STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555515	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Vista at Morningside	2525 Brea Blvd. Fullerton, CA 92835

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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 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 interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain the infection control practices to help prevent the development and transmission of diseases and infection. * The facility failed to maintain an accurate infection control surveillance log and match the data in the QA infection control for June, July, September, and October 2025. * The facility failed to ensure the infection control practices were implemented in the facility's laundry room. * The facility failed to ensure the EBPs were followed for Resident 55 when the RNA 1 did not wear the appropriate personal protective equipment (PPE) before providing care to the resident. * The facility failed to maintain infection control when the DSD/ IP placed the box of clean gloves on Resident 55's bed, which touched the incontinent pad on the resident's bed during wound care. * The facility failed to follow their Water Management Program's swamp cooler and decorative fountain's testing and maintenance protocol. * CNA 1 failed to maintain infection control standards while feeding Resident 52. * The facility failed to ensure the contact Isolation precautions were followed and implemented by the providers and visitors for Resident 41. * The facility failed to implement the EBPs for Resident 69, who had a central line catheter (a long, thin tube inserted into a large vein near the heart, used for long-term IV access for fluids and medications). These failures posed the risk of not identifying the residents' infections and thereby preventing the implementation of interventions, and control the potential transmission of communicable diseases to other residents in the facility.Findings: 1. Review of the facility's P&P titled Infection Control Guidelines revised on 2/3/22, showed the facility maintains an organized, effective facility-wide program designed to systematically identify and reduce the risk of acquiring and transmitting infections among residents, visitors and healthcare workers. This program involves the collaboration of many programs and services within the facility and is designed to meet the intent of regulatory and other agencies. The Infection Prevention Oversight Committee is responsible for infection prevention in the facility. The functions of the infection prevention oversight committee include, but are not be limited to establishing, reviewing, monitoring, and approving policies and procedures for investigating, controlling and preventing infections in the facility, and maintaining, reviewing, and reporting statistics of the number, types, sources, and locations of infections within the facility including antibiotic resistance trends. The Infection Preventionist's (IP) responsibilities for infection prevention and control include but may not be limited to conducts surveillance for facility associated infections and/or communicable diseases, assures compliance with state/federal regulatory as they pertain to infection prevention/control matters within the facility, maintains facility infection prevention/control policies and procedures, communicates infection prevention and control data to facility leadership, appropriate facility committees, facility staff and other stake holders as appropriate, is a member of the facility's quality assessment and assurance committee and reports to the committee on the Infection Prevention and Control Program on a regular basis. (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/5/25 at 1102 hours, an interview and concurrent facility document review was conducted with the DSD/ IP. The DSD/IP stated she completed the Infection Control Surveillance Log and reported the findings to the QAPI Infection Control meeting monthly and quarterly. Review of the Infection Control QAPI Report and Infection Control Surveillance Log for June, July, September, and October 2025 showed the following: - the Infection Control QAPI Report for June 2025 showed a total of 26 new infections, 14 of which were HAIs and 12 of which were CAIs. However, the June 2025 Infection Control Surveillance Log showed 15 were HAIs and 11 were CAIs. - the Infection Control QAPI Report for July 2025 showed a total of 38 new infections, 23 of which were HAIs and 15 of which were CAIs. However, the July 2025 Infection Control Surveillance Log showed 24 were HAIs, and 11 were CAIs. - the infection Control QAPI Report for September 2025 showed a total of 32 new infections, 17 of which were HAIs. However, the September 2025 Infection Control Surveillance Log showed 15 were HAIs. - the infection Control QAPI Report for October 2025 showed a total of 32 new infections, 21 of which were HAIs. However, the October 2025 Infection Control Surveillance Log showed 22 were HAIs. The DSD/IP verified the above findings. On 12/9/25 at 1206 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Review of the facility's P&P titled Laundry Service for PV revised 4/10/25, showed the clean linen will not touch the floor (any linen that touches the floor when being folded or linens that will fall off the shelf or cart are considered soiled and are set aside for re-washing. No food or drinks are allowed in the laundry room. When handling the clean linen to wear a clean gown. On 12/3/25 at 1553 hours, an observation and concurrent interview was conducted with Laundry Personnel 1. The following was observed in the laundry room: - A drinking water bottle was observed on the clean side of the laundry room. Laundry Personnel 1 stated the water bottle belonged to her. - Laundry Personnel 1 was observed folding the linen towards her body, with the linen touching her clothing and the floor simultaneously multiple times. Four bed linens were observed folded by Laundry Personnel 1 in this manner. - Laundry Personnel 1 was observed folding the clean linen without wearing a clean gown per the facility policy. Laundry Personnel 1 acknowledged the above observations and stated the clean linens should not be touching her clothing and the floor. On 12/3/25 at 1620 hours, an observation and concurrent interview was conducted with the Housekeeping Supervisor. The Housekeeping Supervisor acknowledged the drinking water bottle (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inside the clean side of the laundry room and stated no food, or beverages were allowed in the laundry room. The Housekeeping Supervisor further stated he expected the laundry personnel to wear a gown when folding the clean linen. The Housekeeping Supervisor stated the clean linen should not touch the floor and stated the folded linen will be re-washed. 3.a. Review of the facility's P&P titled Enhanced Standard Precautions Guidelines revised on 10/24/22, showed Enhanced Standard Precautions (ESP) Guidelines primarily includes the expansion of barriers such as gowns and gloves for specific high contact care activities, based on the resident's characteristics that are associated with a high risk of MDRO colonization and transmission, the following might be considered for implementation of ESP: - Presence of indwelling devices [e.g., urinary catheter, feeding tube, endotracheal (insertion of a flexible tube into the windpipe) or tracheostomy tube (surgical procedure that creates an opening in the neck into the windpipe) and vascular catheters (thin, flexible tubes inserted into the blood vessels for long-term access)]. - Wounds or presence of pressure injury (unhealed). - Functional disability and total dependence on others for assistance with activities of daily living (ADL) is also recognized as a risk factor for MDRO transmission and may be considered for residents who do not have an indwelling device or wounds, for example, during transition from contact precautions to ESP for residents identified with MDRO colonization during an outbreak. Review of The Six Moments for Enhanced Standard Precautions posted at Resident 55's room showed for the six groups of care activities, use hand hygiene, gloves, and gowns for residents who are on ESP. The six groups of care activities are morning and evening care; toileting and changing incontinence briefs; caring for devices and giving medical treatments; wound care; mobility assistance and preparing to leave room; and cleaning and disinfecting the environment. Medical record review for Resident 55 was initiated on 12/3/25. Resident 55 was admitted