatment. IP 2/QAN 2 stated the charge nurses are responsible for completion of the form upon resident`s arrival back to the facility or before end of the shift to ensure there were no signs of complication such as abnormal vital signs (a measurement of basic functions of the body), bleeding, and/or altered mental status, as well as any special communication regarding the resident's care from the dialysis clinic. IP 2/QAN 2 stated the charge nurse assigned to Resident 16 should have completed the post hemodialysis evaluation form as it placed Resident 16 at risk for possible missed communication from the dialysis clinic and unmonitored signs of complications from the dialysis such as abnormal vital signs, bleeding, altered mental status. During an interview on 8/29/2025 at 12:30 p.m. with the Director of Nursing (DON), the DON stated the charge nurse is responsible for completing the pre and post hemodialysis evaluation form to ensure the residents are stable prior to leaving the facility and upon return from dialysis clinic. The DON stated the pre and post hemodialysis form serves as a communication tool between the facility and the dialysis clinic for continuity of care, what medications were administered to the resident, and the vital signs were stable. The DON stated Resident 16's post hemodialysis evaluation form should have been completed by the charge upon the resident's arrival from the dialysis center or before the end of shift as it placed Resident 16's at risk for any missed communication from the dialysis clinic concerning Resident 16's care, unmonitored complications such as unstable vital signs, signs of bleeding, and/or altered mental status. During a review of the facility's policy and procedure (P&P) titled, PACS Dialysis Communication: PACS Bes Practice Workflow, last reviewed on 5/30/2025, the P&P indicated that the care of the resident receiving dialysis services must reflect ongoing communication, coordination, and collaboration between the facility and the dialysis staff. The P&P further indicated: -The use of a dialysis communication form helps ensure the coordination of safe and effective care of residents who need dialysis treatments. -The Post Dialysis Communication is completed by the nurse after the dialysis

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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide trauma-informed care (a framework for understanding and responding to the effects of trauma in individuals, families, and communities) for one of two sampled residents (Resident 42) reviewed for behavior-emotional care area by: 1.Failing to ensure appropriate referrals were provided to Resident 42 when the resident had a history of trauma (refers to an emotional, psychological, or physical response to a deeply distressing or disturbing event that overwhelms a resident's ability to cope) in the past. 2.Failing to complete a timely trauma-informed care assessment. 3. Failing to conduct an interdisciplinary team (IDT - professionals from various disciplines who collaborate to address a patient's complex needs, aiming for a coordinated and comprehensive care plan) meeting to address the resident's specific needs These deficient practices may result in delayed identification of underlying trauma-related issues, which could compromise Resident 42's care, delay appropriate referrals, and negatively impact resident-outcomes. Findings: During a review of Resident 42's admission Record, the admission Record indicated the facility admitted the resident on 8/15/2023 with diagnoses including psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) dated 8/15/2023, generalized anxiety disorder (a mental health condition where excessive fear and worry interfere with daily life, causing significant distress) dated 2/8/2024, and post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event) dated 2/8/2024. During a review of Resident 42's History and Physical (H&P) dated 10/16/2024, the H&P did not indicate Resident 42's capacity to understand and make decisions. During a review of Resident 42's Minimum Data Set (MDS, a resident assessment tool), dated 7/11/2025, the MDS indicated Resident 42 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was unable to understand and made her needs known. The MDS further indicated Resident 42 required set-up or clean-up assistance with eating, substantial/maximal assistance with oral hygiene, upper and lower body dressing, and personal hygiene, and total assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 42 had a diagnosis of PTSD. During a review of Resident 42's care plan (CP) on trauma-informed care related to PTSD, initiated on 2/5/2024 and last revised on 7/23/2025, the CP indicated to monitor for signs and symptoms of decrease psychosocial well-being, adjustment issues, emotional distress, ineffective coping skills, poor impulse control, adverse effects on function, mental, physical, social, or spiritual wellbeing and report as one of the interventions. During a concurrent interview and record review on 8/27/2025 at 8:27 a.m. Resident 42's admission Record, social services assessments dated 8/18/2023 and 9/1/2024, social services notes dated 1/14/2024, and IDT notes dated 2/14/2024, 5/9/2024, 7/29/2024, 10/24/2024, 1/23/2025, 4/9/2025, and 7/15/2025 were reviewed with Social Services Designee (SS Designee) 1. SS Designee 1 stated the admission Record indicated Resident 42 had a diagnosis of PTSD dated 2/8/2024 and there was no documented evidence indicated in the social services assessments, social services notes, and IDT notes that Resident 42 had a history of trauma in the past. SS Designee 1 stated that upon admission and annually, the social services staff was responsible in completing an assessment and includes asking the residents or responsible party for any history of trauma in the past. SS Designee 1 stated residents will be referred to a psychologist and/or psychiatrist to determine a diagnosis of PTSD if there is history of trauma. SS Designee 1 stated the facility failed to provide referrals for Resident 42 to address the trauma in the past. SS Designee 1 stated that the social services assessments were not completed to indicate Resident 42's history of trauma in the past. SS Designee 1 stated referrals for psychiatrist/psychologist for Resident 42 should have been done to help the facility in providing a resident centered care as it affects Resident 42 emotionally which can lead to emotional distress and ineffective coping skills. During a concurrent interview and record review on 8/27/2025 at 9:07 a.m., Resident 42's admission Record, MDS assessments dated 2/8/2024, 5/3/2024, and 7/11/2025, social services assessments dated 8/18/2023 and 9/1/2024, social services notes dated 1/14/2024, IDT notes dated 2/14/2024, 5/9/2024, 7/29/2024, 10/24/2024, 1/23/2025, 4/9/2025, and 7/15/2025 care plan, H&P dated 10/16/2024, psychologist dated 8/28/2023, and psychiatrist notes 1/2/2024, 8/16/2024, and 9/1/2024 were reviewed with MDS Nurse (MDSN) 1. MDSN 1 stated the admission Record indicated Resident 42 had a diagnosis of PTSD dated 2/8/2024 and the MDS assessments indicated a diagnosis of PTSD, but there was no documented evidence in the social services

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to provide necessary behavioral health care and services for one of two sampled residents (Resident 42) reviewed for behavior-emotional care area when the facility failed to conduct a behavioral interdisciplinary team (IDT - a coordinated group of experts from several different fields who work together) meeting on the use of Seroquel (an antipsychotic medication used to treat several kinds of mental health conditions) and escitalopram (medication used to treat depression [a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities once enjoyed]). This deficient practice had the potential to negatively affect the delivery of care and services the resident needed. Cross reference F656 Findings: During a review of Resident 42's admission Record, the admission Record indicated the facility admitted the resident on 8/15/2023 with diagnoses including psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) dated 8/15/2023, generalized anxiety disorder (a mental health condition where excessive fear and worry interfere with daily life, causing significant distress) dated 2/8/2024, and post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event) dated 2/8/2024. During a review of Resident 42's History and Physical (H&P) dated 10/16/2024, the H&P did not indicate Resident 42's capacity to understand and make decisions. During a review of Resident 42's Minimum Data Set (MDS, a resident assessment tool), dated 7/11/2025, the MDS indicated Resident 42 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was unable to understand and make her needs known. The MDS further indicated Resident 42 required set-up or clean-up assistance with eating, substantial/maximal assistance with oral hygiene, upper and lower body dressing, and personal hygiene, and total assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 42 had a diagnosis of anxiety disorder. During a review of Resident 42's Order Summary Report dated 8/29/2025, the Order Summary Report indicated a physician's order dated 5/6/2025 for Ativan (a fast-acting medication used for conditions like severe anxiety, panic attacks, and seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) oral tablet to give 1 tablet by mouth one time a day every Tuesday, Friday for anxiety 30 minutes prior to ADL care/showering due to fear of being transferred and becoming aggressive with staff. During an observation 8/25/2025 at 10:54 a.m. inside Resident 42's room, observed Resident 42 lying in bed, awake, alert, and responded inappropriately. Observed Resident 42 putting the edges of a white sheet and blanket on the mouth, biting, and pulling at it. During a concurrent observation and interview on 8/25/2025 at 11:25 a.m. inside Resident 42's room with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 42 had the behavior of putting things in the mouth and biting for quite a while now but unable to tell how long. CNA 1 stated the behavior is the reason why the staff ensure that things are not in close reach to put in the mouth. During an interview on 8/26/2025 at 9:45 a.m. with Licensed Vocational Nurse (LVN) 8, LVN 8 stated that Resident 42 had the behavior of putting things in the mouth and biting for at least one year now. LVN 8 stated Resident 42 had an order for Ativan tablet during shower days as the resident had the tendency to be combative and aggressive towards staff when touched or transferred. LVN 8 stated there was no medication ordered for the behavior of putting things in the mouth. During a concurrent interview and record review on 8/27/2025 at 9:07 a.m., Resident 42's CP, physician's order, psychologist consultation note dated 8/28/2023, psychiatrist consultation and follow up notes dated 1/2/2024, 8/16/2024, and 9/1/2024 were reviewed with MDS Nurse (MDSN) 1. MDSN 1 stated she was made aware of Resident 42's behavior of putting things in the mouth on 8/25/2025, hence the CP addressing the behavior was initiated on 8/25/2025. MDNS 1 stated the physician's order for Ativan was for anxiety 30 minutes prior to ADL care/showering due to fear of being transferred becoming aggressive with staff. MDSN 1 stated the psychiatrist notes did not indicate the behavior of putting in the mouth and biting, hence not addressed. MDSN 1 stated if there is a new behavior issue or problem observed by the staff, the physician should be notified for the facility to be able to provide the necessary behavioral health care and services for the resident. MDSN 1 stated Resident 42's behavior of putting things in the mouth should have been identified timely by the interdisciplinary team (IDT - professionals from various disciplines who collaborate to address a patient's complex needs, aiming for a coordinated and comprehensive care plan) and addressed with the physician or psychiatrist as it placed Resident 42 at risk for increased episodes of putting things in the mouth and biting if left untreated or

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1.Accurately account for one dose of oxycodone/APAP (a controlled medication used to treat pain) 10/325 milligrams (mg - a unit of measure for mass) affecting Resident 7 in one of five inspected medication carts (Station 2 Cart C.) 2.Administer one dose of lidocaine (a topical adhesive patch that delivers a local anesthetic to a specific area of the body to relieve pain) four percent (% - one part in every hundred) for one of five sampled resident (Resident 51) reviewed during pain management care area. This deficient practice of failing to maintain accountability of controlled substances increased the risk of diversion (any use other than that intended by the prescriber) of controlled mediations (medications with a high risk for diversion) and the risk that Resident 7 could have received too much or too little medication due to lack of documentation possibly resulting in serious health complications requiring hospitalization. The deficient practice of failing to administer lidocaine per the physician's order increased the risk that Resident 51 may have experienced increased pain, possibly contributing to a decline in her quality of life. Findings: a. During an observation and concurrent interview of Station 2 Cart C on 8/26/25 at 2:48 p.m. with the Licensed Vocational Nurse (LVN) 7, the following discrepancies were found between the Narcotic and Hypnotic Record (a log signed by the nurse with the date and time each time a controlled substance is given to a resident) and the medication card (a bubble pack from the dispensing pharmacy labeled with the resident’s information that contains the individual doses of the medication): 1.Resident 7’s Narcotic and Hypnotic Record for oxycodone/apap 10/325 mg indicated there were 7 doses left; however, the medication card contained 6 doses. During a concurrent interview with LVN 7, LVN 7 stated she dispensed the missing dose of oxycodone 10/325 to Resident 7 this morning at 11:41 a.m. and failed to sign the narcotic record at that time. LVN 7 stated the narcotic record should be signed as soon as the medication is removed from the bubble pack. LVN 7 stated failing to sign the narcotic record increases the risk of diversion which could result in the misappropriation of resident property and increases the risk that doses of PRN (as needed) pain medications could be administered too frequently, possibly leading to drowsiness, dizziness, or difficulty breathing. During a review of the facility’s policy titled, “Controlled Substances,” revised 5/2024, indicated, “… an individual resident-controlled substance record is made for each resident who will be receiving a controlled substance… This record contains… signature of nurse administering medication… Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up… The system of reconciling the receipt, dispensing, and disposition of controlled substances includes the following: … Declining inventory records….” (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. During a review of Resident 51’s admission Record (AR), the AR indicated that the facility originally admitted the resident on 8/14/2024 and readmitted on [DATE] with diagnoses including cauda equina syndrome (a condition where the nerve roots at the bottom of the spinal cord [cauda equina] are compressed, leading to damage and dysfunction), generalized muscle weakness, polyosteoarthritis (a condition where multiple joints experience inflammation and degeneration of cartilage) unspecified (exact cause or type of polyosteoarthritis is unknown). During a review of Resident 51’s History and Physical (H&P), dated 8/16/2024, the H&P indicated that the resident had the capacity to make decisions. During a review of Resident 51’s Minimum Data Set (MDS-a resident assessment tool), dated 6/7/2025, the MDS indicated the resident had clear speech, made self understood, and had the ability to understand others. The MDS indicated Resident 51 as cognitively intact (a person's thinking, learning, and memory abilities are functioning normally and are not impaired). The MDS indicated Resident 51 required assistance from staff with ADLs including shower/bathing, upper and lower body dressing, putting on/taking off footwear, personal hygiene, and toileting hygiene. The MDS indicated Resident 51 required assistance with mobility including sit to lying on the bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, and walking. During a review of Resident 51’s Care Plan (CP) focus on musculoskeletal disorder, dated 10/21/2024, the CP indicated the resident’s pain will be managed to a tolerable level with interventions including to observe for signs and symptoms of joint stiffness, fracture, change in function, or increased report of pain and notify physician of abnormal findings; to monitor pain level every shift and as needed; and to administer medication as ordered and monitor effectiveness. During a review of Resident 51’s Order Audit Report (OAR), dated 8/27/2025, the OAR indicated the order summary: lidocaine External Patch 4 %, apply to bilateral shoulders topically one time a day for pain on 12 hours (hrs), off 12 hours, and remove per schedule. The OAR indicated the order details history for lidocaine indicated administered by unsupervised self-administration and the directions to apply to bilateral shoulders topically one time a day for pain unsupervised self-administration on 12 hrs, off 12 hrs, and remove per schedule. During an interview on 8/25/2025 at 9:52 a.m. with Resident 51, Resident 51 stated she had an order for a patch for her left shoulder pain, and no one had given it to her since yesterday. Resident 51 stated she did not have a patch on her left shoulder currently. Resident 51 stated she told one of the medication nurse a few days ago that she has pain on her left shoulder and she could not raise it higher because of the pain. During a concurrent observation and interview on 8/25/2025 at 9:54 a.m. with Licensed Vocational Nurse (LVN) 1, inspected medication cart A for Station 2, LVN 1 stated she was the charge nurse for Resident 51, and she had finished passing Resident 51’s morning medications. LVN 1 stated Resident 51’s lidocaine patch container had 10 patches inside. LVN 1 stated the 10 patches were delivered yesterday, 8/24/2025. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/25/2025 at 9:57 a.m., Resident 51’s physician orders, self-administration of medication assessment, and electronic Medication Administration Record (eMAR) for the month of 8/2025 were reviewed with LVN 1. LVN 1 stated she has not applied the lidocaine patch and will apply it now. LVN 1 stated on 8/24/2025 and 8/25/2025 it indicated initialed U-SA means supervised self-administration, and on her screen it showed green meaning it was done but she does not know why it was signed when she had not clicked it. LVN 1 stated it would show her initials that she had given it. LVN 1 stated when a resident self-administers a medication a self-administration of medication assessment is completed. LVN 1 stated self-administration of medication assessment for Resident 51 was not done. LVN 1 stated it is done before the resident can self-administer a medication. During an interview on 8/27/2025 at 6:34 a.m. with LVN 1, LVN 1 stated the Quality Assurance Nurse (QAN) 1 clarified the order with Resident 51’s physician. LVN 1 stated she was already past the administration time, so a one-time dose was ordered on 8/25/2025. LVN 1 stated she would verify if the resident had a self-administration assessment completed prior the resident can self-administer medications. LVN 1 stated when the medication is not administered timely it would result in a delay in care. During an interview on 8/27/2025 at 9:57 a.m. with the Assistant Director of Nursing (ADON), the ADON stated the charge nurse verifies the order and administers as prescribed. The ADON stated when the order is not followed there is potential for the resident’s pain to be uncontrolled. During an interview on 8/27/2025 at 11:29 a.m. with the Assistant Director of Nursing (ADON) stated Resident 51's mobility, ADLs, and activities, and level of participation can be affected when their pain is not monitored. The ADON stated it should show detailed documentation on what the licensed nurse did including pain assessment, doctor notification, and what the intervention was. The ADON stated the purpose of assessing the resident’s pain is to help them address the resident’s underlying pain and develop care plan to manage the resident’s pain. During an interview on 8/27/2025 at 2:17 p.m. with the Director of Nursing (DON), the DON stated on 8/25/2025 the lidocaine patch for unsupervised self-administration was not administered. The DON stated QAN clarified the order with the resident's physician for the medication to be administered by the licensed nurses. The DON stated the charge nurse verifies the medication order prior to administration. The DON stated for unsupervised self-administration on the eMAR would automatically turn green, which means it was done. During a review of the facility’s policy and procedure (P&P) titled, “Pain Assessment and Management,” last reviewed 5/30/2025, the P&P indicated that the purpose of this procedure is to help the staff identify pain in the resident, develop interventions consistent with the resident’s goals and needs, and address the underlying causes of pain. The P&P indicated that pain management is a multidisciplinary process that included following: “e. developing and implementing approaches to pain management based on accepted standards of practice; f. monitoring for the effectiveness of interventions; and g. modifying approaches as necessary.” (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The P&P indicated comprehensive pain assessments are conducted including when there is an onset of new pain or worsening of existing pain. The P&P indicated that the pain management interventions are consistent with the resident’s goals for treatment. The P&P indicated that the medication regimen is implemented as ordered and results of the interventions are documented and communicated directly to the provider when appropriate. During a review of the facility’s P&P titled, “Administering Medications,” last reviewed 5/30/2025, the P&P indicated that medications are administered in safe and timely manner, and as prescribed. The P&P indicated medications are administered in accordance with prescriber orders, including any required timeframe. The P&P indicated medications are documented within one hour of their prescribed time. The P&P indicated the individual administering the medication initials the resident’s MAR on the appropriate line after giving each medication and before administering the next ones. The P&P indicated residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Antelope Valley Care Center	44567 North 15th St. West Lancaster, CA 93534

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five percent (%). Four errors out of 32 opportunities contributed to an overall error rate of 12.5 % affecting three of six residents observed for medication administration (Resident 67, 99, and 187). The errors noted were as follows: 1.Incorrect preparation of Lokelma (a medication used for kidney failure) for Resident 187. 2.Incorrect time of administration for sevelamer (a medication used for kidney failure) for Resident 187. 3.Failure to administer metformin (a medication used to treat high blood sugar) with food per the physician order for Resident 99. 4.Failure to administer potassium chloride (a potassium supplement) with food per the physician order for Resident 67. The deficient practice of failing to administer medications in accordance with the physician's orders or professional standards increased the risk that Residents 67, 99, and 187 may have experienced medical complications possibly resulting in hospitalization. Findings: During an observation of medication administration on 8/26/2025 at 8:13 a.m. with the Licensed Vocational Nurse (LVN) 8, LVN 8 was observed preparing the following medications for Resident 187: 1.One packet of Lokelma powder mixed in approximately seven ounces of water 2.One tablet of sevelamer 800 milligrams (mg - a unit of measure for mass) During a concurrent observation of Resident 187's pharmacy label for Lokelma indicated that one packet should be mixed with 45 (approximately one and a half ounces) milliliters (ml - a unit of measure for volume.) During an observation on 8/26/2025 at 8:14 a.m., LVN 8 was observed entering Resident 187's room to administer the Lokelma preparation and was stopped by the surveyor. During a concurrent interview, LVN 8 stated she mixed the Lokelma with seven ounces of water, but the order is for one packet to be mixed with only 45 ml of water. LVN 8 stated she mixed the Lokelma with too much water because it is the resident's preference to take it this way. LVN 8 stated she should have contacted the physician for an order clarification and created a care plan with this resident preference if she intended to deviate from the written instructions. LVN 8 stated if the medication is mixed with too much water, there is a risk that the resident could not receive the entire dose possibly leading to further kidney complications. During an observation and concurrent interview on 8/26/2025 at 8:24 a.m. with LVN 8, LVN 8 stated that sevelamer should be administered with food and was observed offering Resident 187 a granola bar to take along with the sevelamer. Resident 187 was observed stating he did not want the granola bar as he had finished his breakfast earlier. During a concurrent observation of Resident 187's prescription label for sevelamer, the pharmacy label indicated that sevelamer should be administered with meals. During an observation of medication administration on 8/26/2025 at 8:34 a.m., Resident 187 was observed taking one tablet of sevelamer by mouth. During an interview on 8/26/2025 at 8:35 a.m. with LVN 8, LVN 8 stated Resident 187 completed his breakfast around 7:45 a.m. and should have received the sevelamer at the time he received his breakfast. LVN 8 stated sevelamer needs to be given with meals in order to remove phosphate (a mineral that accumulates in the blood of patients with kidney failure) from the food. LVN 8 stated the sevelamer should have been given at the same time Resident 187 was served breakfast. LVN 8 stated giving sevelamer outside of mealtimes could lead to too much phosphate in the blood leading to medical complications. During a review of Resident 187's admission Record (a document containing diagnostic and demographic information), dated 8/27/2025, the admission record indicated the resident was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including end-stage renal disease (kidney failure.) During a review of Resident 187's History and Physical (H&P-a record of a physician's comprehensive medical assessment), dated 5/8/2025, the H&P indicated Resident 187 had end-stage renal disease and was on dialysis (a method of mechanically filtering a patient's blood that becomes necessary due to kidney failure). During a review of Resident 187's Order Summary Report (a monthly summary report of all active physician orders), dated 8/27/2025, the order summary report indicated Resident 187's attending physician prescribed the following: 1.Lokelma oral packet 10 grams (gm - a unit of measure for mass) to give one packet by mouth one time a day on non-dialysis days (Tuesdays, Thursdays, Saturdays, and Sundays) for hyperkalemia (too much potassium in the blood.) 2.Sevelamer 800 mg by mouth three times a day for hyperphosphatemia (too much phosphate in the blood). Take with meals. During an observation of medication administration on 8/26/2025 at 9:35 a.m. with the Licensed Vocational Nurse (LVN) 9, LVN 9 was observed preparing the following medications for Resident 99: 1.One tablet of metformin 500 mg During an observation on 8/26/2025 at 9:36 a.m., LVN 9 was observed administering the metformin to Resident 99

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors (when the observed or identified preparation or administration of medications or biologicals are not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) for: 1.Three of three sampled residents (Residents 157, 10, and 14) reviewed for insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (sq, beneath the skin) insulin administration sites. The deficient practice had the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). 2.One of five medication carts (Station 2 Cart C). The error notes were as follows: a.Incorrect preparation of Lokelma (a medication used for kidney failure) for Resident 187. b.Incorrect time of administration for sevelamer (a medication used for kidney failure) for Resident 187. c.Failure to administer metformin (a medication used to treat high blood sugar) with food per the physician order for Resident 99. d.Failure to administer potassium chloride (a potassium supplement) with food per the physician order for Resident 67. e.Failure to administer one dose of hydrocodone/apap (a medication used to treat pain) to Resident 147. f.Failure to administer one dose of hydrocodone/apap to Resident 159. The deficient practice of failing to administer medications in accordance with the physician's orders or professional standards increased the risk that Residents 67, 99, 147, 159, and 187 may have experienced medical complications possibly resulting in hospitalization. Cross reference F658. Findings: 1.During a review of Resident 157’s admission Record (AR), the AR indicated the facility admitted the resident on 8/26/2024, and readmitted the resident on 5/22/2025, with diagnoses including type two (2) diabetes mellitus (DM 2, a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic neuropathy (is nerve damage caused by high blood sugar over a long period), diabetic polyneuropathy (is a type of multiple nerve damage caused by long-term high blood sugar levels in people with diabetes), and muscle weakness. During a review of Resident 157’s History and Physical (H&P), dated 10/5/2024, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 157’s Minimum Data Set (MDS, a resident assessment tool), dated 8/11/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (is a medical and psychological term that means a person's mental abilities are completely normal and not noticeably damaged or impaired). The MDS indicated that the resident was taking hypoglycemic medication (is a drug used primarily to lower high blood sugar levels in people with type two diabetes) which was considered a high risk drug class medication (a group of medications that pose a significantly elevated risk of causing harm to patients if used incorrectly or if errors occur during administration). During a review of Resident 157’s Order Summary Report (OSR), dated 5/22/2025, the OSR indicated an order for: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Insulin Regular Human Injection Solution 100 unit per milliliters (unit/ml, a measure of how concentrated insulin is, meaning there are 100 units of insulin in every 1 milliliter of liquid) (Insulin Regular Human). Inject as per sliding scale (is a simple chart that tells a person with diabetes how much fast-acting insulin to take, based on their current blood sugar level) subcutaneously before meals and at bedtime for DM 2: if 121 - 150 = 4 units; 151 - 200 = 5 units; 201 - 250 = 6 units; 251 - 300 = 8 units; 301 - 350 = 10 units; 351 - 400 = 12 units. Blood sugar (BS) greater than 400 give 14 units and notify the physician. If BS less than 70 notify the physician. Rotate Injection Sites. Insulin Glargine Subcutaneous Solution 100 unit/ml (Insulin Glargine). Inject 15 units subcutaneously at bedtime for Diabetes, rotate injection sites. During a review of Resident 157’s Location of Administration (LOA) of insulin for 7/2025 to 8/2025, the LOA indicated: Insulin Regular Human Injection Solution 100 unit/ml was administered on, 7/10/2025 at 5:46 p.m. on the Abdomen - Left Upper Quadrant (LUQ) 7/10/2025 at 10:26 p.m. on the Abdomen – LUQ 7/14/2025 at 8:44 p.m. on the Abdomen - Right Lower Quadrant (RLQ) 7/15/2025 at 8:25 p.m. on the Abdomen – RLQ 7/19/2025 at 12:25 p.m. on the Arm - left 7/19/2025 at 8:48 p.m. on the Arm – left 7/20/2025 at 8:08 p.m. on the Abdomen - Left Lower Quadrant (LLQ) 7/21/2025 at 4:11 p.m. on the Abdomen – LLQ 7/22/2025 at 11:46 a.m. on the Abdomen - LUQ 7/23/2025 at 12:01 p.m. on the Abdomen – LUQ 7/25/2025 at 12:26 p.m. on the Abdomen – LLQ 7/25/2025 at 8:04 p.m. on the Abdomen – LLQ 7/26/2025 at 6:27 p.m. on the Abdomen - LLQ 7/26/2025 at 8:36 p.m. on the Abdomen – LLQ 7/27/2025 at 4:47 p.m. on the Abdomen - RLQ 7/27/2025 at 9:06 p.m. on the Abdomen – RLQ (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/2/2025 at 11:26 a.m. on the Abdomen - LUQ 8/2/2025 at 4:47 p.m. on the Abdomen – LUQ 8/5/2025 at 9:27 p.m. on the Abdomen - LLQ 8/6/2025 at 12:22 p.m. on the Abdomen – LLQ 8/12/2025 at 3:36 p.m. on the Abdomen - RLQ 8/13/2025 at 2:43 p.m. on the Abdomen – RLQ During a review of Resident 157’s Care Plan (CP) Report regarding resident requiring hypoglycemic medication Metformin and insulin, last revised on 8/27/2024, the CP indicated an intervention to administer medication as ordered. During a concurrent interview and record review on 8/27/2025, at 1:38 p.m., with the Assistant Director of Nursing (ADON), reviewed Resident 157’s OSR, LOA, and CP. The ADON stated there were multiple instances that the licensed staff did not rotate the insulin administration sites on Resident 157. The ADON stated the licensed staff should rotate insulin administration sites to prevent skin damage to the resident and lipodystrophy. The ADON stated the administration of insulin on sites of lipodystrophy can affect the absorption of the medication causing hypo (low)/hyperglycemia (high blood sugar level) to residents. The ADON stated not rotating insulin administration sites constitutes a medication error. During an interview on 8/28/2025, at 3:20 p.m., with the Director of Nursing (DON), the DON stated the licensed staff should rotate the sites of insulin administration for Resident 157 to prevent lipodystrophy which is the hardening of the skin at the frequently used injection sites causing malabsorption (inability to absorb) of the insulin. The DON stated the blood sugar may not be controlled due to malabsorption and the resident can suffer from hypo/hyperglycemia. The DON stated that not rotating insulin administration site is a medication error. During a review of the facility's recent policy and procedure (P&P) titled Adverse Consequences and Medication Errors, last reviewed on 5/30/2025, the P&P indicated the interdisciplinary team monitors medication usage to prevent and detect medication-related problems such as adverse drug reactions (ADRs) and side effects. Adverse Consequences 1. An “adverse consequence” refers to an unwanted, uncomfortable, or dangerous effect of a drug may have, such as a decline in mental or physical condition, or functional or psychosocial status. An adverse consequence may include: a. adverse drug/medication reaction; b. side effect; c. medication-medication interaction; or (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. medication-food interaction. Medication Errors 1. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with provider's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. During a review of the facility's recent P&P titled Insulin Administration, last reviewed on 5/30/2025, the P&P indicated to provide guidelines for the safe administration of insulin. General Guidelines 18. Select an injection site. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility-provided Highlights of Prescribing Information on the use of Lantus (insulin glargine injection) for subcutaneous injection, with initial U.S. approval in 2000, the Highlights of Prescribing Information indicated to rotate injection sites to reduce the risk of lipodystrophy. During a review of the facility-provided Information for the Physician on the use of Humulin R Regular, Insulin Human Injection, USP, (rDNA Origin) 100 units per ML (U-100), issued 3/2011, indicated injection sites should be rotated within the same region. 2.During a review of Resident 10’s AR, the AR indicated the facility admitted the resident on 8/7/2025, with diagnoses including cerebral infarction (a type of stroke caused by a blocked artery in the brain, leading to the death of brain tissue due to a lack of oxygen and blood flow), dysphagia (difficulty swallowing), and lobar pneumonia (a type of lung infection that causes one or more whole sections (lobes) of the lung to become inflamed and fill with fluid or pus, making it hard to breathe). During a review of Resident 10’s H&P, dated 8/9/2025, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 10’s MDS, dated [DATE], the MDS indicated the resident usually makes self-understood and understand others and had mild cognitive impairment (a condition where a person has greater-than-normal problems with memory or thinking, but it is not severe enough to interfere with daily life). The MDS indicated the resident was on a high-risk drug class hypoglycemic medication. During a review of Resident 10’s OSR, dated 8/15/2025, the OSR indicated an order for: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Insulin Regular Human Injection Solution (Insulin Regular (Human). Inject as per sliding scale: if 0 - 70 = 0 unit. Give 1/2 glass Orange Juice; 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 600 = 12 units. Call MD, subcutaneously after meals and at bedtime for DM 2, rotate site of injection. Inject 6 unit subcutaneously before meals for DM 2, rotate site of injection. Insulin Glargine Subcutaneous Solution 100 unit/ml (Insulin Glargine). Inject 12 units subcutaneously at bedtime for Type 2 Diabetes Mellitus rotate site of injection. During a review of Resident 10’s LOA of insulin for 6/2025 to 8/2025, the LOA indicated: Insulin Glargine Subcutaneous Solution 100 unit/ml was administered on, 8/8/2025 at 9:34 p.m. on the Arm - right 8/9/2025 at 10:15 p.m. on the Arm – right Insulin Regular Human Injection Solution was administered on, 8/8/2025 at 10:50 a.m. on the Abdomen - RLQ 8/8/2025 at 4:32 p.m. on the Abdomen – RLQ 8/17/2025 at 11:40 a.m. on the Arm - left 8/17/2025 at 10:12 a.m. on the Arm – left 8/18/2025 at 5:18 p.m. on the Abdomen - RLQ 8/19/2025 at 6:01 a.m. on the Abdomen – RLQ 8/20/2025 at 4:49 p.m. on the Abdomen - LLQ 8/21/2025 at 7:44 a.m. on the Abdomen – LLQ 8/23/2025 at 12 p.m. on the Arm - left 8/23/2025 at 6:43 p.m. on the Arm - left 8/24/2025 at 6:45 a.m. on the Arm – left During a review of Resident 10’s CP Report regarding the resident having a diagnosis of diabetes mellitus, last revised on 8/7/2025, the CP indicated an intervention to administer medication as ordered. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/27/2025 at 1:38 p.m., with the ADON, reviewed Resident 10’s OSR, LOA, and CP. The ADON stated there were multiple instances that the licensed staff did not rotate the insulin administration sites on Resident 10. The ADON stated the licensed staff should rotate insulin administration sites to prevent skin damage to the resident and lipodystrophy. The ADON stated the administration of insulin on sites of lipodystrophy can affect the absorption of the medication causing hypo/hyperglycemia to residents. The ADON stated not rotating insulin administration sites constitutes a medication error. During an interview on 8/28/2025, at 3:20 p.m., with the DON, the DON stated the licensed staff should rotate sites of insulin administration for Resident 10 to prevent lipodystrophy which is the hardening of the skin at the frequented sites of administration causing malabsorption of the insulin. The DON stated the blood sugar may not be controlled due to malabsorption and the resident can suffer from hypo/hyperglycemia. The DON stated that not rotating insulin administration site is a medication error. During a review of the facility's recent P&P titled Adverse Consequences and Medication Errors, last reviewed on 5/30/2025, the P&P indicated the interdisciplinary team monitors medication usage to prevent and detect medication-related problems such as adverse drug reactions (ADRs) and side effects. Adverse Consequences 1. An “adverse consequence” refers to an unwanted, uncomfortable, or dangerous effect of a drug may have, such as a decline in mental or physical condition, or functional or psychosocial status. An adverse consequence may include: a. adverse drug/medication reaction; b. side effect; c. medication-medication interaction; or d. medication-food interaction. Medication Errors 1. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with provider's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. During a review of the facility's recent P&P titled Insulin Administration, last reviewed on 5/30/2025, the P&P indicated to provide guidelines for the safe administration of insulin. General Guidelines 18. Select an injection site. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility-provided Highlights of Prescribing Information on the use of Lantus (insulin glargine injection) for subcutaneous injection, with initial U.S. approval in 2000, the Highlights of Prescribing Information indicated to rotate injection sites to reduce the risk of lipodystrophy. During a review of the facility-provided Information for the Physician on the use of Humulin R Regular, Insulin Human Injection, USP, (rDNA Origin) 100 units per ML (U-100), issued 3/2011, indicated injection sites should be rotated within the same region. 3.During a review of Resident 14’s AR, the AR indicated the facility admitted the resident on 11/13/2023, and readmitted the resident on 4/6/2024, with diagnoses including type 2 diabetes mellitus with diabetic chronic kidney disease (happens when high blood sugar from diabetes damages the small filters in the kidneys, making them leak and lose their ability to clean the blood), diabetic neuropathy, and heart failure (occurs when the heart cannot pump enough blood and oxygen to meet the body’s needs). During a review of Resident 14’s H&P, dated 8/21/2025, the H&P indicated the resident was alert and oriented times (X) 3-4 (a person is awake, knows their name [Person], where they are [Place], and the approximate current time or date [Time]). During a review of Resident 14’s OSR, dated 6/20/2024, the OSR indicated an order for Insulin Regular Human Solution 100 unit/ml. Inject as per sliding scale: if 150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 299 = 7 units; 300 - 349 = 10 units, subcutaneously before meals and at bedtime for diabetes. Call MD for BS less than 70 or more than 350. Rotate insulin injection sites. During a review of Resident 14’s LOA of insulin from 6/2025 to 8/2025, the LOA indicated: Insulin Regular Human Solution 100 unit/ml was administered on, 7/1/2025 at 9:02 p.m. on the Abdomen - LLQ 7/3/2025 at 8:44 p.m. on the Abdomen – LLQ 7/16/2025 at 5:12 p.m. on the Abdomen - LLQ 7/17/2025 at 4:11p.m. on the Abdomen – LLQ 7/22/2025 at 8:07 p.m. on the Abdomen - LLQ 7/23/2025 at 8:20 p.m. on the Abdomen – LLQ 8/05/2025 at 8:19 p.m. on the Abdomen - LLQ (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/11/2025 at 4:38 p.m. on the Abdomen – LLQ During a review of Resident 14’s CP Report regarding the resident having a diagnosis of diabetes and is at risk for complications, last revised on 6/11/2025, the CP indicated an intervention to administer medication as ordered. During a concurrent interview and record review on 8/27/2025, at 1:38 p.m., with the ADON, reviewed Resident 14’s OSR, LOA, and CP. The ADON stated there were multiple instances that the licensed staff did not rotate the insulin administration sites for Resident 14. The ADON stated the licensed staff should rotate insulin administration sites to prevent skin damage to the resident and lipodystrophy. The ADON stated the administration of insulin on sites of lipodystrophy can affect the absorption of the medication causing hypo/hyperglycemia to residents. The ADON stated not rotating insulin administration sites constitutes a medication error. During an interview on 8/28/2025, at 3:20 p.m., with the DON, the DON stated the licensed staff should rotate sites of insulin administration for Resident 14 to prevent lipodystrophy which is the hardening of the skin at the frequented sites of administration causing malabsorption of the insulin. The DON stated the blood sugar may not be controlled due to malabsorption and the resident can suffer from hypo/hyperglycemia. The DON stated that not rotating insulin administration site is a medication error. During a review of the facility's recent P&P titled Adverse Consequences and Medication Errors, last reviewed on 5/30/2025, the P&P indicated the interdisciplinary team monitors medication usage to prevent and detect medication-related problems such as adverse drug reactions (ADRs) and side effects. Adverse Consequences 1. An “adverse consequence” refers to an unwanted, uncomfortable, or dangerous effect of a drug may have, such as a decline in mental or physical condition, or functional or psychosocial status. An adverse consequence may include: a. adverse drug/medication reaction; b. side effect; c. medication-medication interaction; or d. medication-food interaction. Medication Errors 1. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with provider's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. During a review of the facility's recent P&P titled Insulin Administration, last reviewed on 5/30/2025, the P&P indicated to provide guidelines for the safe administration of insulin. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	General Guidelines 18. Select an injection site. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility-provided Information for the Physician on the use of Humulin R Regular, Insulin Human Injection, USP, (rDNA Origin) 100 units per ML (U-100), issued 3/2011, indicated injection sites should be rotated within the same region. 4.During an observation of medication administration on 8/26/2025 at 8:13 a.m. with the Licensed Vocational Nurse (LVN) 8, LVN 8 was observed preparing the following medications for Resident 187: 1.One packet of Lokelma powder mixed in approximately seven ounces of water 2.One tablet of sevelamer 800 milligrams (mg – a unit of measure for mass) During a concurrent observation of Resident 187’s pharmacy label for Lokelma indicated that one packet should be mixed with 45 (approximately one and a half ounces) milliliters (ml – a unit of measure for volume). During an observation on 8/26/2025 at 8:14 a.m., LVN 8 was observed entering Resident 187’s room to administer the Lokelma preparation and was stopped by the surveyor. During a concurrent interview, LVN 8 stated she mixed the Lokelma with seven ounces of water, but the order is for one packet to be mixed with only 45 ml of water. LVN 8 stated she mixed the Lokelma with too much water because it is the resident's preference to take it this way. LVN 8 stated she should have contacted the physician for an order clarification and created a care plan with this resident preference if she intended to deviate from the written instructions. LVN 8 stated if the medication is mixed with too much water, there is a risk that the resident could not receive the entire dose possibly leading to further kidney complications. During an observation and concurrent interview on 8/26/2025 at 8:24 a.m. with LVN 8, LVN 8 stated that sevelamer should be administered with food and was observed offering Resident 187 a granola bar to take along with the sevelamer. Resident 187 was observed stating he did not want the granola bar as he had finished his breakfast earlier. During a concurrent observation of Resident 187’s prescription label for sevelamer, the pharmacy label indicated that sevelamer should be administered with meals. During an observation of medication administration on 8/26/2025 at 8:34 a.m., Resident 187 was observed taking one tablet of sevelamer by mouth. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/26/2025 at 8:35 a.m. with LVN 8, LVN 8 stated Resident 187 completed his breakfast around 7:45 AM and should have received the sevelamer at the time he received his breakfast. LVN 8 stated sevelamer needs to be given with meals in order to remove phosphate (a mineral that accumulates in the blood of patients with kidney failure) from the food. LVN 8 stated the sevelamer should have been given at the same time Resident 187 was served breakfast. LVN 8 stated giving sevelamer outside of mealtimes could lead to too much phosphate in the blood leading to medical complications. During a review of Resident 187’s admission Record (a document containing diagnostic and demographic information), dated 8/27/2025, the admission record indicated the resident was admitted to the facility on [DATE], and most recently readmitted on [DATE], with diagnoses including end-stage renal disease (kidney failure). During a review of Resident 187’s History and Physical (H&P-a record of a physician’s comprehensive medical assessment), dated 5/8/2025, the H&P indicated Resident 187 had end-stage renal disease and was on dialysis (a method of mechanically filtering a patient’s blood that becomes necessary due to kidney failure.) During a review of Resident 187’s Order Summary Report (a monthly summary report of all active physician orders), dated 8/27/2025, indicated Resident 187’s attending physician prescribed the following: 1.Lokelma oral packet 10 grams (gm – a unit of measure for mass) to give one packet by mouth one time a day on non-dialysis days (Tuesdays, Thursdays, Saturdays, and Sundays) for hyperkalemia (too much potassium in the blood.) 2.Sevelamer 800 mg by mouth three times a day for hyperphosphatemia (too much phosphate in the blood). Take with meals. During an observation of medication administration on 8/26/2025 at 9:35 a.m. with the Licensed Vocational Nurse (LVN) 9, LVN 9 was observed preparing the following medications for Resident 99: 1.One tablet of metformin 500 mg During an observation on 8/26/2025 at 9:36 a.m., LVN 9 was observed administering the metformin to Resident 99 without offering any food. During a concurrent interview with Resident 99, Resident 99 stated he was not hungry this morning and did not have any breakfast today. During an interview on 8/26/2025 at 9:39 a.m., LVN 9 stated she failed to offer the metformin to Resident 99 with food as required by the physician order. LVN 9 stated this could lead to stomach upset possibly causing a decline in his quality of life. During a review of Resident 99’s admission Record, dated 8/27/2025, indicated the resident was admitted to the facility 6/20/2023, and most recently readmitted on [DATE], with diagnoses including type two (2) diabetes mellitus (a medical condition characterized by a lack of blood sugar control). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 99’s H&P, dated 11/2/2024, the H&P indicated he had the capacity to make decisions. During a review of Resident 99’s Order Summary Report, dated 8/27/2025, the order summary report indicated Resident 99’s attending physician prescribed the following: 1.Metformin 500 mg

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 one opened Humulin 70/30 (a medication used to control high blood sugar) insulin pen was labeled with an open date as required by the manufacturer's specifications affecting Resident 172 in one of five inspected medication carts (Station 3 Cart A.) The deficient practice of failing to label open insulin pens with an open date increased the risk that Resident 172 may have insulin that had become ineffective or toxic due to improper storage possibly leading to health complications resulting in hospitalization or death. Findings: During a concurrent observation and interview on [DATE] at 2:20 p.m. of Station 3 Cart A with the Licensed Vocational Nurse (LVN 10), the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications: 1.One opened Humulin 70/30 pen for Resident 172 was found stored at room temperature in the medication cart unlabeled with an open date. According to the product labeling, unopened Humulin 70/30 insulin pens should be stored in the refrigerator. Humulin 70/30 insulin pens should be used or discarded within 31 days of opening or storing at room temperature. During a concurrent interview, LVN 10 stated the Humulin 70/30 is good for 31 days once opened or stored at room temperature. LVN 10 stated the Humulin 70/30 pen for Resident 172 was open and stored at room temperature but not labeled with an open date. LVN 10 stated an open date is required on all open insulin to know when it will expire based on manufacturer's requirements. LVN 10 stated if insulin is given after it has expired to Resident 172, it could cause medical complications due to poor blood sugar control possibly resulting in hospitalization. During a review of the facility's policy titled, Storage of Medications, revised 5/2024, the policy indicated, The facility stores all drugs and biologicals in a safe, secure, and orderly manner. drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light, and humidity controls. Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured location.

