STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555524	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the facility failed to ensure food was stored and equipment was maintained in accordance with professional standards for food safety when undated food items, food past their discard by date, uncovered food, rotten vegetables, and old, chipped, worn-out equipment were found in the kitchen.These failures had the potential to cause the growth of micro-organisms which could cause foodborne illness and cross-contaminated food for the 44 residents eating at the facility, with one resident on tube feeding and still eating lunch.Findings:On 1/26/26, at 9:10 a.m., during an observation of the kitchen with executive chef E (EC E), the following were observed: a. One pure [NAME] maple syrup with discard by dated 1/23/26b. One opened and undated Tamari soy saucec. Five cooked beets with discard by dated 1/25/26d. One [NAME] Caesar dressing with discard by dated 1/3/26e. One opened and undated Dijon mustardf. One opened and undated bag of frozen onion ringg. Three butter pecan ice cream containers not coveredh. Four undated blue ribbon ice cream [NAME]. Two pies with discard by dated 1/20/26j. Seventy-five of 4 ounces Mighty Shakes fortified shake vanilla with use by dated 4/17/25k. Three opened and undated mint chocolate chip ice cream containersl. One opened and undated sweet and sour saucem. One opened and undated box of 48 prune juicen. One opened half and half not coveredo. A 5-pounds bag of shredded carrots with use by dated 12/25/25p. One organic arugula container use by dated 1/24/26q. One undated bag of frozen tortillasr. Eight rotten iceberg lettucess. One opened and undated bag of diced carrotst. One opened and undated bag of diced onionu. Two of 14-ounces tamarin paste with use by dated 11/18/25v. Eight-ounces bag of provolone cheese with discard by dated 1/19/26w. Opened and undated 7-ounces bag of provolone cheesex. One olive oil with discard by dated 2025y. One opened and undated bag of frozen harsh brownz. One opened and undated bag of frozen falafelsaa. Three containers of cookies with discard by dated 1/20/26bb. Fifteen bags of mousse-mix with use by dated 12/2025cc. One country style gravy-mix with discard by dated 1/14/26dd. Ten undated bags of 1-pound orange gelatin During a concurrent interview with EC E, he stated he would throw these items out.During an observation and interview with the director of hospitality and nutrition (DHN) on 1/28/26, at 10:05 a.m., one old and chipped spatula, one worn-out butter spread brush, and one old cutting board with deep cuts and a layer of beige residual on it were found. The DHN confirmed on these items and removed them.Review of the facility's policy, Food Storage, dated 2013, indicated . 13. Food and non-food supplies are to be clearly labeled . 16. All exposed foods should be stored tightly covered.Review of the facility's policy, Infection Control for Health Care Dietary, dated 2005, indicated Chipped service ware should be discarded.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure three of 14 residents (Resident 51, 17 and 59) had been informed about having an advance directive (AD, legal form directing their wishes about their healthcare, whether from them or a named individual on their behalf), when no documentation was found about AD and the Physician Orders for Life-Sustaining Treatment (POLST, a legal document stating the kind of medical treatment residents want toward the end of their lives) were not completed and not readily available in the event of a medical emergency.This failure had the potential to result in inability to make medical decisions and could lead to the delivery of unnecessary or inappropriate medical services.Findings:Review of Resident 51's admission Record indicated he was admitted to the facility on [DATE] with diagnoses including Covid-19 (highly contagious respiratory illness caused by the SARS-CoV-2 virus, rhabdomyolysis (breakdown of muscle tissue that leads to the release of toxic components into the blood), type II diabetes mellitus (high levels of sugar in the blood).Review of Resident 51's electronic medical record on 1/28/26 at 10:10 a.m., indicated there was no advance directive and the POLST was not completed.During a concurrent interview and record review with the Director of Nursing (DON), on 1/28/26 at 1:32 p.m., the DON confirmed Resident 51 has no advance directive and the POLST was not completed.Review of Resident 17's admission Record indicated she was admitted to the facility on [DATE] with a diagnoses including laceration without foreign body of scalp (a torn or cut on the head caused by a blunt impact, such as a fall or blow), orthostatic hypotension (a sudden drop in blood pressure when you stand from a seated or lying down position), polymyalgia rheumatica (inflammatory disorder causing severe pain and stiffness in