to the facility on [DATE]. Review of Resident 55's H&P examination dated 12/26/24, showed Resident 55 had no capacity to understand and make decisions. Review of Resident 55's Order Summary dated 12/5/25, showed the following physician's orders: - dated 4/29/25, for the enhance barrier precaution due to reopened sacrococcyx (triangle bone at the base of the spine) Stage 3 pressure injury (full-thickness skin loss, where the fat layer is visible, but bone, tendon or muscle is not exposed yet). - dated 11/29/25, to provide wound treatment to the reopened sacrococcyx Stage 3 pressure injury as follows: cleanse with normal saline, pat dry, apply skin prep to peri wound. Apply Medi honey (a medical-grade honey product used to manage a variety of wounds by creating a moist healing environment, debriding necrotic tissue, and reducing bacteria) to wound bed cover with calcium alginate and cover with foam dressing. - dated 1/14/25, for left lower extremity active/ passive range of motion exercises daily five times per week as tolerated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated 1/14/25, for right lower extremity active/ passive range of motion exercises daily five times per week as tolerated. - dated 1/15/25, for left upper extremity active/ passive range of motion exercises daily five times per week as tolerated. - dated 1/15/25, for right upper extremity active/ passive range of motion exercises daily five times per week as tolerated. On 12/4/25 at 0915 hours, an observation was conducted with Resident 55 during the range of motion exercises provided by RNA 1. RNA 1 was observed not wearing a protective gown while providing mobility exercises to Resident 55. On 12/4/25 at 1435 hours, an interview was conducted with RNA 1. RNA 1 stated Resident 55 was on ESP. RNA 1 verified she failed to wear a gown while performing the mobility exercises for Resident 55. RNA 1 further stated she should have worn a gown when providing the mobility exercises to the resident. On 12/4/25 at 1508 hours, an interview was conducted with the DSD/ IP. The DSD/IP verified Resident 55 was on ESP. The DSD/ IP stated the expectation was for the RNA to have worn a gown while providing mobility exercises to the resident. b. On 12/5/25 at 1300 hours, a wound care observation was conducted for Resident 55 with the DSD/IP. The DSD/IP was observed placing the clean box of gloves on the resident's bed. There were gloves exposed out of the box, which were touching the resident's incontinent pads. On 12/5/25 at 1332 hours, an interview was conducted with the DSD/IP. The DSD/IP stated she should not have placed the clean box of gloves on the resident's bed while performing wound care to the resident, to prevent contamination of the clean gloves. The DSD/IP stated the gloves were contaminated and would be disposed. Cross reference to F686. 4. Review of the facility's P&P titled Legionella (type of bacteria) Monitoring reviewed 7/19/21, showed the P&P was in place to minimize the risk of microbial growth and spread of legionella and other opportunist water system pathogens to the residents. Review of the facility's Water Safety Plan dated 2022 showed the following:- Quarterly general maintenance and cleaning of the swamp cooler.- Weekly maintenance of the decorative fountain. a. Review of the facility's Quarterly Maintenance Log for Direct Air Evaporative Condensers (Swamp Coolers) showed the maintenance staff to check the chlorine level and ensure it is at least 5 ppm. The Logs for the past 12 months had a blank space for the ppm to be documented, which was incomplete. Review of the facility's Air Evaporative Condensers or Swamp Cooler Maintenance log for 2025 showed the chlorine level was to be 2 – 10 ppm. The log was completed monthly and showed two chlorine tablets were added resulting in a chorine level range of 4 – 5 ppm, with it being under 5 ppm on the following dates:- on 1/17, 5/7, and 6/4/25, with 4 ppm; and- on 2/12, 4/9, and 10/8/25, with 4.5 ppm; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Review of the facility's Weekly Maintenance Logs for Decorative Fountain for the past 12 months showed to add biocide (chemical substance or living organism designed to kill, deter or control harmful organisms) tablets to achieve 5 ppm and measure the halogen (a group of highly reactive non-metallic elements which include chlorine) residual with test strips. The form also showed to measure the halogen residual and add additional chemicals, if necessary, until 2-5 ppm is reached. The form was blank to show the ppm results for each weekly maintenance. Review of the facility's Maintenance Work Orders for the decorative fountain for 2025 showed every two weeks a work order for two caps full every two weeks. Review of the facility's Weekly Maintenance Log Decorative Fountain for 2025, showed the chlorine level was to be 2 – 10 ppm. The log was completed every two weeks and showed two chlorine tablets were added resulting in a chorine level range of 4 – 5.5 ppm, with it being under 5 ppm on the following dates:- on 1/3, 1/29, 5/7, 6/18, 7/2, 9/10, and 9/29/25, with 4.5 ppm; and- on 4/9, 4/23, 7/16, 7/30, and 12/3/25, with 4 ppm. On 12/5/25 at 1419 hours, an interview and concurrent facility document review was conducted with the Director of Maintenance, Maintenance Supervisor, and Maintenance Technician. The Director of Maintenance stated the facility used chlorine and verified the Water Management Plan templates showed for the chlorine levels to be at least 5 ppm. The Director of Maintenance stated the tasks were completed per the Weekly Maintenance Log Decorative Fountain and the Quarterly Maintenance Log for Direct Air Evaporative Condensers (Swamp Coolers) forms. The Maintenance Supervisor stated the Maintenance Technician checked the chlorine levels for the fountain and he would transfer the information onto the logs. On 12/9/25 at 0848 hours, a follow-up interview was conducted with the Director of Maintenance, Maintenance Supervisor, and Maintenance Technician. The Maintenance Technician stated he maintained the fountain when the task was triggered by the electronic work order system. The Director of Maintenance, Maintenance Supervisor, and Maintenance Technician verified the fountain's work order logs showed the task was to be completed every two weeks, and not weekly as per the Water Management Program. The Director of Maintenance and Maintenance Supervisor verified the Weekly Maintenance Log Decorative Fountain and Air Evaporative Condensers or Swamp Cooler Maintenance logs, showed the acceptable chlorine level was to be 2 – 10 ppm, which did not match the facility's Water Safety Plan. 5. Medical record review for Resident 52 was initiated on 12/4/25. Resident 52 was readmitted to the facility on [DATE]. On 12/3/25 at 0838 hours, CNA 1 was observed feeding Resident 52. CNA 1 was wearing a uniform and sitting on the armrest of the resident's bedside chair, with her knees on the resident's bed, the bed and bedding were observed indented where the CNA's knees were placed. CNA 1 stated she was sitting that way because the chair was too low to feed the resident. CNA 1 verified she should not have her knees on the resident's bed. CNA 1 verified the resident had an electric bed, which could be moved up and down. On 12/4/25 at 1103 hours, an interview was conducted with the DSD/IP. The DSD/IP stated the facility staff's uniforms should not come in contact with the residents' bed linens to avoid contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Review of the facility's P&P titled Contact Precaution revised 6/2024 showed guidelines for infection control precautions had been established to assure appropriate techniques are implemented to meet the needs of the resident by decreasing transmission of disease-causing microorganisms. Review of the facility's document titled Infection Control Guidelines revised 2/2022 showed infection prevention and control provided education to residents, families, and visitors as appropriate. According to CDC Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Setting, Appendix A showed the precautions for C. Difficile (a bacterial infection that causes diarrhea) included to handwash with soap and water because of the absence of sporicidal activity in antiseptic hand rubs and to use hypochlorite solutions for cleaning if transmission continued. Medical record review for Resident 41 was initiated on 12/3/25. Resident 41 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 41's H&P examination dated 12/3/25, showed Resident 41 had a C. Difficile infection. Review of Resident 41's Order Summary Report