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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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1.An aerosol can of whipped cream was without a cover with the nozzle or tip exposed remained on the top shelf of the walk-in refrigerator. 2.A metal container of turkey and cheese sandwiches in the walk-in refrigerator did not indicate a preparation date. 3. One can of sliced apples with dent remained at the bottom shelf in the dry storage room with the non-dented cans. 4.Six plastic containers of food were stacked wet in the drying rack in the dishwashing room. These failures had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (transfer of bacteria from one object to another) in 167 of 177 medically compromised residents who received food from the kitchen. Findings: During an initial kitchen tour on 8/25/2025 at 8:15 a.m. with Assistant Dietary Supervisor (Asst DS), observed in the walk-in refrigerator top shelf an aerosol can of whipped cream without a cover with the nozzle exposed. The Asst DS stated the aerosol can of whipped cream nozzle or tip did not have a cover and was exposed. The Asst DS stated the aerosol can of whipped cream should have been discarded as it could have possibly been contaminated. The Asst DS stated if used on the deserts for residents, it can cause foodborne illness. During a concurrent observation and interview on 8/25/2025 at 8:23 a.m., observed on another shelf in the walk-in refrigerator a metal container contained prepared food item and had no product name label and the preparation date. The Asst DSD stated the prepared items in the metal container were turkey and cheese sandwiches and will be served as nourishments for 8/25/2025 at 10 a.m. The Asst DSD stated it should have been labeled with the product name and preparation date to make sure staff were aware the sandwiches were not old and what kind of sandwiches they were serving the residents. During a concurrent observation and interview on 8/25/2025 at 8:30 a.m. inside the dry storage room with the Asst DS, observed 1 can of sliced apples with a dent on the side of the can remained at the bottom shelf with non-dented cans. The Asst DS stated he checks the cans daily and place the dented cans in a designated shelf in the kitchen area for return to the supplier. The Asst DS stated the can with dent should not be used as the seal was already compromised and placed the residents at risk for foodborne illnesses. During a concurrent observation and interview on 8/26/2025 at 10:45 a.m. inside the dishwashing room with the Dietary Assistant (DA), observed 6 plastic food containers were stacked wet. The DA stated the containers were stacked wet. The DA stated the containers should have been air dried as bacteria can grow in the containers and is not good for the residents when preparing food. During an interview on 8/28/2025 at 1:50 p. m. with the Dietary Supervisor (DS), the DS stated the aerosol canister of whipped cream without the cover should have been discarded as the tip or nozzle was already contaminated and can cause foodborne illnesses if served to the residents. The DS stated the container of prepared sandwiches should have been labeled with the product name and the preparation date so the staff would be aware of what they are serving the residents, which can cause allergic reactions in case of food allergies or even food dislikes. The DS stated food items should be labeled with preparation date to ensure the staff were aware the food they were serving were not old which can cause an upset stomach. The DS stated canned products are inspected every day for any dents and placed in a separate shelf for the dented cans to be returned to the supplier. The DS stated the dented cans cannot be used anymore as the seal was already compromised and can possibly cause food poisoning if used on the residents. The DS stated after dishwashing, the dishwasher was supposed to place all the clean dishes in the drying racks in the dish room to air dry and stacked when dried. The DS stated the dishwasher did not air dry the plastic food containers. The DS stated the dishwasher should have air-dried the plastic containers before stacking them together as bacteria can grow when stacked wet. The DS stated the residents can get sick as a potential outcome when food is prepared in the containers that were stacked wet. During a review of the facility's policy and procedure (P&P) titled, Labeling and Dating of Food, last reviewed on 5/30/2025, the P&P indicated all food item in the storeroom, refrigerator, and freezer need to be labeled and dated. The P&P further indicated all prepared foods need to be covered, labeled, and dated. Items can be dated individually or in bulk stored on a tray with masking tape if going to be used for meal service (such as salads, drinks, and other miscellaneous items for tray line. During a review of the facility's P&P titled, Sanitization, last reviewed on 5/30/2025, the P&P indicated the food service area is maintained in a clean and sanitary manner. The P&P further indicated food preparation equipment and utensils that are manually washed are allowed to air dry whenever practical. Drying food

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review the facility failed to ensure the facility's policy regarding use and storage of foods brought to residents by family and other visitors was followed for one of one sampled resident refrigerator by failing to ensure the facility's resident refrigerator was within acceptable temperature range per facility's policy and procedure for refrigerator at equal or less than (=/< - a unit of measurement) 41 degrees Fahrenheit (F, a scale for measuring temperature). This deficient practice had the potential to result in food-borne illnesses (food poisoning) of residents and can lead to other serious medical complications and hospitalization. Findings: During an interview on 8/27/2025 at 1 p.m. with the Dietary Assistant (DA), the DA stated the kitchen staff is not responsible for checking the residents` refrigerators for food brought from home or by visitors or family members. The DS stated the refrigerator for the residents is located in the orientation room and can be accessed by nursing staff. During a concurrent observation and interview on 8/28/2025 at 1:59 p.m., inside the orientation room with the Director of Staff Development (DSD), the DSD stated the refrigerator temperature indicated 56 degrees F and had 4 plastic bags of food items with the residents' names dated 8/28/2025. The DSD stated the refrigerator did not feel cold when it was opened and she (DSD) was unsure of the acceptable temperature requirement. The DSD stated the housekeeper is responsible for checking the refrigerator temperatures two times a day. The DSD stated the housekeeper checks for expired food items that have been stored for more than three (3) days as per facility policy, disposes of them and notifies the nursing staff. The DSD stated the maintenance department should be notified if there is a problem with the resident refrigerator. The DSD stated the abnormal temperature in the resident's refrigerator can spoil the food items inside and cause food borne illnesses in the residents. During an interview on 8/28/2025 at 2:15 p.m. with Registered Nurse (RN) 2, RN 2 stated refrigerator for the residents is located in the orientation room and nursing staff have access to it. RN 2 stated nursing staff must label the food items with the resident's name and date the item was received. Food must be discarded after three (3) days. Residents must be notified when a food item is beyond the allowed date and will be discarded, in order to prevent foodborne illnesses. RN 2 stated the housekeeping department was responsible in checking the refrigerator temperature and the expiration date every day. During an interview on 8/28/2025 at 2:36 p.m. with the Housekeeping Supervisor (HSKS), the HSKS stated the housekeeping department is responsible for cleaning and checking the refrigerator for the proper temperature and food items that were stored more than three (3) days. The housekeeper is also responsible in making sure the refrigerator was not overfilled with resident food items as it can increase the refrigerator temperature potentially spoiling the food which can cause foodborne illnesses in the residents. The HSKS stated she was made aware by the DSD that the temperature of the refrigerator was 56 degrees F during the inspection and there were four (4) plastic bags of food items belonging to the residents. The HSKS stated expired food and out of range refrigerator temperatures could cause food poisoning, upset stomach and other stomach issues as a potential outcome. The HSKS stated they needed to throw all the residents' food away and replace them as they could be spoiled already. The DS stated residents may become upset when their food is discarded. The HSKS stated if there is a problem with the refrigerator temperature the maintenance department should be notified. The HSKS the refrigerator temperature should be </= 41 degrees F at all times to keep the food safe. During an interview on 8/29/2025 at 12:30 p.m. with the Director of Nursing (DON), the DON stated the housekeeping department was responsible for checking the resident refrigerator temperature twice a day and the temperature should be at least =/< 41 degrees F at all times to keep the food safe. The housekeeper should notify the maintenance department if there is a problem with the residents' refrigerator to replace the refrigerator. The DON stated he was made aware that the residents' refrigerator was at 56 degrees F upon inspection and there were four (4) plastic bags of resident food items in the refrigerator which could have been affected by the abnormal temperature. The DON stated the food items inside the refrigerator with 56 degrees F temperature can be spoiled and placed the residents at risk for food borne illnesses when consumed. During a review of the facility's policy and procedure (P&P) titled, Refrigerator, Storage of From Outside Sources, last reviewed on 5/30/2025, the P&P indicated the facility will ensure that food brought into the facility by families, visitors, or staff for residents is safely stored, handled, and monitored in facility-designated refrigerators to reduce the risk of foodborne illness. The P&P further indicated: -The facility provided designated refrigerators for the storage of food items brought from outside sources for residents. These refrigerators will be maintained in a clean, sanitary, and temperature-controlled

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain an accurate and complete medical records for two of three sampled residents (Resident 197 and 14) reviewed for documentation by: 1.Failing to ensure Licensed Vocational Nurse 3 (LVN 3)'s code status documentation on Physician Orders for Life-Sustaining Treatment (POLST- a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) matches the Physicians Order on [DATE] for Resident 197. 2.Failing to ensure LVN 4 documented her observation and intervention when Resident 197 was unresponsive on [DATE]. 3.Failing to account for and document the events that happened to the resident when the Census indicated Resident 14 was on Hospital Leave (is the temporary status that keeps their spot open at the Skilled Nursing Facility [SNF]) on [DATE] and [DATE]. These failures resulted in medical records containing inaccurate documentation and had the potential to result in a lack of or a delay in communication between the staff and the potential to cause confusion in care and a delay in emergency response. Findings: a. During a review of Resident 197’s admission Record, the admission Record indicated the facility admitted Resident 197 on [DATE], with diagnoses including unspecified (unconfirmed) lumbar region (lower back) discitis (serious infection that causes the soft, cushion-like disc between your spinal bones to become inflamed), unspecified Alzheimer’s Disease (a disease characterized by a progressive decline in mental abilities) and legal blindness. During a review of Resident 197’s Physician Order, dated [DATE], the Physician Order indicated Do not attempt to resuscitate (DNR- a medical order written by a doctor to instruct health care providers NOT to do cardiopulmonary resuscitation [CPR-life-saving emergency procedure performed by an untrained person, or layperson, on someone who is unresponsive and not breathing due to a cardiac or respiratory arrest] if breathing stops or the heart stops beating), selective treatment, no artificial nutrition including feeding tubes (delivers liquid nutrition through a flexible tube that goes in through your nose or directly into your stomach). During a review of Resident 197’s POLST form, dated [DATE], the POLST indicated attempt resuscitation /CPR. During a review of Resident 197’s Minimum Data Set (MDS- a resident assessment tool), dated [DATE], the MDS indicated Resident 197’s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. During a concurrent interview and record review on [DATE], at 9:22 a.m., with Social Service Designee 1 (SS Designee 1), Resident 197’s POLST form and Physician Order dated [DATE] were reviewed. SS Designee 1 stated LVN 3 documented two different code statuses (your decision about whether you want doctors and nurses to perform emergency life-saving measures like CPR if your heart stops or stop breathing) for Resident 197. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE], at 10:15 a.m., with the Assistant Director of Nursing (ADON), the ADON stated if there are two different code statuses documented on the same day, the facility follows the POLST since it was signed by the physician on [DATE]. The ADON stated LVN 3 documented incorrectly. The ADON stated the importance of accurate code status was for accurate treatment and to provide CPR timely as needed. The ADON stated because of two code statuses documented in Resident 197’s medical record, it could cause confusion in the care that might result to a delay in CPR and cause death. During an interview on [DATE], at 2:22 p.m., with LVN 3, LVN 3 stated on [DATE], upon Resident 197 admission, Resident 197 wanted to be a full code (means that medical person would do everything possible to save your life in a medical emergency) and Family Member 1 agreed who was at the bedside. LVN 3 stated the POLST form was provided to Resident 197 for completion and Nurse Practitioner 2 (NP 2) came and signed the POLST form on [DATE]. LVN 3 stated she (LVN 3) had called Physician 1 for admission orders and Physician 1 ordered full code. LVN 3 stated she mistakenly documented DNR under physician’s order in the computer instead of full code. LVN 3 stated the importance of accurate code status in Resident 197’s medical record was for accurate care and treatment and prevent confusion in care. LVN 3 stated the possible effect to Resident 197 could be delay in CPR that could cause Resident 197’s death. During an interview on [DATE], at 7:43 a.m., with Registered Nurse 3 (RN 3), RN 3 stated LVN 3 should have documented code status accurately to prevent confusion in the care that could delay responding to emergency situation. RN 3 stated Resident 197 could die if not provided with life saving measures like cardiac compression (the act of manually and forcefully pushing on a person's chest as a part of CPR to circulate blood to the brain and vital organs when the heart has stopped or is not effectively beating). During concurrent interview and record review on [DATE], at 3:19 p.m., with the Director of Nursing (DON), the facility’s policy and procedure (P&P) titled, “Charting and Documentation,” dated 5/2024, and last reviewed on [DATE], was reviewed. The P&P indicated, “Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.” The DON stated LVN 3 should have confirmed the POLST form matches the Physician’s order. The DON stated there could be a possible delay in treatment and delay in CPR as a result. The DON stated the facility’s policy was to have complete and accurate documentation. During a review of facility’s P&P titled, “Physician Orders for Life-Sustaining Treatment (POLST),” dated 5/2024, and last