the shoulders, neck, and hips).During a concurrent interview and record review with the DON, on 1/28/26 at 1:38 p.m., the DON confirmed that Resident 17 has no advance directive and the POLST was not completed. The DON also stated the POLST should be completed.During an interview with the Director of Social Services (DSS), on 1/29/26 at 2:12 p.m., the DSS stated she was not informed that Resident 17's POLST was not completed. The DSS stated she would have followed up with the resident if she was informed that the POLST was not completed.Review of Resident 59's admission Record indicated she was admitted to the facility on [DATE] with diagnoses including bacterial infection (harmful bacteria enter the body) unspecified asthma (condition causing airways narrow and swell making breathing difficult), Sjogren syndrome (immune system disorder affecting the eyes and mouth)During a concurrent interview and record review with the DON, on 1/28/26 at 1:42 p.m., the DON confirmed Resident 59 does not have an advance directive and the POLST was not completed. The DON also stated that the POLST should be completed.During an interview with the Medical Records Supervisor (MRS), on 1/30/26 at 1:11 p.m., the MRS stated that medical records audit (review) the POLST to check if complete. The MRS stated she did not know why the POLST for Residents 51, 17 and 59 were not completed.Review of the facility's policy and procedure, titled Advance Directives, dated 2011, indicated Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, and/or his/her family members, about the existence of any written advance directives. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.

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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. Based on interview and record review, the facility failed to ensure 3 out of 5 sampled residents (Residents 1, 35, and 51) were free from unnecessary psychotropic medications (drugs that affects brain activities associated with mental processes and behavior) when:1. Resident 1 received trazodone (an antidepressant) for insomnia without side effect monitoring and without adequate monitoring when staff did not monitor the quantity (hours) of sleep to evaluate whether the medication was effective for her insomnia.2. Resident 35 received trazodone for insomnia without adequate monitoring for hours of sleep.3. Resident 51's as-needed (PRN) order for trazodone did not have a 14-day end date, as required.The failures resulted in inadequate and ineffective monitoring for side effects and effectiveness of psychotropic medications.1. A review of Resident 1's clinical record indicated she was admitted to the facility with diagnoses including depression (mood disorder that causes a persistent feeling of sadness and loss of interest) and insomnia (inability to sleep). A review of the physician's orders indicated Resident 1 had a physician's order, dated 11/6/25, for trazodone (an antidepressant medication) 50 milligrams (mg, unit of measurement), 1 tablet at bedtime for insomnia m/b [manifested by] inability to sleep. A review of Resident 1's clinical record indicated there was no care plan developed for insomnia. There was no documented record of causes of insomnia and type of insomnia the resident experienced such as sleep onset insomnia (trouble falling asleep) or sleep maintenance insomnia (trouble staying asleep). There was a care plan in Resident 1's clinical record, titled Resident is AT RISK for Side Effects from Psychotropic Medications. Trazodone, dated initiated 11/06/2025, indicating Monitor every shift for side effects of psychotropic medications and notify physician if side effects are present. However, neither the care plan nor any place in the clinical records indicated the staff were monitoring for the side effects of trazodone. A review of the January 2026 Medication Administration Record (MAR, where the nursing staff documented mediation administration and the behavior monitoring) indicated the staff placed a YES or NO for inability to sleep each day during the trazodone administration at 8 PM, but it did not include the number of hours of sleep (e.g., 6 hours, 8 hours) during the shifts to evaluate how many hours of sleep the resident had each day or night. During a concurrent interview and record review with the Director of Nursing (DON) on 1/28/26 at 12:48 p.m., the DON verified there had been no monitoring for the trazodone side effects. Regarding the YES/NO monitoring for insomnia, the DON stated the nursing staff would get supplemental information from the CNA [certified nursing assistant] .if the resident voices she can't sleep, then they would put a NO on the MAR. The DON stated the staff had not been monitoring for hours of sleep. He confirmed that the staff monitoring for quantity of sleep would be a more effective method to evaluate medication effectiveness, to see whether the medication helps the resident fall asleep, or to stay asleep during the night, including for those residents who cannot verbalize their inability to sleep. 