dated 12/1/25, showed a physician's order to place Resident 41 on transmission-based precautions due to C. Difficile and Burkholderia (bacteria) in sputum. Review of Resident 41's Care Plan Report revised 12/2/25, showed a plan of care for Resident 41's C. Difficile infection. The interventions included to educate the staff, resident, and family the correct procedure to wash hands and importance to adhere to good hand hygiene. On 12/3/25 1049 hours, during the initial tour of the facility, a contact precaution sign was observed by Resident 41's room, informing everyone must clean their hands before entering and when leaving the room. Providers and staff must put on gloves and gown before room entry and discard gloves and gown before room exit, and use the dedicated or disposable equipment and to clean and disinfect the reusable equipment before use on another person. A isolation cart was observed by Resident 41's room, which contained gowns, gloves, and ABHR. a. On 12/4/25 at 1132 hours, the NP was observed performing hand hygiene with the ABHR, then donning a gown and gloves prior to entering Resident 41's room. On 12/4/25 at 1138 hours, the NP was observed removing her gown and gloves prior to exiting Resident 41's room. The NP opened the first drawer of the isolation cart, located outside of Resident 41's room and began to disinfect a yellow stethoscope with the alcohol wipes. The NP then placed the stethoscope into the first drawer of the isolation cart and performed hand hygiene with the ABHR. On 12/4/25 at 1140 hours, an interview and concurrent observation was conducted with the NP. The NP verified Resident 41's contact isolation precautions were because of his C. difficile and Burkholderia (bacteria) infections. The NP was observed placing her hand on the handrail across from Room A in the hallway. The NP verified the wipes she used to disinfect the yellow stethoscope used for Resident 41 were alcohol based. The NP further stated the alcohol wipes were not effective against the C. difficile germs. When the NP was asked if she performed hand hygiene with soap and water after the resident care, the NP stated she sanitized her hands with ABHR and was going to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wash hands at the nursing station. b. On 12/4/25 at 0940 hours, an interview was conducted with Family Member 1. Family Member 1 stated the facility staff members educated her about Resident 41's contact precautions: to wear gown and gloves when visiting Resident 41's room and to perform hand hygiene. When Family Member 1 was asked how she performed hand hygiene, Family Member 1 stated she used the ABHR. On 12/5/25 at 0841 hours, and on 12/8/25 at 0905 hours, Family Member 2 was observed removing their gown and gloves prior to exiting Resident 41's room. Family Member 2 was then observed performing hand hygiene with the ABHR after exiting Resident 41's room. On 12/8/25 at 1141 hours, an interview was conducted with the DSD/IP. The DSD/IP stated the transmission-based precautions for C. difficile was to place the resident in contact isolation, use bleach to disinfect the equipment used for the resident, and to perform hand hygiene with soap and water. The DSD/IP was informed and acknowledged the above findings. The DSD/IP stated the contact precautions were to prevent the transmission of organisms to the residents and staff. The DSD/IP stated the best practice for the visitors when they leave a C. Difficile contact isolation was for them to wash their hands with soap and water to protect themselves from the infection. On 12/9/25 at 1346 hours, an interview was conducted with AIT, Executive Director, and DON. The AIT, Executive Director, and DON were informed and acknowledged the above findings for Resident 41. 7. Review of the facility's P&P titled Enhanced Barrier Precautions Guidelines revised 6/2024, showed EBPs are used to prevent, contain, and mitigate MDROs in the facility. Examples of EBPs indicated for residents include infection or colonization with a CDC-targeted MDRO when TBP do not apply and wounds and/or indwelling medical devices including central lines, urinary catheters, feeding tubes. Gloves and gowns shall be worn while performing high-contact tasks associated with the greatest risk for MDRO contamination. Examples of high-contact activities may include: - device care, for example, urinary catheter, feeding tube, tracheostomy, and vascular catheter. - bathing, peri-care, assisting with toileting; and - changing bed linens. Medical record review for Resident 69 was initiated on 12/3/25. Resident 69 was admitted to the facility on [DATE]. Review of Resident 69's Care Plan Report revised 11/27/25, showed a plan of care for Resident 69's double lumen PICC line to his right upper arm. On 12/3/25 at 0934 hours, during initial tour of the facility, an observation was conducted of Resident 69 in his room. Resident 69 was observed with a double lumen PICC line located on his right upper arm. There was no EBP signage observed inside or outside of the room. On 12/4/25 at 1239 hours, an interview was conducted with DON. The DON stated EBP precautions were indicated for the residents with central venous catheters. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/4/25 at 1247 hours, an observation and concurrent interview was conducted with RN 1 in Resident 69's room. There was no EBP signage or isolation cart observed inside or outside of the room. RN 1 verified the above findings. On 12/9/25 at 1346 hours, an interview was conducted with the AIT, Executive Director, and DON. The AIT, Executive Director, and DON were informed and acknowledged the above findings for Resident 69.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the development of new pressure injury (areas of damaged skin caused by staying in one position for a long time which reduces blood flow to the area and causes the skin to die and develop a sore) and promote healing of the existing pressure ulcer for one of two final sampled residents (Resident 55) reviewed for pressure injury. * The facility failed to ensure Resident 55's pressure injury was evaluated regularly. * The DSD/IP failed to ensure to follow the physician's order to cleanse Resident 55's pressure injury with normal saline during wound care observation. These failures posed the risks of complications and delayed wound healing for Resident 55.Findings: a. Review of the facility's P&P titled Pressure Injury Mitigation and Skin Management Program reviewed on 11/27/24, showed the care and intervention for any identified skin breakdown or wound will be aimed at close monitoring of the response to treatment and manage any pain control issues related to the skin injury. Upon identification of a wound, a full wound evaluation, including its location, size, and description of the tissue involved, shall be completed. Interventions and progress toward outcome focused goals need regular documentation according to established procedures. Review Medical record review for Resident 55 was initiated on 12/3/25. Resident 55 was admitted to the facility on [DATE]. Review of Resident 55's H&P examination dated 12/26/24, showed Resident 55 had no capacity to understand and make decisions. Review of Resident 55's Weekly Pressure Injury Evaluation dated 10/27/25, showed the resident's pressure injury was acquired on 4/21/25. The wound measured at 1 cm in length, 0.8 cm in width, and 0 cm in depth. Further review of Resident 55's medical record failed to show the Weekly Pressure Injury Evaluation was completed after 10/27/25. Review of Resident 55's Order Summary dated 12/5/25, showed the following physician's orders:- dated 4/29/25, for the enhance barrier precaution due to reopened sacrococcyx (triangle bone at the base of the spine) Stage 3 pressure injury (full-thickness skin loss, where the fat layer is visible, but bone, tendon or muscle is not exposed yet).- dated 10/14/25, to provide wound treatment to the reopened sacrococcyx Stage 3 pressure injury daily until 11/4/25, as follows: cleanse with normal saline, pat dry, apply skin prep to peri wound. Apply Medi honey (a medical-grade honey product used to manage a variety of wounds by creating a moist healing environment, debriding necrotic tissue, and reducing bacteria) to wound bed cover with calcium alginate (a natural, highly absorbent, gelatinous substance from seaweed used primarily in wound dressings) and cover with foam dressing and as needed for soilage and dislodgement.