reviewed on [DATE], the P&P indicated, “POLST does not replace the Advance Directive (a legal document indicating resident preference on end-of-life treatment decisions). When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts. POLST must be completed by a health care provider based on patient preferences and medical indications. To be valid a POLST form must be signed by (l) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy. Reviewing POLST It is recommended that POLST be reviewed periodically. Review is recommended when: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The patient is transferred from one care setting or care level to another, or -The is a substantial change in the patient's health status, or -The patient's treatment preferences change.” b. During a review of Resident 197 Progress Notes, dated [DATE], the Progress Notes indicated at 4:37 a.m. , Registered Nurse 3 (RN 3) was informed by Licensed Vocational Nurse 4 (LVN 4) that Resident 197 was unresponsive with no pulse and no respiration. The Progress Notes indicated LVN 4 started the cardiac compression while code blue was announced overhead. The Progress Notes indicated 911 was called at 4:39 a.m. and emergency medical service (EMS) arrived at 4:50 a.m. The Progress Note indicated CPR continued until 5:18 a.m. until Los Angeles County Officer Medic pronounced Resident 197 expired. During a concurrent interview and record review on [DATE] at 7:43 a.m., with RN 3, Resident 197 Progress Notes dated [DATE], was reviewed. RN 3 stated Resident 197 Progress Notes did not indicate LVN 4’s documentation. RN 3 stated on [DATE], he (RN 3) heard an overhead page (public announcement made over a loudspeaker system in a building) of a code blue (an alert for a patient experiencing cardiac or respiratory arrest, signaling a life-threatening emergency requiring immediate resuscitation efforts) at Resident 197’s room. RN 3 stated LVN 4 started the CPR while he (RN 3) assessed Resident 197. RN 3 stated when he responded to the code blue, Resident 197 was on oxygen, warm to touch, left arm flaccid (soft and limp) with no pulse and not breathing. RN 3 stated LVN 4 should have documented her (LVN 4) nurses notes because she (LVN 4) was the first staff who saw Resident 197’s status, and she (LVN 4) was the one who overhead paged the code blue. RN 3 stated they looked at the POLST form and determined Resident 197 was a full code the reason why they started the CPR. During an interview on [DATE], at 8:33 a.m., with LVN 4, LVN 4 stated Resident 197 used the call light (also called a nurse call button, is a simple tool for a resident in a hospital or nursing home to quickly get a staff member's attention) three times from 11 p.m., of [DATE], to 3 a.m. of [DATE], for coffee. LVN 4 stated Resident 197 was provided with coffee on the first two calls but on the third call at 3 a.m., she (LVN 4) notified Resident 197 to wait until the morning, and Resident 197 went back to sleep. LVN 4 stated at 4:30 a. m., she (LVN 4) was preparing medications when she (LVN 4) noticed Resident 197 was not breathing and with no pulse. LVN 4 stated she (LVN 4) went out and used the hallway phone to overhead page a code blue. LVN 4 stated RN 3 came and checked Resident 197, and she (LVN 4) started CPR. LVN 4 stated compressions were started after paging code blue. LVN 4 stated she (LVN 4) should have documented her (LVN 4) observation and intervention from the start of her shift at 11 p.m., until she (LVN 4) found Resident 197 unresponsive and what happened after. LVN 4 stated the importance of documentation was to show how staff found Resident 197 and what was done. LVN 4 stated if it was not documented it did not happen, and it was not done. During concurrent interview and record review on [DATE], at 3:19 p.m., with the DON, facility’s policy and procedure (P&P), titled, “Charting and Documentation” dated 5/2024, and last reviewed on [DATE], 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…. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The following information is to be documented in the resident medical record: a. Objective observations; b. Medications administered; c. Treatments or services performed; d. Changes in the resident's condition; e. Events, incidents or accidents involving the resident; and f. Progress toward or changes in the care plan’s goals and objectives. 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate…. 7. Documentation of procedures and treatments will include care-specific details, including: a. the date and time the procedure/treatment was provided; b. the name and title of the individual(s) who provided the care; c. the assessment data and/or any unusual findings obtained during the procedure/treatment; d. how the resident tolerated the procedure/treatment; e. whether the resident refused the procedure/treatment; f. notification of family, physician or other staff, if indicated; and g. the signature and title of the individual documenting.” The DON stated LVN 4 should have documented her (LVN 4) nurses notes to ensure Resident 197 was seen and was not declining the whole shift. The DON stated nurses should document what was found and what was done to show intervention was provided to prevent delay in care. The DON stated the facility’s policy was to have complete and accurate documentation. During an interview on [DATE], at 11:42 a.m., the DON stated the facility failed to ensure LVN 4 documented her observation and intervention when she (LVN 4) found Resident 197 unresponsive on [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. During a review of Resident 14’s admission Record, the admission Record indicated the facility admitted the resident on [DATE], and readmitted the resident on [DATE], with diagnoses including chronic kidney disease stage 4 (the kidneys are severely damaged and function at only 15-29% of normal capacity, leading to a significant buildup of waste products in the blood), dependence on renal dialysis (means that a person's kidneys have failed and they require regular, life-sustaining treatment with a dialysis machine or cleansing fluid to stay alive), and heart failure (a chronic condition where the heart is not able to pump enough blood to meet the body's needs). During a review of Resident 14’s History and Physical (H&P), dated [DATE], the H&P indicated the resident was alert and oriented times (X) 3 to 4 (means a person is fully awake and aware of who they are [person], where they are [place], and the current date and time [time]). During a review of Resident 14’s Census Tab in the electronic healthcare record (EHR), the Census indicated the resident was on hospital leave on the following dates [DATE] and [DATE]. During a review of Resident 14’s Physician's Progress Notes (PPN), dated [DATE], the PPN indicated Resident 14 was admitted to General Acute Care Hospital (GACH) 1 for fluid overload (is simply having too much fluid in your body) between [DATE] to [DATE]. During a concurrent interview and record review on [DATE], at 11:14 a.m., with the ADON, reviewed Resident 14’s Census Tab in EHR, PPN, Situation, Background, Assessment, and Recommendation (SBAR)-Change of Condition (COC) (is a structured communication framework that can help teams share information about the condition of a patient or team member or about another issue your team needs to address) and Progress Notes. The ADON stated there was no SBAR-COC done on [DATE] and [DATE]. The ADON stated there should have been a progress note indicating Resident 14 was transferred to GACH 1 for fluid overload between [DATE] to [DATE] from the hemodialysis (HD) center (is a special clinic where people with kidney failure go to have their blood cleaned by a machine) as documented by the physician on their progress note. The ADON stated it was important to document the resident's status especially if the resident's change of condition happened outside of the facility to ensure resident’s safety. During an interview on [DATE], at 3:20 p.m., with the DON, the DON stated the licensed staff who received the call from the HD center for Resident 14 should have created a progress note regarding the resident’s transfer to the hospital. The DON stated the licensed staff need to inform the physician and the family member about the change of condition of Resident 14. The DON stated it is important to make sure the insurance is not billed during the hospital leave and to ensure the doctor is aware of the resident’s change in condition to plan for resident’s care. The DON stated the family is informed to honor their right to be informed of medical treatment from the GACH 1. The DON stated if the HD Center did not inform the facility of the resident being transferred to GACH 1, the licensed staff in charge of the resident should call the HD Center and check on the resident’s status and make a progress note. During a review of the facility's recent P&P titled, Charting and Documentation, last reviewed on [DATE], the P&P indicated all services 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. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Interpretation and Implementation 1. Documentation in the medical record may be electronic, manual or a combination. 2. The following information is to be documented in the resident medical record: c. Treatments or services performed; d. Changes in the resident's condition; e. Events, incidents or accidents involving the resident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement infection control practices for three of 10 sampled residents (Residents 121, 26, and 12) by: 1. Failing to ensure Licensed Vocational Nurse (LVN) 11 wore personal protective equipment (PPE- gown, gloves, face shield), gown, while conducting a gastrostomy tube (G-tube-a medical device that delivers nutrition, fluids, and medications directly into the stomach through a small opening in the abdomen) assessment on Resident 121`s who was under Enhanced Barrier Precautions (EBP- an infection control intervention to reduce transmission of bacteria and other microorganisms that have developed resistance to antibiotics making infections hard to treat). 2.Failing to ensure Certified Nursing Assistant (CNA) 5 wore PPE, gown, while providing incontinence care (helping a person who cannot control their bladder or bowel movements) to Resident 26 who was on EBP. 3.Failing to ensure the laundry area was kept clean and sanitary. On 8/26/2025, three water bottle containers were observed inside the clean laundry room. 4.Failing to ensure the resident's BiPAP (bilevel positive airway pressure - breathing support device that delivers two different levels of air pressure: a higher pressure for breathing in and a lower pressure for breathing out)/CPAP (continuous positive airway pressure - a breathing machine designed to increase air pressure, keeping the airway open when the person breathes in) tubing was not touching the floor. These failures had the potential for cross contamination (unintentional transfer of bacteria or germs or other contaminant from one surface to another) and spread of infections and illnesses to residents, and staff. Findings: a. During a review of Resident 121’s admission Record, the admission Record indicated the facility initially admitted the Resident 121 on 1/28/2013, and readmitted on [DATE], with diagnoses including but not limited to dysphagia (a condition characterized by difficulty or inability to swallow), gastro-esophageal reflux disease (GERD-a condition where stomach contents flow back up into the esophagus, causing discomfort and irritation), and adult failure to thrive (a condition with significant unintentional weight loss, muscle wasting, and weakness). During a review of Resident 121’s History and Physical (H&P), dated 1/22/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 121’s Minimum Data Set (MDS, a resident assessment tool), dated 7/25/2025, the MDS indicated Resident 121 did not have the ability to make self-understood and understand others. The MDS indicated Resident 121’s cognition was severely impaired (significant decline in a resident’s mental abilities that profoundly impacts their daily life and independence) and family participated in the assessment and goal setting of healthcare management. During a review of Resident 121’s Order Summary Report, dated 4/30/2024, the Order Summary Report indicated an order for: [EBP] during high contact resident care activities (including but not limited to dressing, hygiene, brief changes, device care and wound care) secondary to G-tube. During a review of Resident 121’s care plan (CP), titled “Enhanced Barrier Precaution,” revised on 8/6/2025, the CP interventions included to utilize PPE during high contact resident care activities. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 8/25/2025, at 3:25 p.m., observed EBP sign and PPE supply cart with gown, mask and gloves outside the door of Resident 121. At the back of EBP sign indicated G-tube next to the room number of Resident 121. During a concurrent observation, and interview on 8/25/2025, at 3:30 p.m., with LVN 11, in the resident’s room, observed LVN 11 not wearing a PPE, gown, during assessment of Resident 121’s G-tube. LVN 11 stated he (LVN 11) did not wear a gown even though there was an EBP sign placed at the door for Resident 121’s G-tube device. LVN 11 stated that he (LVN 11) attended the in-service on EBP and it is a procedure for infection prevention. LVN 11 stated he (LVN 11) should have paid attention to the EBP sign and followed the EBP procedure. LVN 11 stated he (LVN 11) can potentially transmit infection to other residents. During an interview on 8/29/2025, at 11:55 a.m., with the Director of Nursing (DON), the DON stated all staff should adhere to the infection control policy and EBP is an infection control procedure. The DON stated residents on EBP is indicated at the back of EBP sign by the resident’s door and should have PPE available to staff. The DON stated EBP included wearing a gown for incontinent and G-tube care as defined by the facility’s policy and procedure (P&P). The DON stated LVN 11 should have worn a gown during G-tube care. The DON stated not following the EBP procedure can cause cross contamination. b.During a review of Resident 26’s admission Record, the admission Record indicated the facility initially admitted the resident on 9/12/2023, and readmitted on [DATE], with diagnoses including but not limited to muscle weakness, heart failure (a condition where the heart muscle cannot pump blood effectively enough to meet the body's needs) and deep tissue damage (injury to the skin and the layers of soft tissue underneath, such as muscle and fascia, often caused by prolonged pressure). During a review of Resident 26’s MDS, dated [DATE], the MDS indicated Resident 26 can make self-understood and understand others. The MDS indicated Resident 26’s cognition was intact (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 26, and family participated in the assessment and goal setting of healthcare management. During a review of Resident 26’s Order Summary Report, dated 4/1/2025, the Order Summary Report indicated an order for [EBP] during high contact resident care activities secondary to wound. During a review of Resident 26’s CP, titled “Enhanced Barrier Precaution,” revised on 4/1/2025, the CP indicted interventions included to utilize PPE during high contact resident care activities including but not limited to device care, brief changes and wound care. During an observation on 8/27/2025, at 8:11 a.m., observed EBP sign and PPE supply cart with gown, mask and gloves outside the door of Resident 26. At the back of EBP sign indicated wound next to the room number of Resident 26. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation, and interview on 8/27/2025, at 8:15 p.m., with CNA 5, in the resident’s room, observed CNA 5 not wearing a PPE, gown, during incontinence care of Resident 26. CNA 5 stated she (CNA 5) did not wear a gown when a brief change was done to Resident 26. CNA 5 stated she (CNA 5) should have checked the back of EBP sign to verify who is the resident requiring EBP. CNA 5 stated the sign indicated to stop and wear PPE. CNA 5 stated the use of appropriate PPE should have been done as indicated to maintain EBP. CNA 5 stated not wearing the gown could potentially cause cross contamination and spread of infection to other residents. During an interview on 8/28/2025, at 11:00 a.m., with LVN 12, LVN 12 stated Resident 26 was on EBP for wound. LVN 12 stated using the gown for PPE is indicated for residents in high contact care. LVN 12 stated that incontinence care is a high contact care and the gown as PPE should be used. During an interview on 8/29/2025, at 11:55 a.m., with the DON, The DON stated all staff should adhere to the infection control policy and EBP is an infection control procedure. The DON stated residents on EBP is indicated at the back of EBP sign by the resident’s door and should have PPE available to staff. The DON stated EBP included wearing a gown for incontinence care and G-tube care as defined at the P & P. The DON stated that CNA 5 should have worn a gown during incontinence care. The DON stated not following the EBP procedure can cause cross contamination and increase the risk of infection to other residents. During a review of the facility’s recent policy and procedure (P&P) titled “Infection Prevention and Control Program,” last reviewed on 5/30/2025. The P&P indicated: Policy Statement An infection prevention and control program (IPCP) are established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Policy Interpretation and Implementation 4.The IPCP provides a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement. Elements of the IPCP… 7.Prevention of Infection a. Important facets of infection prevention include: (7) Implementing appropriate enhanced barrier and transmission-based precautions when necessary; and (8) following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility’s P&P titled “Isolation - Initiating Transmission-Based Precautions,” reviewed on 5/30/2025. The P&P indicated: Policy Statement Transmission-based precautions are initiated when a resident is at risk of transmitting infection to other residents. Transmission-based precautions may include contact precautions, droplet precautions, or airborne precautions. Policy Interpretation and Implementation 3.When transmission-based precautions are implemented, the infection preventionist (or designee): e. ensures that protective equipment (i.e., gloves, gowns, masks, etc.) is maintained outside the resident's room so that anyone entering the room can apply the appropriate equipment. c. During a concurrent observation, and interview on 8/26/2025, at 7:46 a.m., with Laundry Staff 1 (LS 1), inside the clean laundry room. Observed a clear blue plastic container filled with clear liquid on top of the table beside the folded clean clothes. LS 1 stated the water container belongs to her (LS 1). LS 1 stated she (LS 1) was not sure if she (LS 1) was allowed to have the water bottle inside the clean laundry room. During a concurrent observation, and interview on 8/26/2025, at 7:47 a.m., with LS 2 inside the clean laundry room. Observed two reusable drinking containers on top of the hanging shelves. LS 2 stated both containers were empty. LS 2 stated staff breakroom had lockers and is located across the laundry room. During a concurrent observation, and interview on 8/26/2025, at 7:48 a.m. with the DON, inside the clean laundry room. The DON stated staff are not allowed to have personal items, food or drinks inside the clean laundry room to prevent cross contamination. During an interview on 8/28/2025, at 11:26 a.m., with Assistant Director of Nursing (ADON), ADON stated staff are not allowed to have food and personal belongings in the clean area to prevent cross contamination and spread of infection. During an interview on 8/28/2025, at 2:36 p.m., with the Housekeeping Supervisor (HSKS), the HSKS stated staff should place their food and personal belongings in the employee lounge just across the laundry area. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview, and record review on 8/28/2025, at 3:19 p.m., with the DON, facility’s P&P, titled, “Laundry Storage”, dated 5/2024, and last reviewed on 5/30/2025, the P&P indicated, “To prevent cross contamination, pest, fire hazards and obstruction of workflow and to ensure compliance with state and federal laws. Personal belongings: any non-facility property not actively being laundered (purses, backpacks, food/drinks, phones, coats, shoes, gifts, decorations, shopping bags, mobility devices, resident toiletries, medications, electronics). No personal items present in any laundry area (clean/soiled).” The DON stated the importance of separating clean clothes from personal belongings and food was to maintain sanitation and prevent cross contamination. The DON it is in the facility’s P&P to keep personal belongings out of the laundry area. During an interview on 8/29/2025, at 11:42 p.m., with the DON, the DON stated the facility failed to ensure the clean laundry room was free of drinks and personal belongings. d. During a review of Resident 12’s admission Record, the admission Record indicated the facility admitted the resident on 7/2/2025, with diagnoses including urinary tract infection (UTI- an infection in the bladder/urinary tract), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and generalized muscle weakness. During a review of Resident 12’s H&P dated 7/4/2025, the H&P indicated Resident 12 had the capacity to understand and make decisions. During a review of Resident 12’s MDS, dated [DATE], the MDS indicated Resident 12 had an intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand and make her needs known. The MDS indicated Resident 12 required set-up or clean-up assistance with eating; partial/moderate assistance with oral hygiene; substantial/maximal assistance with upper body dressing, and bed mobility; and total assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 12 received oxygen therapy. During a review of Resident 12’s Order Summary Report dated 8/29/2025, the Order Summary Report indicated a physician’s order dated 7/29/2025 to apply BiPAP with nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) at bedtime with oxygen at three (3) liters per minute. During a concurrent observation, and interview on 8/25/2025, at 11:42 a.m. inside Resident 12’s room, Resident 12 was lying in bed awake, alert and responds appropriately. Observed Resident 12’s BiPAP/CPAP machine placed on top of the bedside table with the corrugated tubing touching the floor. Resident 12 stated the staff assists her (Resident 12) in applying the BiPAP/ CPAP at bedtime and removes it in the morning upon waking up. During a concurrent observation, and interview on 8/25/2025, at 11:50 a.m., inside Resident 12’s room with LVN 2, LVN 2 stated Resident 12’s BiPAP/CPAP tubing was touching the floor. LVN 2 stated after using the BiPAP/CPAP, the nurses have to place tubing inside the bag to keep the tubing clean. LVN 2 stated Resident 12’s BiPAP/CPAP should have been placed inside the bag and not touching the floor as the resident is at risk for acquiring infection from the contaminated tubing as the floor was dirty. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/29/2025, at 12:30 p.m. with the DON, the DON stated the licensed nurses are supposed to place the BiPAP/CPAP tubing inside the plastic storage bag while not in use to keep the tubing clean and free from contamination. The DON stated the BiPAP/CPAP should not be touching the floor at any time of the day. The DON stated Resident 12’s BiPAP/CPAP tubing should have been placed inside the plastic storage bag by the nurses after use to prevent the tubing from touching the floor which contaminates the tubing and placed Resident 12 at risk for acquiring infection due to the contaminated tubing. During a review of the facility’s P&P titled, “Respiratory Therapy – Prevention of Infection,” last reviewed on 5/30/2025, the P&P indicated a purpose to guide prevention of infection associated with respiratory therapy tasks and equipment among residents and staff. The P&P further indicated to keep the oxygen cannula and tubing in a plastic bag when not in use. During a review of the facility’s P&P titled, “Infection Prevention and Control Program,” last reviewed on 5/30/2025, the P&P indicated an infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement policies for Infection Prevention and Control Program, and Antibiotic (medication used to treat infection) Stewardship (efforts in doctors' offices, hospitals, long-term care facilities, and other health care settings to ensure that antibiotics are used only when necessary and appropriate, means prescribing the right drug at the right dose at the right time for the right duration) Program for two of two sampled residents (Resident 106 and 202) reviewed under infection control facility task and five of five sampled residents (resident 93, 10, 12, 155, and 16) reviewed for antibiotic use by: 1.Failing to monitor Resident 106 for the adverse effects (an unintended, negative health outcome or unwanted event that occurs as a result of a treatment, medication, or exposure to a substance) of levofloxacin (an antibiotic medication used to treat infection) from 8/13/2025 to 8/17/2025 while Resident 106 was on antibiotic therapy. 2.Failing to monitor Resident 202 for the adverse effects of amoxicillin-potassium clavulanate (an antibiotic medication used to treat infection) from 8/19/2025 to 8/25/2025 while Resident 202 was on antibiotic therapy. 3.Failing to monitor Resident 93 for the adverse effects of Avycaz (an antibiotic medication used to treat infection). 4.Failing to monitor Resident 10 for the adverse effects of Amoxicillin (an antibiotic medication used to treat infection). 5.Failing to monitor Residents 12 and 155 for adverse effects of cefdinir (an antibiotic used to treat bacterial infections in the ear, sinus, throat, lungs, and skin) while receiving the medication. 6.Failing to screen Resident 16 for the appropriateness of the use of cephalexin (an antibiotic used to treat infection) for a presumptive (something is assumed to be true based on strong evidence or likelihood, but not yet fully confirmed) urinary tract infection (UTI - an infection in the bladder/urinary tract). 7.Failing to monitor Resident 16 for adverse effects of cephalexin. These failures had the potential to place Residents 106, 202, 93, 10, 12, 155, and 16 at increased risk for adverse effects, multidrug resistant organisms (MDRO) resistance (means that a germ, like a bacteria or fungus, has evolved to a point where multiple drugs that once killed it are no longer effective) to antibiotics. Cross-reference F882. Findings: a. During a review of Resident 106’s admission Record (AR), the AR indicated the facility admitted Resident 106 on 8/12/2025, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis weakness on one side of your body that can affect your arm, leg, or face) following cerebral infarction (a condition where blood flow to the brain is interrupted, leading to tissue damage and death), unspecified organism (unconfirmed) pneumonia (an infection/inflammation in the lungs) and generalized muscle weakness. During a review of Resident 106’s Minimum Data Set (MDS - a resident assessment tool), dated 8/19/2025, the MDS indicated Resident 106’s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 106 was on antibiotic. During a review of Resident 106’s Order Summary Report (OSR), dated 8/12/2025, the OSR indicated levofloxacin oral tablet 750 milligram (mg - metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth daily for pneumonia for five days. During a review of Resident 106’s Care Plan, dated 8/13/2025, on risk of complication (a secondary medical problem or condition that arises during or after a disease, procedure, or treatment) related to pneumonia, the Care Plan indicated an intervention to monitor response or side effects and notify physicians if abnormal. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 106’s Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 8/2025, the MAR indicated Resident 106 received a levofloxacin tablet daily from 8/13/2025 to 8/17/2025 at 9 a.m. During a concurrent interview and record review on 8/26/2025 at 8:38 a.m. with Infection Preventionist (IP) 2, Resident 106’s MAR, dated 8/2025, and Progress Notes, dated 8/13/2025 to 8/17/2025, were reviewed. IP 2 stated there was no documented monitoring for levofloxacin adverse/side effects for five days from 8/13/2025 to 8/17/2025 on Resident 106’s MAR and Progress Notes. b. During a review of Resident 202’s AR, the AR indicated the facility admitted Resident 202 on 8/18/2025, with diagnoses including acute pulmonary edema (fluid in the lungs), unspecified organism pneumonia, and shortness of breath. During a review of Resident 202’s History and Physical (H&P - a medical examination that involves a doctor taking a resident’s medical history, performing a physical exam, and documenting their findings), dated 8/19/2025, the H&P indicated Resident 202 had the capacity to understand and make decisions. During a review of Resident 202’s OSR, dated 8/18/2025, the OSR indicated amoxicillin-potassium clavulanate tablet 875-125 mg, give one tablet by mouth every 12 hours for pneumonia for seven days. During a review of Resident 202’s MAR dated 8/2025, the MAR indicated Resident 202 received amoxicillin-potassium clavulanate for seven days twice a day from 8/19/2025 to 8/25/2025. During a concurrent interview and record review on 8/26/2025 at 8:38 a.m. with IP 2, Resident 202’s Care Plan, dated 8/19/2025, on antibiotic therapy and Progress Notes, dated 8/19/2025 to 8/15/2025, was reviewed. The Care plan indicated an intervention to observe possible side effects every shift and monitor every shift for adverse reactions. IP 2 stated the nurses know that they need to document the monitoring of antibiotics in Resident 202’s Progress Notes. IP 2 stated there was no documented monitoring from 8/19/2025 to 8/25/2025. IP 2 stated the nurses failed to monitor and document for side effects of adverse reaction. During an interview on 8/27/2025 at 6:47 a.m. with Registered Nurse (RN) 3, RN 3 stated residents on antibiotics medication need to be monitored for side effects or adverse effects every shift and should be documented in residents’ Progress Notes under health status. RN 3 stated nurses need to document what the antibiotic was, if the resident was tolerating the medication, specify what is being monitored and if there was any reaction. RN 3 stated if Residents 106 and 202 were not monitored for antibiotic side effects, Residents 106 and 202 could develop an allergic reaction. During an interview on 8/27/2025 at 11:26 a.m. with the Assistant Director of Nursing (ADON), the ADON stated residents on antibiotics are monitored for adverse effects for the duration of antibiotics until 72 hours after the dose to make sure there was no late reaction. The ADON stated if residents are not monitored, residents could develop an adverse effect, delay in identifying change in condition, delay in physician notification. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/28/2025 at 3:19 p.m. with the Director of Nursing (DON), the facility’s policy and procedure (P&P) titled, “Adverse Consequences and Medication Errors”, dated 5/2024 and last reviewed on 5/30/2025, the P&P indicated, “The interdisciplinary team monitors medication usage to prevent and detect medication-related problems such as adverse drug reactions (ADRs) and side effects…. 3. Residents receiving medication are monitored for adverse consequences…. When a resident receives a new medication order, review: a. dose, route of administration, duration, and monitoring are consistent with current clinical practice, clinical guidelines, and/or manufacturer's specifications for use.” The DON stated nurses should monitor Resident 106 and Resident 202 for antibiotic adverse and side effects from the initial antibiotic administration for 72 hours after completion of the medication. The DON stated the importance of monitoring was to catch if there will be any adverse effects and notify the physician. The DON stated the potential effects if Residents 106 and 202 were not monitored for antibiotic adverse and side effects, there could be a delay in care and treatment. The DON stated it is the facility’s policy to monitor residents on antibiotics for adverse/side effects. During an interview on 8/29/2025 at 11:42 a.m. with the DON, the DON stated the facility failed to monitor Residents 106 and Resident 202 for antibiotic adverse/side effects. During a review of facility’s P&P titled, “Infection Prevention and Control Program”, dated 5/2024 and last reviewed on 5/20/2025, the P&P indicated, “An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections…. 