2. A review of Resident 35's clinical record indicated she was admitted to the facility with diagnoses including unspecified insomnia. Her physician's orders included: Trazodone 50 mg, 0.5 tablet at bedtime for insomnia m/b inability to sleep, dated 12/19/25. A review of Resident 35's January 2026 MAR indicated the nursing staff placed a YES or NO along with the entry for trazodone medication administration daily at 10 p.m., but there was no monitoring for hours of sleep during the shifts to evaluate how many hours of sleep the resident had each day or night. During a concurrent interview and record review with the DON on 1/28/26 at 1:08 p.m., he stated, The insomnia is monitored but not number of hours of sleep. He stated the monitoring of YES/NO only allows superficial assessment of insomnia but not very effective. 3. Resident 51 was admitted to the facility with diagnoses including insomnia. He received a physician's order, dated 1/25/26, for trazodone 50 mg, give 0.5 tablet by mouth every 24 hours as needed for insomnia May repeat for 1 additional dose if needed. This order did not have a 14-day end date. During a concurrent interview and record review with the DON on 1/28/26 at 1:11 p.m., he (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reviewed Resident 51's trazodone order and stated it needs to have 14-day end date. A review of the facility's Medication Utilization and Prescribing - Clinical Protocol, revision date 4/2018, indicated, When a medication is prescribed for any reason, the physician and staff will identify the indications (condition or problem for which it is being given, or what the medication is supposed to do or prevent) . Symptoms should be characterized in sufficient detail (onset, duration, frequency, intensity, location, etc.) to help identify whether a problem exists or whether a symptom is just a variation of normal. A review of the facility's policy and procedure titled Psychotropic Medication Use, revision date 2/2025, indicated: Psychotropic medication management . includes adequate monitoring for efficacy and adverse consequences, Residents receiving psychotropic medication are monitored and the response to treatment is documented, and PRN orders for psychotropic medications are limited to 14 days.

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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 interview and record review, the facility failed to ensure the comprehensive care plan with measurable objectives, goals, and interventions, was developed and implemented for 4 out of 14 sampled residents (Residents 1, 3, 38, and 52), when:1. Resident 1 did not have care plans for migraine and insomnia;2. Resident 38 did not have a care plan related to use of apixaban (Eliquis, an anticoagulant - or blood thinner- to prevent blood clots) and osteoporosis (a bone disease causing weak, brittle bones due to decreased bone mass). 3. Resident 3 did not have a care plan developed for pressure ulcer; and4. Resident 52 did not have a care plan for the use of urinary catheter (flexible tube inserted into the bladder to drain urine).This failure placed the residents at risk of not being provided appropriate, consistent, and individualized care for their medical conditions. 1. A review of Resident 1's clinical record indicated she was admitted to the facility with diagnoses including migraine with aura (a recurring headache that strikes after or at the same time as nervous system symptoms called aura. Aura symptoms include flashes of light, blind spots, and other vision changes that affect both eyes) and insomnia. A review of Resident 1's physician's orders indicated she has been receiving: a. Topiramate (medication to prevent seizure and migraine) 25 milligrams (mg, unit of measurement) one time daily for migraines since 11/6/25. b. Trazodone (an anti-depressant medication) 50 mg, 1 tablet at bedtime for insomnia manifested by inability to sleep, dated 11/6/25. A review of Resident 1's clinical record indicated there were no comprehensive care plans for migraine with aura (such as triggers for migraine, goals, and interventions when resident experiences a migraine episode) and for insomnia (such as causes for insomnia, whether resident had difficulty falling asleep or staying asleep, resident preference or goal of hours of sleep per night, non-drug interventions, etc.). During concurrent interview and record review with the Director of Nursing (DON) on 1/28/26 at 12:48 p.m., he reviewed Resident 1's clinical record and confirmed there were no care plans, but should have been, developed for the resident's migraine and insomnia. 