- dated 11/29/25, to provide wound treatment to the reopened sacrococcyx Stage 3 pressure injury as follows: cleanse with normal saline, pat dry, apply skin prep to peri wound. Apply Medi honey to wound bed cover with calcium alginate and cover with foam dressing. On 12/4/25 at 1539 hours, an interview and concurrent medical record review was conducted with the DSD/IP. The DSD/IP stated Resident 55's pressure injury had reopened. The DSD/IP was unable to identify when the wound healed after 10/27/25. The DSD/IP stated a Weekly Pressure Injury Evaluation should had been completed after 10/27/25. On 12/4/25 at 1559 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated the Resident 55's pressure injury had reopened; however, the DON was unable to identify when it healed and had reopened. The DON verified Resident 55's medical record failed to show the Weekly Pressure Injury Evaluation was completed after 10/27/25. The DON stated she expected a Weekly Pressure Injury Evaluation to be completed weekly for all the residents with pressure injury. The DON was informed and acknowledged the above findings. The DON further stated she would complete a Weekly Pressure Injury Evaluation for Resident 55. b. Review of facility's P&P titled Physician Order revised 10/24/25, showed the facility established clear guidelines for the receipt, documentation, implementation, and review of the physicians, orders ensuring safe, effective and compliant with resident care. All the resident care (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided in the facility must be based on a valid physician's order. The physician's orders must be documented, verified, and implemented in accordance with regulatory requirements and facility standards. Nursing staff are responsible for ensuring orders are accurately transcribed, communicated, and carried out. Nursing staff must review and implement physician's orders. Treatment and therapy orders must be scheduled and carried out as directed. On 12/5/25 at 1300 hours, a wound care observation was conducted for Resident 55 with the DSD/IP. The DSD/ IP was observed using Skintegrity wound cleanser to cleanse Resident 55's sacrococcyx pressure injury. The bottle of Skintegrity wound cleanser was observed with another resident's name. On 12/5/25 at 1325 hours, an interview and concurrent observation was conducted with the DSD/IP. The DSD/IP verified she used the Skintegrity wound cleanser to cleanse Resident 55's pressure injury. The DSD/IP verified the Skintegrity wound cleanser spray bottle was labeled with another resident's name with a date opened 10/13/25. The Skintegrity wound cleanser label showed it contained water Polysorbate 80, cocoamphodiacetate, and Lauryl Polyglucose, along with other gentle ingredients like Sorbitol, Lactic Acid, Triethanolamine, Disodium EDTA, Methylparaben, and Diazolidinyl Urea (or Imidazolidinyl Urea) (non-ionic surfactants). The DSD/IP stated this was the wound cleanser supplied by the hospice agency for another resident in which the same hospice agency Resident 55 was admitted to. The DSD/IP stated she did not want to waste the supply. On 12/5/25 at 1620 hours, an interview was conducted with the DON. The DON verified Resident 55's physician's order dated 11/29/25, for the wound treatment for the reopened sacrococcyx Stage 3 pressure injury was to cleanse the pressure injury with normal saline. The DON stated the expectation was for the licensed nurses to follow the physician's order when providing wound care for the residents. The DON was informed and acknowledged the above findings. Cross reference to F880, example #3.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the appropriate care and services for one final sampled resident (Resident 65) reviewed for the use of an indwelling urinary catheter. * The facility failed to monitor Resident 65's fluid output every shift for the use of the indwelling urinary catheter. In addition, the facility failed to provide bladder training prior to discontinuing the indwelling urinary catheter as ordered by the physician. These failures had the potential for not providing the necessary care and services and posed a risk for adverse complications related to the indwelling urinary catheter use for Resident 65.Findings: Review of the facility's P&P titled Intake and Output Protocol revised 11/11/24, showed the fluid intake and output is recorded for each resident if ordered by the physician, for each resident with new indwelling catheter. Intake and output are recorded daily and evaluated weekly. Residents with justified diagnosis for new indwelling urinary catheters will have their intake and output monitored for 30-day period. Measure and record liquid stools, vomitus, or nasogastric drainage, urostomy, wounds/ drains, and other body fluids as possible and deemed necessary by the licensed nurse. Review of the facility's P&P titled Indwelling Foley Catheter (type of an indwelling urinary catheter) revised 8/19/24, showed indwelling urinary catheters shall be managed according to evidences- based infection control practices should be limited to medically necessary situations, and care will be provided in a manner that respects resident's dignity, prevents complications, and complies with CDC, CMS, and CDPH guidelines. Medical record review for Resident 65 was initiated on 12/3/25. Resident 65 was admitted to the facility on [DATE]. Review of Resident 65's H&P examination dated 11/26/25, showed Resident 65 had the capacity to understand and make decisions. Review of Resident 65's Order Summary dated 12/9/25, showed the following physician's orders:- dated 11/27/25, for the placement of an indwelling urinary catheter closed system size 16 Fr/10 ml for mechanical dysfunction or blockage of the urinary catheter system. - dated 11/27/25, to monitor intake and output every shift for new the indwelling urinary catheter for 30 days. - dated 12/1/25, for bladder training, clamp the indwelling urinary catheter for two hours and unclamp for fifteen minutes every shift until 12/3/25. a. Review of Resident 65's MAR failed to show Resident 65's intake and output was documented/monitored as ordered by the physician. Review of Resident 65's Task-Output monitoring dated November 2025 failed to show entries documentation for the monitoring of Resident 65's output as ordered by the physician. Further review of Resident 65's medical record failed to show Resident 65's fluid output was monitored as ordered by the physician on 11/27/25. b. Review of Resident 65's TAR showed a physician's order for the bladder training, clamp the indwelling urinary catheter for two hours and unclamp for fifteen minutes every shift dated 12/1 until 12/3/25. A check mark was documented on the TAR on the following dates and shifts:- on 12/1/2, for the evening and night shift; and- on 12/2/25, for the day, evening and night shift. Further review of Resident 65's medical record failed to show the bladder training was provided by clamping the indwelling urinary catheter for two hours and for fifteen minutes as ordered by the physician. On 12/4/25 at 0855 hours, an observation and interview was conducted with Resident 65. Resident 65 was observed without the indwelling urinary catheter drainage bag. Resident 65 stated the nursing staff had removed her indwelling urinary catheter. Resident 65 stated she was not aware if the nursing staff were monitoring her fluid intake and output. Resident 65 further stated the nursing staff would clamp her indwelling urinary catheter but was not sure if they had clamped it every two hours because they had a lot of things to do. Resident 65 stated there were a couple of times she felt pressure on her bladder because the nursing staff forgot to unclamp her indwelling urinary catheter. On 12/9/25 at 1018 hours, an interview and concurrent medical record review was conducted with the DSD/ IP. The DSD/IP verified Resident 65's Task -Output monitoring failed to show the resident's fluid output was (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitored and Resident 65's MAR failed to show the resident's intake and output was documented on the MAR since 11/27/25. The DSD/IP verified Resident 65's TAR failed to show the resident's indwelling urinary catheter was clamped every two hours and unclamped after fifteen minutes to show the bladder training was provided to Resident 65. The DSD/ IP further stated the clamping of the indwelling catheter should have been scheduled every two hours in the TAR. 12/9/25 at 1030 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the appropriate care and services for the use of the GT was provided for one of two final sampled residents (Resident 42) reviewed for the GT use. * The facility failed to ensure Resident 42's HOB (head of bed) was elevated at a 90-degree angle during the infusion of the enteral feeding via GT as per the physician's order, to reduce the risk of aspiration (inhaling foreign material i.e. food, liquid or vomit, into the lungs). This failure posed the risk of complications related to the use of the GT for Resident 42.Findings: Review of the facility's P&P titled Physician Order revised 10/24/25, showed to establish clear guidelines for the receipt, documentation, implementation, and review of physician order ensuring safe, effective, and compliant with resident care. Nursing staff must review and implement physician orders. Medical record review for Resident 42 was initiated on 12/3/25. Resident 42 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 42's MDS assessment dated [DATE], showed Resident 42 had a feeding tube and a medical diagnosis of aphasia (inability to understand or produce speech). Review of Resident 42's Order Summary Report dated 12/5/25, showed the following physician's orders:- dated 8/20/25, to elevate the HOB at 90-degrees during feeding and after the feeding has stopped.