4. Antibiotic Stewardship a. Culture reports (a medical laboratory report detailing the presence or absence of microorganisms), sensitivity data, and antibiotic usage reviews are included in surveillance activities. b. Medical criteria and standardized definitions of infections are used to help recognize and manage infections. c. Antibiotic usage is evaluated, and practitioners are provided feedback on reviews.” During a review of facility’s P&P titled, “Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcomes”, dated 5/2024 and last reviewed on 5/30/2025, the P&P indicated, “Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for the improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship…. 4. All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include: a. resident name and medical record number; (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. unit and room number; c. date symptoms appeared; d. name of antibiotic; e. start date of antibiotic; f. pathogen (bacterium, virus, or other microorganism that can cause disease) identified; g. site of infection; h. date of culture; i. stop date; j. total days of therapy; k. outcome; and l. adverse events.” During a review of facility’s P&P titled, “Antibiotic Stewardship”, dated 12/2016 and last reviewed on 5/30/2025, the P&P indicated, “Antibiotics will be prescribed and administered to residents under the guidance of the facility’s Antibiotic Stewardship Program. The purpose of our Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents.” c. During a review of Resident 93’s AR, the AR indicated the facility admitted the resident on 6/10/2025, and readmitted the resident on 8/6/2025, with diagnoses including extended spectrum beta lactamase (ESBL) resistance (means that some bacteria have evolved a special defense mechanism against certain common antibiotics, making those medications useless), klebsiella pneumoniae (is a severe lung infection caused by a type of bacteria called Klebsiella pneumoniae), and severe septic shock (a life-threatening condition where an infection triggers a dangerously low blood pressure and organ failure because the body's response to the infection starts to damage its own tissues and organs). During a review of Resident 93’s H&P, dated 8/9/2025, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 93’s MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (means a major and debilitating loss of thinking skills). The MDS indicated the resident was on a high-risk drug class intravenous (IV, within a vein) antibiotic medication. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 93’s OSR, dated 8/8/2025, the OSR indicated an order for Avycaz Intravenous Solution Reconstituted 2.5 (2-0.5) grams (gm, a unit of weight) (Ceftazidime-Avibactam Sodium). Use 2.5 gram intravenously every 8 hours for ESBL urine until 8/12/2025 11:59 p.m. During a review of Resident 93’s Care Plan (CP) Report regarding the resident being at risk for complications and side effects of antibiotic use, last revised on 8/16/2025, the CP indicated an intervention to monitor for side effects of antibiotic therapy (i.e. diarrhea, nausea, vomiting, gastrointestinal (GI - usually refers to your digestive system (gastrointestinal system), which includes the path food travels through your body—your mouth, esophagus, stomach, intestines, and rectum—to get broken down and absorbed for energy) distress, rash, fever, symptoms of secondary infection) and notify physician if observed. During a concurrent interview and record review on 8/27/2025 at 1:31 p.m. with the ADON, Resident 93’s OSR, Progress Notes, and CP were reviewed. The ADON stated there was an order for Avycaz Intravenous Solution Reconstituted 2.5 (2-0.5) gm (Ceftazidime-Avibactam Sodium). The ADON stated there was no monitoring for the adverse effect of the use of the antibiotic (Avycaz). The ADON stated the staff documents the monitoring for adverse effect on the use of antibiotics in the Progress Notes every shift. The ADON stated there was no documentation of monitoring for adverse effect on the use of Avycaz for fifteen (15) shifts. The ADON stated the failure of the staff to monitor for adverse effects of the use of the antibiotic had predisposed the resident to the adverse effects of the medication and potential antibiotic resistance. During an interview on 8/28/2025 at 3:20 p.m. with the DON, the DON stated the licensed staff should have monitored for the adverse effect on the use of Avycaz on Resident 93 to ensure its safe use. The DON stated the licensed staff should have monitored for its adverse effects so they can report to the physician right away and intervene. The DON stated the failure of the staff to monitor for the adverse effects on the use of antibiotics had the potential for delay of care and services to the resident. The DON stated it should be on the Progress Notes every shift and if it is not documented, it is not done. During a review of the facility’s recent P&P titled “Antibiotic Stewardship- Review and Surveillance of Antibiotic Use and Outcomes,” last reviewed on 5/30/2025, the P&P indicated antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. Policy Interpretation and Implementation 3. All Resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include: c. date symptoms appeared; l. adverse events. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility-provided Highlights of Prescribing Information on the use of Avycaz (ceftazidime and avibactam) for injection, for intravenous use, with initial U.S. approval in 2015, the Highlights of Prescribing Information indicated a warning and precautions: -Hypersensitivity reactions: Includes anaphylaxis and serious skin reactions. Cross-hypersensitivity may occur in patients with a history of penicillin allergy. If an allergic reaction occurs, discontinue Avycaz. -Clostridium difficile (a type of bacteria) associated diarrhea (CDAD): CDAD has been reported with nearly all systemic antibacterial agents, including Avycaz. Evaluate if diarrhea occurs. -Central Nervous System Reactions: Seizures and other neurologic events may occur, especially in patients with renal impairment. Adjust dose in patients with renal impairment. d. During a review of Resident 10’s AR, the AR indicated the facility admitted the resident on 8/7/2025, with diagnoses including cerebral infarction, dysphagia (difficulty swallowing), and lobar pneumonia (a severe lung infection where one or more of the lung's lobes (sections) become completely filled with fluid and pus, making it difficult to breathe). During a review of Resident 10’s H&P, dated 8/9/2025, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 10’s MDS, dated [DATE], the MDS indicated the resident usually had the ability to make self-understood and understand others and had mild cognitive impairment (a decline in thinking or memory that is greater than expected for a person's age but does not interfere with daily life, such as managing money or household tasks). The MDS indicated the resident was on a high-risk drug class antibiotic medication. During a review of Resident 10’s OSR, dated 8/8/2025, the OSR indicated an order for Amoxicillin-Pot Clavulanate Tablet 875-125 mg. Give one tablet via gastrostomy tube (g-tube - a feeding tube that goes directly into the stomach through a small hole in the belly) every 12 hours for pneumonia until 8/14/2025 11:59 p.m. During a concurrent interview and record review on 8/27/2025 at 1:31 p.m. with the ADON, Resident 10’s OSR, Progress Notes, and CP were reviewed. The ADON stated there was an order for Amoxicillin-Pot Clavulanate Tablet 875-125 mg. Give one tablet via g-tube every 12 hours for pneumonia until 8/14/2025 23:59. The ADON stated there was no monitoring for adverse effect of the use of the antibiotic (Amoxicillin). The ADON stated the staff documents the monitoring for adverse effect on the use of antibiotics in the Progress Notes every shift. The ADON stated there was no documentation of monitoring for adverse effect on the use of Amoxicillin for nine (9) shifts. The ADON stated the failure of the staff of not monitoring for adverse effects had predisposed the resident to the adverse effects of the medication and potential antibiotic resistance. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/28/2025 at 3:20 p.m. with the DON, the DON stated the licensed staff should have monitored for the adverse effect on the use of Amoxicillin on Resident 10 to ensure its safe use. The DON stated the licensed staff should have monitored for its adverse effects so they can report to the physician right away and intervene. The DON stated the failure of the staff on monitoring the adverse effects on the use of antibiotics had the potential for delay of care and services to the resident. The DON stated it should be on the Progress Notes every shift and if it is not documented, it is not done. During a review of the facility’s recent P&P titled “Antibiotic Stewardship- Review and Surveillance of Antibiotic Use and Outcomes,” last reviewed on 5/30/2025, the P&P indicated antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. Policy Interpretation and Implementation 3. All Resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include: c. date symptoms appeared; l. adverse events. During a review of the facility-provided Highlights of Prescribing Information on the use of Amoxil (amoxicillin) capsules, tablets, or powder for oral suspension, with initial U.S. approval in 1974, the Highlights of Prescribing Information indicated a warning and precautions: -Anaphylactic reactions: Serious and occasionally fatal anaphylactic reactions have been reported in patients on penicillin therapy. Serious anaphylactic reactions require immediate emergency treatment with supportive measures. -Clostridium difficile-associated diarrhea (ranging from mild diarrhea to fatal colitis): Evaluate if diarrhea occurs. e. During a review of Resident 12’s AR, the AR indicated the facility admitted the resident on 7/2/2025 with diagnoses including UTI, chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), and generalized muscle weakness. During a review of Resident 12’s H&P, dated 7/4/2025, the H&P indicated Resident 12 had the capacity to understand and make decisions. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 12’s MDS, dated [DATE], the MDS indicated Resident 12 had an intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand and make her needs known. The MDS further indicated Resident 12 required set-up or clean-up assistance with eating; partial/moderate assistance with oral hygiene; substantial/maximal assistance with upper body dressing, and bed mobility; and total assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 12’s OSR, dated 8/29/2025, the OSR indicated a physician’s order dated 7/2/2025 for cefdinir oral capsule 300 mg give one capsule by mouth every 12 hours for UTI for five (5) days. During a concurrent interview and record review on 8/28/2025 at 11:52 a.m., with Quality Assurance Nurse (QAN) 1, Resident 12’s Order Summary Report, care plans, and nurses notes were reviewed. QAN 1 stated Resident 12 had a physician’s order of cefdinir dated 7/2/2025 for UTI upon admission from the hospital. QAN 1 stated there was no documentation in the nurses’ notes for monitoring of adverse side effects for the use of cefdinir. QAN 1 stated Charge Nurses (CN) were supposed to indicate in their shift charting that the resident is being monitored for any adverse reactions for the duration of the antibiotic therapy plus another three (3) days after completion. QAN 1 stated the CN should have monitored Resident 12 for any adverse reactions while receiving cefdinir and 3 days after completion to ensure the effectiveness of the medication, that Resident 12 tolerated the use of antibiotic, and notify the physician if not tolerating the antibiotic which may lead to a delay in receiving the appropriate care Resident 12 needed. During an interview on 8/29/2025 at 12:30 p.m. with the DON, the DON stated the nurses are supposed to monitor the residents for adverse effects of the antibiotic during the duration of therapy and after 72 hours of completion to ensure the resident was treated properly for infection and observe for any delayed adverse effects during and after completion of the antibiotic therapy. The DON stated the facility policy indicated the monitor the residents for any adverse effects from the use of antibiotics every shift and should be documented in the progress notes or nurses’ notes. The DON stated the licensed nurses failed to monitor Resident 12 for any adverse effects while receiving the cefdinir and 72 hours after which may lead to a delay in the care and treatment the resident needed. During a review of the facility’s P&P titled, “Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes,” last reviewed on 5/30/2025, the P&P indicated antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The P&P further indicated: -The data will be used to guide decisions for the improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. -All Resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include: c. date symptoms appeared l. adverse events (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. During a review of Resident 155’s AR, AR indicated the facility originally admitted Resident 155 on 10/21/2023 and readmitted in the facility on 6/4/2025 with diagnoses including UTI, dementia (a progressive state of decline in mental abilities), and generalized muscle weakness. During a review of Resident 155’s H&P dated 6/7/2025, the H&P indicated Resident 155 had the capacity to understand and make decisions. During a review of Resident 155’s MDS, dated [DATE], the MDS indicated Resident 155 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and was able to understand and make her needs known. The MDS further indicated Resident 155 required supervision or touching assistance with eating; partial/moderate assistance with upper body dressing; substantial/maximal assistance with oral hygiene; and total assistance from staff with all other ADLs. The MDS indicated Resident 12 had UTI in the last 30 days and received antibiotic therapy prior to admission and while in the facility. During a review of Resident 115’s Order Summary Report, dated 8/29/2025, the Order Summary Report indicated a physician’s order dated 6/4/2025 for cefdinir oral capsule 300 mg give one capsule by mouth every 12 hours for UTI for five (5) days. During a concurrent interview and record review on 8/29/2025 at 8:52 a.m., with IP 2/QAN 2, Resident 155’s OSR, care plans, and nurses notes were reviewed. IP 2/QAN 2 stated Resident 155 had a physician’s order of cefdinir dated 6/4/2025 for UTI upon readmission from the hospital. IP 2/QAN 2 stated there was no documentation in the nurses’ notes for monitoring adverse side effects for the use of cefdinir except on 6/6/2025 3 p.m. to 11 p.m. shift and 6/10/2025 11 p.m. to 7 a.m. shift. IP 2/QAN 2 stated Charge Nurses (CN) were supposed to indicate in their shift charting that the resident is being monitored for any adverse reactions for the duration of the antibiotic therapy plus another 72 hours after completion. IP 2/QAN 2 stated the CN should have monitored Resident 155 for any adverse reactions from 6/4/2025 to 6/12/2025 to ensure the effectiveness of the medication, that Resident 155 tolerated the use of antibiotic, and notify the physician if not tolerating the antibiotic which may lead to a delay in receiving the appropriate care Resident 155 needed. During an interview on 8/29/2025 at 12:30 p.m. with the DON, the DON stated the nurses are supposed to monitor the residents for adverse effects of the antibiotic during the duration of therapy and after 72 hours of completion to ensure the resident was treated properly for infection and observe for any delayed adverse effects during and after completion of the antibiotic therapy. The DON stated the facility policy indicated the monitor the residents for any adverse effects from the use of antibiotics every shift and should be documented in the progress notes or nurses’ notes. The DON stated the licensed nurses failed to monitor Resident 155 for any adverse effects while receiving the cefdinir and 72 hours after which may lead to a delay in the care and treatment the resident needed. During a review of the facility’s P&P titled, “Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes,” last reviewed on 5/30/2025, the P&P indicated antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The P&P further indicated: (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The data will be used to guide decisions for the improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. -All Resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include: c. date symptoms appeared l. adverse events g. During a review of Resident 16’s AR, the AR indicated the facility originally admitted Resident 16 on 11/19/2018 and readmitted in the facility on 7/11/2024 with diagn[TRUNCATED]