2. During a review of Resident 38's clinical record indicated Resident 38 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation (is an irregular and often very rapid heart rhythm) and other osteoporosis without current pathological fracture (a bone break caused by an underlying disease or condition). A review of Resident 38's physician's orders indicated the following: -apixaban oral tablet 5 mg (milligram) give 1 tablet by mouth two times a day for DVT prophylaxis (prevention of deep vein thrombosis, a blood clot in a deep vein, usually in the legs), dated 12/12/25. -raloxifene (used to treat postmenopausal osteoporosis and the risk reduction of invasive breast cancer in post-menopausal women) oral tablet 60 mg give 1 tablet by mouth one time a day for (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	osteoporosis, dated 12/12/25. A review of Resident 38's clinical record indicated there were no care plans developed and implemented for Resident 38's use of apixaban and diagnosis of osteoporosis. During a concurrent interview and record review on 1/28/26 at 1:22 p.m., with the Director of Nursing (DON), the DON reviewed Resident 38's clinical record and the DON stated did not see a care plan for Eliquis [brand name for apixaban]. The DON agreed that there should be a care plan. During a follow up interview and record review on 1/30/26 at 9:21 a.m., with the Director of Nursing (DON), the DON reviewed Resident 38's clinical record and confirmed there was no care plan developed for diagnosis of osteoporosis. The DON stated they should have a care plan for diagnosis upon admission. The DON further stated the care was just made on 1/29/26 and there was no care plan osteoporosis prior to 1/26/26. 3. Review of Resident 3's admission Record indicated she was admitted to the facility on [DATE] with diagnoses including aftercare following joint replacement surgery (a surgical procedure to replace some or all of a joint [the part of the body where two or more bones meet to allow movement], presence of right artificial hip joint (prosthesis, a man-made device designed to replace a damaged hip joint), muscle weakness generalized (loss of strength in the muscles that results in inability to do specific tasks). Review of Resident 3's Clinical Admission, dated 1/22/26, indicated new skin issue of stage 1 pressure ulcer on the right heel and left heel present on admission. Review of Resident 3's care plan indicated that a pressure ulcer care plan had not been developed. During a concurrent interview and record review with the DON, on 1/30/25 at 9:13 a.m., the DON confirmed that Resident 3 has stage 1 pressure ulcer on both heels. The DON also confirmed there was no pressure ulcer care plan done upon admission. The DON further stated there should be a care plan done for pressure ulcer. 4. Review of Resident 52's admission Record indicated she was admitted to the facility on [DATE] with diagnoses including fracture right pubis (a break in one of the bones of the pelvis [the ring of bones connecting the spine to the legs], fracture of other parts of pelvis, major depressive disorder (persistent low or depressed mood). Review of Resident 52's Physician's order, dated 1/22/26, indicated May insert 14fr foley catheter, one time only for PVR greater than 300ml, for 3rd time for 1 day. Review of Resident 52's care plan indicated that a foley catheter care plan had not been developed. During a concurrent interview and record review with the DON, on 1/28/26 at 1:32 p.m., the DON confirmed Resident 52 has a foley catheter inserted on 1/22/26. The DON also confirmed there was no care plan initiated after the insertion of foley catheter. The DON further stated there should be a care plan done. Review of the facility's policy and procedure, titled Care Plans, Comprehensive Person-Centered, dated 3.22, indicated A comprehensive, person-centered care plan that included, measurable (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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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 interview and record review, the facility failed to manage pain for one of 5 residents (29) when license nurses did not administer pain medication to Resident 29 according to the pain level ordered by the physician. This failure had the potential for the residents to experience avoidable pain and could negatively affect their quality of life.Findings:Review of Resident 29's admission Record indicated he was admitted to the facility on [DATE] with pain in left knee and gout (characterized by sudden, severe attacks of pain, swelling, redness and tenderness in one or more joints, most often in the big toe) diagnoses.Review of Resident 29's physician order, dated 2/11/25, indicated he had an order for acetaminophen (a drug that reduces pain and fever) 325 milligrams (mg, a metric unit of mass) 2 tablets every 4 hours as needed for mild pain level 1-4.Review of Resident 29's Medication Administration Record (MAR), from 9/2025 to 1/2026, indicated two tablets