- dated 9/19/25, to administer Isosource 1.5 (enteral feeding formula) via pump at 65 ml per hour for 18 hours per day, to provide 1170 ml/1755 kcals, and start at 0500 hours, and continue until the required dose was completed. On 12/3/25 at 0851 hours, Resident 42 was observed lying in bed and receiving the enteral feeding with the HOB elevated less than 90-degrees. On 12/4/25 at 1624 hours, an observation and concurrent interview was conducted with LVN 2. LVN 2 verified Resident 42's HOB was elevated less than 90-degrees while the resident was receiving the enteral tube feeding. LVN 2 stated Resident 42's HOB should have been elevated while the resident was receiving the enteral feeding as ordered by the physician, to prevent aspiration. On 12/4/25 at 1630 hours, an interview and concurrent medical record review for Resident 42 was conducted with the DON. The DON stated when a resident was receiving the enteral feeding, the expectation was to monitor the resident to ensure they tolerated the feeding and to elevate the HOB at 90 degrees during and after feeding, to prevent aspiration pneumonia (lung infection when food, liquid, or other material are inhaled into the lungs). On 12/5/25 at 1508 hours, an interview was conducted with the DON, AIT, and Executive Director. The DON, AIT, and Executive Director were informed and acknowledged the above findings.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review and facility P&P, the facility failed to ensure the appropriate physicians' orders were obtained for one of two final sampled residents (Resident 35) reviewed for the intravenous therapy. * Resident 35 did not have current physicians' orders for the midline catheter's monitoring and dressing changes. This failure had the potential for the residents not receiving proper midline catheter care, as well as a delay in identifying and preventing potential catheter complications.Findings: Review of the facility's P&P titled Physician Order revised 10/24/25, showed all the resident care in the facility must be based on a valid physician order. Medical record review for Resident 35 was initiated on 12/3/25. Resident 35 was admitted to the facility on [DATE]. Review of Resident 35's IV MAR for November 2025 showed the following physician's orders:- to measure the arm circumference three inches above the midline catheter insertion site every week and PRN with dressing changes. This was last documented on 11/23/25, and the order was discontinued on 11/29/25.- to measure the midline catheter length every dressing change to ensure catheter migration has not occurred. This was last documented on 11/23/25, and the order was discontinued on 11/29/25.- to monitor the IV site every shift for redness, tenderness, edema, and leaking. This was last documented on 11/29/25, for the day shift and the order was discontinued on 11/29/25. Review of Resident 35's Order Summary Report dated 12/4/25, showed the following physician's orders:- dated 11/11/25, for the midline catheter to the right upper arm.- dated 11/29/25, to flush the midline catheter with 10 ml of NS (normal saline) every 12 hours for maintenance.However, there were no other active physician's orders for the midline catheter monitoring and dressing changes. On 12/4/25 at 1139 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 stated there should have been a physicians' order for the midline catheter maintenance, measuring, monitoring, and dressing changes for all the resident's with a midline catheters. RN 1 reviewed Resident 35's physicians' orders and verified there were no orders for the midline site monitoring, arm and catheter measurements, and dressing changes.

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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, medical record review, and facility P&P review, the facility failed to provide the respiratory care and services for two of two final sampled residents (Residents 36 and 66) reviewed for respiratory care. * The facility failed to follow the physician's order for the administration of continuous oxygen and failed to ensure the nasal cannula was labeled with date for Resident 36. * The facility failed to clean Resident 66's CPAP (Continuous Positive Airway Pressure, is a machine that uses mild air pressure to keep breathing airways open while a person sleeps) machine as ordered by the physician. These failures had the potential for the residents not to receive the appropriate care and may negatively impact on the residents' medical conditions.Findings: Review of the facility's P&P titled Physician Order revised 10/24/25, showed to establish clear guidelines for the receipt, documentation, implementation, and review of physician order ensuring safe, effective, and compliant with resident care. The nursing staff must review and implement physician orders. Review of the facility's P&P titled Oxygen Management revised 10/3/25, showed the nasal cannulas, masks, and tubing should be changed every seven days, dated, time, and initialed. 1. Medical record review for Resident 36 was initiated on 12/3/25. Resident 36 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of acute respiratory failure (life threatening condition where the lungs can not get enough oxygen to the blood) with hypoxia (the body or specific part if it doesn't get enough oxygen to function properly). Review of Resident 36's H&P examination dated 10/11/25, showed Resident 36 had no capacity to understand and make decisions. a. Review of Resident 36's Phone Order dated 12/1/25, showed a physician's order to administer continuous oxygen to titrate at a rate of 2 to 5 liters per minute via nasal canula for SOB or when the oxygen saturation level was less than 92%. On 12/3/25 at 0818 hours, an observation and concurrent interview for Resident 36 was conducted with RN 1, inside Resident 36's room. Resident 36 was observed sitting on the wheelchair and the nasal cannula was observed in Resident 36's nostrils. RN 1 verified there was no date on Resident 36's nasal canula. RN 1 stated the nasal canula should have been labeled with the date for the facility staff to know when the nasal canula should be changed, to prevent potential respiratory infection. b. On 12/4/25 at 1218 hours, an observation, interview, and concurrent medical record review was conducted with RN 1. Resident 36 was observed sitting on her wheelchair not receiving oxygen therapy. Resident 36 was asked if she removed the nasal cannula, which she replied that she did not know why she did not have the nasal cannula on. RN 1 verified Resident 36 was not receiving oxygen via nasal cannula. RN 1 was then observed obtaining Resident 36's oxygen saturation level, which was measured at 88%. RN 1 verified the physician's order showed to administer continuous oxygen via nasal cannula at a rate of 2 to 5 liters per minute when Resident 36's oxygen saturation levels were less than 92%. On 12/5/25 at 1508 hours, an interview was conducted with the AIT, DON, and Executive Director. The AIT, DON, and Executive Director were informed and acknowledged the above findings. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the facility's P&P titled CPAP Therapy revised 6/1/21, showed the cleaning and maintenance of the CPAP equipment as follows: Follow these steps for cleaning your CPAP patient circuit: - Wash your hands per standard hand washing procedure. - Remove the headgear from the mask or nasal pillows shell. Disconnect the mask or shell, swivel, and tubing. - With a soft cloth, gently wash the mask or pillows with a solution of warm water, and a mild clear liquid detergent. - Rinse thoroughly. If the mask still feels oily, repeat step C. - Allow the mask or pillows to air dry. Do not place any supplies in the dryer. - Wash tubing as necessary with a solution of warm water, and a mild clear liquid detergent. Rinse thoroughly and allow to air dry. - Clean and inspect all components regularly. The mask, tubing, and headgear should last approximately 6 to 12 months, but the actual life of the equipment can vary greatly. - Clean the CPAP unit as necessary - Unplug the unit before cleaning it. Never immerse the unit in water - Using a damp cloth, wipe the outside of the unit. - Use a dry cloth to wipe the unit dry. - Make sure the unit is thoroughly dry before plugging it in. The P&P further showed the filter maintenance will depend on the model of the unit you have. There may be two filters on some models. The first filter is usually disposable, and the second filter is reusable. Disposable filters should be replaced per manufacturers' recommendations. Reusable filters should be rinsed of dust and allowed to air dry. Never put a damp filter in your CPAP unit. Medical record review for Resident 66 was initiated on 12/3/25. Resident 66 was admitted on [DATE]. Review of Resident 66's plan of care showed a focus problem dated 11/23/25, addressing Resident 66's risk for altered respiratory status or difficulty breathing. The interventions included cleaning the CPAP machine and mask per manufacturer's instructions every Sunday on the 7-3 shift. Review of Resident 66's H&P examination dated 11/24/25, showed Resident 66 had the capacity to understand and make decisions. Review of Resident 66's MAR for November 2025 showed LVN 1's initial on 11/30/25, for the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician's order to clean the CPAP machine and mask per manufacturer's instructions every week on (Sunday) on 7-3 shift. Review of Resident 66's Order Summary dated 12/4/25, showed a physician's orders dated 11/23/25, to clean the CPAP machine and mask per manufacturer's instructions every week on (Sunday) on 7-3 shift. On 12/3/25 at 0904 hours, during the initial tour of the facility, Resident 66 was observed on the wheelchair. A CPAP mask and strap were observed hanging on the head of the bed, placed on the mattress and not stored in a bag. Resident 66 stated she used the CPAP machine at night to help her breath. Resident 66 further stated she had not cleaned the CPAP machine since she was admitted in the facility. On 12/3/25 at 0920 hours, an interview and concurrent observation was conducted with LVN 1. LVN 1 verified the above findings. LVN 1 stated the CPAP equipment should be placed in a bag for infection prevention. On 12/4/25 at 1015 hours, a follow up interview was conducted with LVN 1. LVN 1 stated the facility did not have the manufacturer's manual to refer to when cleaning Resident 66's CPAP machine. LVN 1 verified she had initialed the resident's MAR for the CPAP machine and mask cleaning per the manufacturer's instructions every week on (Sunday) on 11/30/25, for the 7-3 shift as completed, however, LVN 1 did not clean the resident's CPAP machine or check with resident if the CPAP machine was cleaned. On 12/9/25 at 1215 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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, medical record review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure proper medication storage. * The facility failed to ensure medications were not kept in the resident's room for one of 15 final sampled residents (Resident 42). The facility failed to ensure a container of CBD Pain Relief Ointment (pain reliever) medication was not kept at Resident 42's bedside table. * The facility failed to ensure the medications were stored and labeled properly in one of two medication carts inspected (Medication Cart A). * The facility failed to ensure the orally administered medications were stored separately from the externally used medications in one of two medication storage rooms inspected (Medication Room A). These failures posed the risk of unauthorized access, drug diversion, and medication administration errors and posed the risk for cross contamination of the medications.Findings: Review of the facility's P&P titled Storage and Expiration Dating of Medications, Biological, Syringes and Needles revised 6/23/25, showed the following:- Facility should not administer/provide bedside medications or biologicals without a physician/Prescriber order and approval by the Interdisciplinary Care Team and facility administration.- Facility should store bedside medications of biologicals in a locked compartment within the resident's room- Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. - Facility should ensure that external use medications and biologicals are stored separately from internal use medications and biologicals. 1. Medical record review for Resident 42 was initiated on 12/3/25. Resident 42 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 42's H&P examination dated 9/15/25, showed Resident 42 had the capacity to understand and make decisions. On 12/3/25 at 1146 hours, an observation was conducted with Resident 42. Resident 42 was observed awake and a container of CBD Pain Relief Ointment medication was observed on top of the bedside cabinet. On 12/3/25 at 1155 hours, an observation, interview and concurrent medical record review was conducted with LVN 1. LVN 1 verified Resident 42 had container of CBD Pain Relief Ointment medication on top of the bedside cabinet. LVN 1 stated she did not know Resident 42 had the medication on his bedside table. LVN 1 further stated Resident 42 had no physician's order for the CBD Pain Relief Ointment. 2. On 12/3/25 at 1529 hours, an inspection for Medication Cart A and concurrent interview was conducted with DSD/IP. The following was observed:- one open and cut individual pack of Cutimed Sorbion Sachet S (a sterile, hydroactive, gel forming, superabsorbent wound dressing), open and cut. The package description showed it was a single use only dressing.- one open and cut individual pack of Skin Closure Strips Reinforced Wound Closure (strong adhesive bandage). The package instruction showed to not reuse. The DSD/IP was asked about the process of opening an individual pack supply. The DSD/IP stated the individual pack supplies were single use and needed to be discarded after the single use. The DSD/IP verified the above findings. 3. On 12/3/25 at 1255 hours, an inspection of Medication Room A and concurrent interview was conducted with DON. The following was observed:- five bottles Fleet Enema Saline Laxative medications were stored with three bottles of Chest Congestion Relief (cough medication) oral solutions and a box of Lidocaine (pain reliever) relief patch. The DON was asked about the process of storing the medications. The DON stated the external and internal medications needed to be separated and not stored in the same cabinet. On 12/5/25 at 1508 hours, an interview was conducted with the AIT, DON, and Executive Director. The AIT, DON, and Executive Director were informed and acknowledged the above findings.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the kitchen staff had the appropriate skill sets to safely perform the daily operation of the Food and Nutrition Services Department. * The Dietary Aide failed to check the temperature of the hot beverages correctly during tray line. This failure posed the risk of burn injury to the residents receiving hot beverages from the kitchen.Findings: Review of the facility's document titled Residents per Dining Room - Lunch dated 12/9/25, showed seven residents received hot water prepared in the kitchen. Review of the facility's P&P titled Safe Holding and Serving Temperatures for Hot Beverages revised 5/2/17, showed to serve the hot beverages between 140 and 155 degrees Fahrenheit. The Dietary should record hot beverage temperatures for every meal. Allow hot liquids to cool before serving. Review of the facility's in-services for temperature checking and logging of hot beverages dated 9/6, 9/15, 10/23 through 10/26/25, and 12/4/25. The Dietary Aide was in attendance for all in-services. On 12/4/25 at 1200 hours, the Dietary Aide was observed checking the temperature of the hot beverages during tray line. The end of the thermometer was observed touching the base of the cup and the reading was at 158 degrees Fahrenheit. On 12/5/25 at 0836 hours, an interview was conducted with the Dietary Aide. The Dietary Aide stated he checked the temperature for the hot water, juices, and