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and record review, the facility failed to ensure the Infection Preventionist (IP) performed the duties of the position by failing to implement the antibiotic (medication used to treat infection) stewardship program (efforts in doctors' offices, hospitals, long-term care facilities, and other health care settings to ensure that antibiotics are used only when necessary and appropriate, means prescribing the right drug at the right dose at the right time for the right duration) and the infection prevention and control program for three of five sampled residents (Residents 10, 106 and 202) by: 1.Failing to ensure Residents 106 and 202 were monitored for antibiotic adverse effects (undesired or harmful effects). 2.Failing to ensure Resident 106 was vaccinated for Coronavirus Disease 2019 (COVID-19, an infectious disease that most people infected with the virus will experience mild to moderate respiratory illness and recover without requiring special treatment) and pneumonia (an infection/inflammation in the lungs) after Responsible Party 1 (RP 1) consented (gave permission) on 8/12/2025. 3.Failing to ensure Resident 202 was vaccinated for pneumonia after resident consented on 8/18/2025. 4.Failing to complete Infection Surveillance Monthly Report log for three residents (Residents 10, 106 and 202). These failures had the potential to increase antibiotic resistance (don't respond to a drug) from unnecessary or inappropriate antibiotic use, had the potential for Residents 106 and 202 to experience an adverse reaction and can be infected with COVID-19 and pneumonia. Cross-reference F881, F883, and F887 Findings: a.During a review of Resident 106's admission Record, the admission Record indicated the facility admitted Resident 106 on 8/12/2025, with diagnoses including hemiplegia (total paralysis [unable to move or feel] of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of your body that can affect your arm, leg, or face) following cerebral infarction (a condition where blood flow to the brain is interrupted, leading to tissue damage and death), unspecified organism (unconfirmed) pneumonia (an infection/inflammation in the lungs) and generalized muscle weakness. During a review of Resident 106's Order Summary Report, dated 8/12/2025, the Order Summary Report indicated Resident 106 was ordered levofloxacin (medication used to treat infection) oral tablet 750 milligram (mg-metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth daily for pneumonia for five days. During a review of Resident 106's Minimum Data Set (MDS - a resident assessment tool), dated 8/19/2025, the MDS indicated Resident 106's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 106 was on antibiotic. During a review of Resident 106's Care Plan, dated 8/13/2025, on risk of complication (a secondary medical problem or condition that arises during or after a disease, procedure, or treatment) related to pneumonia, the Care Plan indicated an intervention to monitor response or side effects and notify physicians if abnormal. During a review of Resident 106's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 8/2025, the MAR indicated Resident 106 received a levofloxacin tablet daily from 8/13/2025 to 8/17/2025 at 9 a.m. During a concurrent interview and record review on 8/26/2025 at 8:38 a.m. with IP 2, Resident 106's MAR, dated 8/2025, and Progress Notes, dated 8/13/2025 to 8/17/2025, were reviewed. IP 2 stated there was no documented monitoring for levofloxacin adverse/side effects (undesirable effect of a drug) for five days from 8/13/2025 to 8/17/2025 on Resident 106's MAR and Progress Notes. During a review of Resident 202's admission Record, the admission Record indicated the facility admitted Resident 202 on 8/18/2025, with diagnoses including acute pulmonary edema (fluid in the lungs), unspecified organism pneumonia and shortness of breath. During a review of Resident 202's History and Physical (H&P - a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 8/19/2025, the H&P indicated Resident 202 had the capacity to understand and make decisions. During a review of Resident 202's Order Summary Report, dated 8/18/2025, the Order Summary Report indicated amoxicillin-potassium clavulanate (medication used to treat infection) tablet 875-125 mg, give one tablet by mouth every 12 hours for pneumonia for seven days. During a review of Resident 202's MAR, dated 8/2025, the MAR indicated Resident 202 received amoxicillin-potassium clavulanate for seven days twice a day from 8/19/2025 to 8/25/2025. During a concurrent interview and record review on 8/26/2025 at 8:38 a.m. with IP 2, Resident 202's Care Plan, dated 8/19/2025, on antibiotic therapy and Progress Notes, dated 8/19/2025 to 8/15/2025, were reviewed. The Care plan indicated an intervention to observe possible side effects every shift and monitor every shift for adverse reactions. IP 2 stated there was no documented monitoring from

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to administer the pneumococcal vaccine (helps protect children and adults from various types of pneumococcal bacteria causing lung infection) to two of five sampled residents (Residents 106 and 202) after the two residents had provided their consent to receiving the vaccine and the physician ordered the vaccine administration. These failures placed Resident 106 and Resident 202 at a higher risk of acquiring and transmitting pneumonia (an infection/inflammation in the lungs) to other residents in the facility. Findings: 1.During a review of Resident 106's admission Record, the admission Record indicated the facility admitted Resident 106 on 8/12/2025, with diagnoses including hemiplegia (total paralysis [unable to move or feel] of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of your body that can affect your arm, leg, or face) following cerebral infarction (a condition where blood flow to the brain is interrupted, leading to tissue damage and death), unspecified organism (unconfirmed) pneumonia and generalized muscle weakness. During a review of Resident 106's Minimum Data Set (MDS - a resident assessment tool), dated 8/19/2025, the MDS indicated Resident 106's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. During a review of Resident 106's Physician Order, dated 8/12/2025, the Physician Order indicated give pneumonia vaccine 0.5 cubic centimeter (cc-unit of measurement) intramuscular (IM- injection or administration of medication directly into a muscle tissue) every five years, if not contraindicated (a specific reason a resident should not receive a particular treatment or medication because it could cause harm). During a review of Resident 106's Informed Consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered)-Immunization (the process of becoming protected from an infectious disease, usually through vaccination), dated 8/12/2025, the Informed Consent-Immunization form indicated Responsible Party (RP) 1 consented (gave permission) for Resident 106 to receive pneumonia vaccine on 8/12/2025, at 10:40 p.m. During a review of Resident 106's Immunization Report (a record of vaccinations an individual has received), dated between 8/1/2025 to 8/31/2025, the Immunization Report indicated Resident 106 pneumonia vaccine immunization was pending. During an interview on 8/26/2025 at 11:22 a.m. with Infection Preventionist (IP) 2, IP 2 stated Resident 106 was screened and was found to be eligible to receive pneumonia vaccine on 8/12/2025. IP 2 stated Resident 106's RP gave consent for Resident 106 to receive the pneumonia vaccine on 8/12/2025. IP 2 stated the pneumonia vaccine should have been given since the physician ordered the vaccine. IP 2 stated Resident 106 could have pneumonia if he (Resident 106) was not vaccinated. 2.During a review of Resident 202's admission Record, the admission Record indicated the facility admitted Resident 202 on 8/18/2025, with diagnoses including acute pulmonary edema (fluid in the lungs), unspecified organism pneumonia and shortness of breath. During a review of Resident 202's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 8/19/2025, the H&P indicated Resident 202 had the capacity to understand and make decisions. During a review of Resident 202's Physician Order, dated 8/18/2025, the Physician Order indicated give pneumonia vaccine 0.5 cc, IM every five years, if not contraindicated. During a review of Resident 202's Informed Consent-Immunization, dated 8/18/2025, the Informed Consent-Immunization indicated Resident 202 consented to receiving pneumonia vaccine on 8/12/2025 at 4:00 p.m. During a review of Resident 202's Immunization Report, dated 8/1/2025 to 8/31/2025, the Immunization Report indicated Resident 202 had a pending pneumonia vaccine immunization. During an interview on 8/26/2025 at 11:22 a.m. with IP 2, IP 2 stated Resident 202 was screened and was found to be eligible to receive pneumonia vaccine on 8/18/2025. IP 2 stated Resident 202 gave consent to receive the pneumonia vaccine on 8/18/2025. During an interview on 8/27/2025 at 6:47 a.m. with Registered Nurse (RN) 3, RN 3 stated after obtaining the informed consent for the vaccine, the nurses call and get an order from the physician for the vaccine administration and then fax the order to the pharmacy. RN 3 stated the vaccine is administered once it's delivered. RN 3 stated the IP keeps track of the admission and the immunization record. RN 3 stated getting the pneumonia vaccine could potentially prevent the pneumonia and if not received residents could get the pneumonia infection. During an interview on 8/27/2025 at 11:26 a.m. with the Assistant Director of Nursing (ADON), the ADON stated the IP and Medical Records missed the pneumonia vaccine of Resident 106 and 202.The ADON stated Resident 106 and 202 could not be protected from pneumonia infection and can get infected if not vaccinated. During a concurrent interview and record

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to administer Coronavirus Disease 2019 (COVID-19 - an infectious disease that most people infected with the virus will experience mild to moderate respiratory illness and recover without requiring special treatment) vaccine to one of five sampled residents (Resident 106) after the residents had provided their consent to receiving the vaccine. This failure placed Residents 106 at a higher risk of acquiring and transmitting COVID-19 to other residents and staff in the facility. Findings: During a review of Resident 106's admission Record, the admission Record indicated the facility admitted Resident 106 on 8/12/2025, with diagnoses including hemiplegia (total paralysis [inability to move or feel] of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of your body that can affect your arm, leg, or face) following cerebral infarction (a condition where blood flow to the brain is interrupted, leading to tissue damage and death), unspecified organism (unconfirmed) pneumonia (an infection/inflammation in the lungs) and generalized muscle weakness. During a review of Resident 106's Informed Consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered)-Immunization (the process of becoming protected from an infectious disease, usually through vaccination), dated 8/12/2025, the Informed Consent-Immunization form indicated Responsible Party (RP) 1 consented (gave permission) for Resident 106 to receive COVID-19 vaccine on 8/12/2025, at 10:40 p.m. During a review of Resident 106's Minimum Data Set (MDS - a resident assessment tool), dated 8/19/2025, the MDS indicated Resident 106's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. During a review of Resident 106's Immunization Report (a record of vaccinations an individual has received), dated between 8/1/2025 to 8/31/2025, the Immunization Report indicated Resident 106 had a pending COVID-19 vaccine immunization. During an interview on 8/26/2025, at 11:22 a.m., with Infection Preventionist (IP) 2, IP 2 stated Resident 106 was screened and found to be eligible to receive COVID-19 vaccine on 8/12/2025. IP 2 stated Resident 106's RP gave consent for Resident 106 to receive the COVID-19 vaccine on 8/12/2025. IP 2 stated the COVID-19 vaccine should have been given. IP 2 stated Resident 106 could have COVID-19 if he (Resident 106) was not vaccinated. During an interview on 8/27/2025 at 6:47 a.m. with Registered Nurse (RN) 3, RN 3 stated after obtaining the informed consent for the vaccine, the nurses call and get an order from the physician for the vaccine administration and then fax the order to the pharmacy. RN 3 stated the vaccine is administered once it's delivered. RN 3 stated the IP keeps track of the admission and the immunization record. RN 3 stated getting the COVID-19 vaccine could potentially prevent the COVID-19 and if not received residents could get the COVID-19 infection. During an interview on 8/27/2025 at 11:26 a.m. with the Assistant Director of Nursing (ADON), the ADON stated the IP and Medical Records missed Resident 106's COVID-19 vaccine administration. The ADON stated Resident 106 could not be protected from COVID-19 infection and can get infected if not vaccinated. During a concurrent interview and record review on 8/28/2025 at 3:19 p.m. with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Coronavirus Disease (COVID-19)-Vaccination of Residents, dated 5/2024 and last reviewed on 5/30/2025, the P&P indicated, Each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident is fully vaccinated. 1. Residents who are eligible to receive the COVID-19 vaccine are strongly encouraged to do so. 2. The resident (or resident representative) can accept or refuse a COVID-19 vaccine and can change his/her decision. 4. The COVID-19 vaccine may be offered and provided directly by the long-term care (LTC) facility or indirectly, such as through an arrangement with a pharmacy partner, local health department, or other appropriate health entity. 19. If a resident requests vaccination, but missed earlier opportunities for any reason, the vaccine will be offered to that resident as soon as possible. Efforts to help the resident obtain vaccination are documented. Documentation and Reporting: . 2. If the resident did not receive the COVID-19 vaccine due to medical contraindications, prior vaccination, or refusal, appropriate documentation is made in the resident's record. The DON stated staff should have followed up with the physician to get an order for the COVID-19 vaccine and notify the pharmacy and administer the COVID-19 vaccine as soon as it is delivered. The DON stated COVID-19 vaccine protects the resident from contracting COVID-19 disease. The DON stated it is the facility's policy to administer the vaccine after the resident gave the consent and physician ordered the medication. During an interview on 8/29/2025 at 11:42 a.m.,with the DON, the DON stated the facility failed to administer the COVID-19 vaccine to Resident 106 when his (Resident 106)'s RP consented for the