of acetaminophen 325 mg were administered to Resident 29 when his pain level was higher than 4 on 9/2/25, 9/9/25, 9/12/25, 9/13/25, 9/16/25, 9/19/25, 9/20/25, 10/10/25, 10/13/25, 10/24/25, 11/13/25, 12/8/25, 1/18/26, and 1/19/26.During an interview with the director of nursing (DON) on 1/30/26, at 11:40 a.m., he reviewed Resident 29's 9/2025 - 1/2026 MARs and confirmed that the licensed nurses administered two tablets of acetaminophen 325 mg to Resident 29 when his pain level was higher than 4 on 9/2/25, 9/9/25, 9/12/25, 9/13/25, 9/16/25, 9/19/25, 9/20/25, 10/10/25, 10/13/25, 10/24/25, 11/13/25, 12/8/25, 1/18/26, and 1/19/26. The DON stated the licensed nurses should follow the physician order.Review of the facility's job description, Licensed Vocational Nurse (LVN), dated 2/2024, indicated . Overall Responsibilities: The Charge Nurse is an LVN who is responsible for overall nursing care/services on the assigned shift, including the accurate and timely administration of medications, treatments, documentation, and emergency calls, as indicated.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure controlled medications (those with a high abuse potential) records were complete and fully accounted when:1. Drug disposition records conducted on [DATE] did not have a registered nurse's (RN's) signature to show the controlled medications were disposed of (destroyed) by a pharmacist and an RN, as required.2. Controlled medication use audit for three out of five sampled residents (Residents 1, 56, and 58) did not reconcile. The residents' controlled medications were signed out of the Controlled Drugs Records (CDR, inventory record of controlled drugs) but not documented on the Medication Administration Record (MAR, record of medications administered to a resident) to indicate they were administered to the residents. The failure resulted in inaccurate accountability and incomplete disposition records which had the potential for abuse and diversion (unlawful distribution or use) of controlled medications.1. During a concurrent interview and record review with the Director of Nursing (DON) on [DATE] at 1:56 p.m., he stated he last conducted the disposition of controlled medications with the consultant pharmacist (CP) on [DATE]. He stated expired, discharged , or discontinued controlled medications were kept secure in a locked box until they were destroyed (disposed of) by him and the CP. He explained that before the CP arrives for the disposal, he would inventory all the controlled medications to be destroyed and put them on the Controlled Substance Inventory Form (document containing the resident name, drug, drug strength, prescription number, physician name, fill date, dispense quantity, and quantity destroyed). During the destruction, the CP would verify all the information on the form versus the medications on hand for correctness; both would destroy the medications together and would sign the inventory form and the residents' individual count sheets (CDRs) to indicate they both destroy the medications together. A review of the [DATE] inventory form and the corresponding CDRs showed they only contained the CP's signature and lacked the DON's signature. The DON he stated he would sign them before giving them to the Medical Records office for recordkeeping but acknowledged he should have signed them on the day of medication destruction. A review of the Controlled Substance Inventory Form, dated [DATE], indicated there were 27 medications destroyed on that day.During a telephone interview with the CP on [DATE] at 3:35 p.m., the CP verified both she and the DON did the disposition of controlled medications together on [DATE]. She stated the disposition records and CDRs should be signed by both.A review of the facility's policy and procedures titled Controlled Substances, dated 11/2022, Indicated: Waste and/or disposal of controlled medication are done in the presence of the nurse and a witness who also signs the disposition sheet. 2. During the survey, the CDRs for five random residents receiving as-needed controlled medications were selected for review.On [DATE] at 12:05 p.m., a concurrent interview and record review was conducted with the DON. He stated nurses document medication administration on the MAR to show they were administered to the residents.a. Resident 1 had a physician's order, dated [DATE], for oxycodone (a potent narcotic for pain) 5 milligrams (mg, unit of measurement), give 0.5 tablet by mouth every 4 hours as needed for pain management.On [DATE] at 12:06 p.m., a review of Resident 1's CDR for oxycodone 5 mg and the [DATE] MAR with the DON indicated the nursing staff signed 1 dose out of the CDR but did not document the administration on the MAR on two occasions: on [DATE] at 12:30 p.m. and on [DATE] at 7:43 a.m. The DON also reviewed the corresponding nursing progress notes, and confirmed two doses were not, but should have