milk by using a thermometer. The Dietary Aide stated the end of the thermometer should not touch sides of bottom of the cup when testing the temperature of beverages. The Dietary Aide acknowledged the thermometer touched the base of the cup when he was testing the temperature of the hot beverages during the tray line on 12/4/25. The Dietary Aide stated if the thermometer touched the base or the sides of the cup, the temperature reading would be inaccurate and could potentially cause a burn to the residents, if not taken correctly. The Dietary Aide stated he was provided in-services on how to check the temperatures of hot beverages in September 2025 and again on 12/4/25. On 12/5/25 at 0859 hours, an interview was conducted with the Food and Beverage Manager. The Food and Beverage Manager stated the correct way to check the temperature of the hot beverages when using a thermometer was to not touch the sides or the bottom of the cup. The Food and Beverage Manager stated if the thermometer touched the bottom or the sides of the cup then the reading of the temperature was inaccurate. The Food and Beverage Manager stated the purpose of checking the temperature of the hot beverages was to prevent the residents from burning injuries. On 12/5/25 at 0859 hours, an interview was conducted with the Executive Chef. The Executive Chef stated the kitchen staff working the front of the house (refers to the part where the residents are received, seated, and served their food and drinks) were provided in-services on how to check the temperatures of the hot beverages. The Executive Chef stated the correct way of checking the temperature of the hot beverages when using a thermometer was to place the thermometer at the center of the liquid, making sure the thermometer was not touching the sides or bottom of the cup. The Executive Chef stated the purpose of checking the temperature of the hot beverages was to prevent the liquids from being too hot and causing a burn. On 12/5/25 at 0920 hours, an interview was conducted with the Dietary Manager. The Dietary Manager acknowledged the Dietary Aide did not check the temperature of the hot beverages correctly. The Dietary Manager stated the Dietary Aide was provided an in-service in October 2025 and again on 12/4/25, on how to check the temperature of hot beverages at the start of tray line. The Dietary Manager stated the thermometer should not touch the base or the sides of the cup when checking the temperature of the liquids. The Dietary Manager stated the importance of checking the hot beverages was to prevent the residents from getting burned.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitary requirements were met in the kitchen. * The facility failed to ensure the Dietary Aide sanitized the thermometer before checking the temperature of hot beverage during tray line. * The facility failed to ensure one of the three ice machines (Ice Machine 1) was sanitary, kept free of buildup, and free from accumulation of rust. These failures had the potential to cause foodborne illnesses for the residents receiving beverages and ice from the kitchen.Findings: Review of the facility's MDS Resident Matrix dated 12/3/25, 51 residents consumed food prepared in the kitchen. 1. Review of the USDA Food Code 2022, Section 4-702.11 Before Use after cleaning. Utensils and food-contact surfaces of equipment shall be sanitized before use after cleaning. On 12/4/25 at 1200 hours, the Dietary Aide was observed checking the temperature of the hot water during tray line. The Dietary Aide was then observed setting the thermometer down onto a clip board uncovered. The thermometer was observed touching the tie, which kept the thermometer attached to the clip board. The Dietary Aide then continued to use the thermometer to check a resident's hot water temperature without sanitizing the thermometer. On 12/5/25 at 0836 hours, an interview was conducted with the Dietary Aide. The Dietary Aide acknowledged checking the temperature of the hot water beverage using the thermometer that was placed onto the clipboard and touched the tie on the clip board. The Dietary Aide verified the thermometer was not sanitized prior to using it. The Dietary Aide stated the importance of sanitizing the thermometer before and after use was to avoid contamination. On 12/5/25 at 0849 hours, an interview was conducted with the Food and Beverage Manager. The Food and Beverage Manager stated prior to using the thermometer, it should be sanitized. The Food and Beverage Manager stated the importance of sanitizing the thermometer before using it was to avoid cross-contamination. On 12/5/25 at 0859 hours, an interview was conducted with the Executive Chef. The Executive Chef stated the thermometer needed to be sanitized before and after use. The Executive Chef stated there was a risk of contaminating the beverages if the thermometer was not sanitized before using, which could lead to risking the health conditions of the residents. 2. Review of the USDA Food Code 2022, Section 4-601.11 Equipment, food-contact surfaces, nonfood-contact surfaces and utensils, (A) Equipment, food-contact surfaces and utensils shall be clean to sight and touch. (C) Nonfood - contact surfaces of equipment shall be kept free from an accumulation of dust, dirt, food reside and other debris. Review of the facility's P&P titles Ice Machine Service revised on 5/27/25, showed it is the policy of the facility to maintain and service the ice machine and ice bin in a matter to obtain a clean and functioning system. To ensure that the ice machine and ice bin are cleaned and sanitized per manufacturer recommendations. On 12/4/25 at 0917 hours, an observation and concurrent interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor stated Ice Machine 1 was used for the residents' ice supply and iced beverages. The inside of the ice machine was observed with a brown residue. The Maintenance Supervisor stated Ice Machine 1 was sanitized twice a year, cleaned every three months and as needed, and inspected monthly. The Maintenance Supervisor acknowledged the brown residue observed inside Ice Machine 1. On 12/5/25 at 0955 hours, an interview was conducted with the Plant Operations Director. The Plant Operations Director was informed and acknowledged the finding of the brown residue within Ice Machine 1. The Plant Operations Director acknowledged Ice Machine 1 was not clean and not maintained.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and facility document review, facility failed to have a full-time, dedicated IP. This failure had the potential for the Infection Prevention and Control Program not being implemented without the proper oversight.Findings: Review of All Facilities Letter (AFL) Summary dated 12/13/21, showed the SNFs continue to be required to employ a full-time, dedicated IP, a role that may be filled by either one full-time IP or by two staff members sharing the IP responsibilities, provided the total time dedicated to the IP role equals at least the time of a full-time staff member. IP hours are prohibited from inclusion in the calculation of 3.5 direct care hours per patient day provided to SNF residents. Review of the facility's All Home time record showed:- The DSD/IP worked with Infection Prevention 20 hours per week for the months of October and November 2025.- RN 2 worked with Infection Prevention for 18.74 hours for the months of October 2025, and a total of eight hours for the month of November 2025. On 12/5/25 at 1102 hours, an interview was conducted with the DSD/IP. The DSD/IP stated she was working in the facility as DSD, as treatment nurse, and IP. The DSD/IP stated she worked four hours a day as the IP. The DSD/IP further stated RN 2 who was a RN Supervisor on the weekends oversaw the Infection Prevention for the facility. The DSD/ IP further stated the previous IP was on maternity leave since last week of August 2025. On 12/5/25 at 1102 hours, an interview and a concurrent facility document review was conducted with the DON. The DON stated the DSD/IP did not work full time as the IP. The DON further stated the DSD/IP worked as the treatment nurse and as the DSD; however, RN 2 worked as a back-up IP for the facility. The DON verified the All Home time record for the DSD/IP showed the DSD/IP worked with Infection Prevention 20 hours per week for October and November 2025. The DON verified RN 2 worked with Infection Prevention for 18.74 hours for October 2025 and a total of eight hours for November 2025. On 12/9/25 at 1206 hours, a follow-up interview was conducted with the DON. The DON was informed and acknowledged findings as above.

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F 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure care was provided in a manner which promoted dignity and respect for one of one final sampled resident (Resident 65) reviewed for the use of an indwelling urinary catheter (flexible tube used to empty the bladder and collect urine in a drainage bag). * The facility failed to ensure Resident 65's indwelling urinary catheter collection bag was inside the privacy bag. This failure had the potential to negatively impact Resident 65's emotional well-being.Findings: On 12/3/25 at 0845 hours, during the initial tour of the facility, Resident 65 was observed lying in bed with an indwelling urinary catheter draining yellow urine into the urine collection bag. The urine collection bag was observed hanging on the right side of Resident 65's bed and not placed inside the privacy bag. On 12/3/25 at 0902 hours, an interview and concurrent observation was conducted with LVN 1. LVN 1 verified the above findings. LVN 1 stated the urine collection bag should be inside the privacy bag for the resident's privacy. Medical record review for Resident 65 was initiated on 12/3/25. Resident 65 was admitted to the facility on [DATE]. Review of Resident 65's H&P examination dated 11/26/25, showed Resident 65 had the capacity to understand and make decisions. Review of Resident 65's Order Summary dated 12/9/25, showed a physician's order dated 11/27/25, for the placement of an indwelling urinary catheter closed system size 16 Fr/10 ml for mechanical dysfunction or blockage of the urinary catheter system. On12/5/25 at 1107 hours, an interview was conducted with the DON. The DON stated for all the residents in the facility with an indwelling urinary catheter, the expectation was to have the collection bags to be inside the privacy bag to provide the resident with dignity. The DON was informed and acknowledged the above findings.

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F 0583 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interview, and facility document review, the facility failed to protect the residents' identifiable information.* The facility's survey results binder for public viewing included four confidential resident rosters. This failure resulted in confidential resident information being accessible to the public.Findings: On 12/9/25 at 0737 hours, the Survey Inspection Results binder was observed in a wall pocket next to the Social Services office and was posted for public view. On 12/9/25 at 1035 hours, a review of the survey binder was completed. The binder included the Confidential Resident Rosters (a list which identified the names of the residents by their identifiers given for surveys to protect the residents' identities) for the following surveys:- A Concurrent Relicensing and Recertification Survey roster dated 12/2 - 12/3/24, with five resident identifiers and their names. - An Abbreviated Survey dated 2/7/20, with six resident identifiers and their names. - An Abbreviated Survey dated 8/26/19, with two resident identifiers and their names. - A Recertification Survey dated 2/27 - 3/5/19, with 22 resident identifiers and their names.The rosters were identified as being confidential and had Confidential printed diagonally across the page in a large grey font. On 12/9/25 at 1041 hours, an interview and concurrent facility document review was conducted with the DON. The DON verified the four confidential resident rosters should not have been in the survey binder for public view.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the MDS assessment was coded accurately for one of three residents reviewed for closed records (Resident 6). * Resident 6's MDS assessment was not coded accurately to show he received hospice services. This failure posed the risk for the resident not to have an individualized plan of care based on the resident's specific needs, and incorrect data being transmitted to CMS. Findings: Review of the facility's P&P titled Minimum Data Set (MDS) Guidelines revised 10/3/25, showed the MDS data will be used to guide care planning, monitoring resident outcomes, support facility quality improvement initiatives. Accuracy, timeliness, and interdisciplinary collaboration are essential to ensure compliance and optimal resident care. Closed medical record review for Resident 6 was initiated on 12/3/25. Resident 6 was readmitted to the facility on [DATE]. Review of Resident 6's Physician's Orders showed an order dated 9/17/25, for hospice services. Review of Resident 6's comprehensive MDS dated [DATE], failed to show the resident received hospice services. On12/5/25 at 1027 hours, an interview and concurrent closed medical record review was conducted with the MDS Coordinator. The MDS Coordinator stated Resident 6's physician's order for hospice services dated 9/17/25, triggered the completion of Resident 6's comprehensive MDS dated [DATE]. The MDS Coordinator stated the MDS assessment was not coded to show the resident received hospice services but should have.

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F 0656 Level of Harm - Potential for minimal 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 interview, medical record review, and facility P&P review, the facility failed to develop the comprehensive plan of care to reflect the individual care needs for two of 15 final sampled residents (Residents 35 and 41). * The facility failed to develop a care plan to address Resident 41's use of the midodrine (blood pressure medication) medication. * The facility failed to develop a care plan to address Resident 35's midline catheter (long, thin, flexible tube inserted into a peripheral vein and advanced until the tip rests below the armpit) use. These failures had the potential risk of not providing the appropriate, consistent, and individualized care to the residents.Findings: Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered revised 10/2025 showed all the residents will receive individualized person-centered care through comprehensive care plans that reflect their medical, psychological, and personal preferences. The care plans must include but are not limited to medical diagnosis and treatments. 1. Medical record review for Resident 41 was initiated on 12/3/25. Resident 41 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 41's Order Summary Report dated 12/1/25, showed to administer midodrine HCl oral tablet 2.5 mg via GT two times a day for hypotension and to hold the medication if the SBP is greater than 140 mmHg. Review of Resident 41's H&P examination dated 12/3/25, showed Resident 41 had a diagnosis of hypotension (low blood pressure). Review of Resident 41's plan of care failed to show a care plan problem was developed to address Resident 41's use of the midodrine medication. On 12/8/25 at 1110 hours, an interview and concurrent medical record review for Resident 41 was conducted with RN 2. RN 2 verified Resident 41's use of the midodrine medication. RN 2 verified there was no care plan developed for the use of midodrine medication. On 12/9/25 at 1346 hours, an interview was conducted with the AIT, Executive Director, and DON. The AIT, Executive Director, and DON were informed and acknowledged the above findings for Resident 41. 2. Medical record review for Resident 35 was initiated on 12/3/25. Resident 35 was admitted to the facility on [DATE]. Review of Resident 35's Order Summary Report showed a physician's order dated 11/11/25, for a midline catheter to the right upper arm. Review of Resident 35's plan of care failed to show a care plan problem to address the resident's midline catheter use. On 12/3/25 at 0832 hours, Resident 35 was observed sitting up in bed, and dressing to her right upper extremity and covered with elastic netting. (continued on next page)

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F 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	On 12/4/25 at 1139 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified Resident 35 had a midline catheter. RN 1 stated the midline catheters should be flushed for maintenance, and the midline site should be checked weekly during dressing changes and measurements. RN 1 reviewed Resident 35's care plan and verified the care plan did not address the resident's midline catheter use, monitoring, and maintenance.