been, documented on the MAR to show it was administered to the resident.b. A review of Resident 56's clinical record indicated a physician's order for tramadol (a controlled medication for pain), give 0.5 tablet by mouth every 6 hours as needed for moderate pain, dated [DATE].On [DATE] at 12:12 p.m., a review of Resident 56's CDR for tramadol 25 mg and the [DATE] MAR with the DON indicated the nursing staff signed 1 dose out of the CDR but did not document the administration on the MAR: on [DATE] at 5:10 a.m. After (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reviewing also the nursing progress notes, the DON confirmed this finding and stated there was no documentation on the MAR or the nursing progress notes to indicate it was administered to the resident.c. A review of Resident 58's clinical record indicated he had a physician's order, dated [DATE], for oxycodone 5 mg, give 1 tablet every 3 hours as needed for pain.On [DATE] at 2:24 p.m., a review of Resident 58's CDR for oxycodone 5 mg and the September and [DATE] MARs with the DON indicated the nursing staff signed out 1 tablet from the CDR but did not document the administration on the MAR on two occasions: on [DATE] at 8:45 p.m. and on [DATE] at 6 a.m. The DON reviewed the resident's clinical record, including the nursing progress notes, and confirmed two oxycodone tablets for Resident 58 were not accounted for. He stated medication administration must be documented on the MAR or progress notes to show they were administered to the residents.Review of facility's policy and procedures titled Administering Medications, revised 4/2019, indicated: The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication . The individual administering the medication records in the resident's medical record. the date and time the medication was administered. the date signature and title of the person administering the drug.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility and the Consultant Pharmacist (CP) failed to ensure the pharmacist's medication regimen review (MRR) recommendations were acted upon/responded to on a timely basis. The CP's recommendations from November 2025 through January 2026 were delayed, resulting untimely response for 4 out of 14 sampled residents (Residents 1, 10, 29, and 38). For Resident 10, CP's recommendation for a dose change of aspirin was not acted on timely. For Resident 1, the recommendation for trazodone (an antidepressant) side effect monitoring was not acted on and carried out timely. For resident 38, the anticoagulant (a blood thinner to prevent blood clot) dose change recommendation was not acted on and carried out timely. For Resident 29, the recommendation to initiate routine acetaminophen (Tylenol) for better pain management was not acted on and carried out timely.The failure resulted in unnecessary medications for the residents including inadequate doses (too high or low) and unmonitored medication use for the residents.1. During the survey on 1/28/26, a binder containing the CP's monthly medication regimen review (MRR) recommendations and reports for year 2025 was requested for review from the Director of Nursing (DON). A review of the MRR binder indicated those recommendations and reports for November and December 2025 were missing. During a concurrent interview and record review with the DON on 1/28/26 at 11:37 a.m., the DON stated he is the primary person responsible for acting upon the pharmacist's recommendations; for those addressed to the physicians, he would put them in a folder for them to respond during their visit to the facility; and he would be responsible for responding to those addressed to the nursing staff. Regarding those in November 2025 and December 2025, he stated he was too busy and did not get to work on them. He additionally stated, during the CP's latest visit on 1/20/26, she told him there were pending reports (recommendations that did not have response yet) and provide him a list from October 2025 to December 2025. He stated he just started working on them after that day and about to get done with all of them including those for this month. He acknowledged the CP's MRRs were not responded to timely. During a telephone interview with the CP on 1/28/2026 at 3:32 p.m., she stated there were two teams doing the MRRs: the new admission team who does review for newly admitted residents, and she herself does MRRs during regular monthly review. When asked about the facility's timely response to her recommendations, she stated the DON was not very good at getting back to me. Communication about the follow up could be better. During another interview and record review with the DON on 1/29/26 at 2:09 p.m., he stated he responded to the pharmacist's recommendations for new admission a few days after received; only those monthly MRR recommendations from the CP were delayed. A review of the CP's recommendations with the DON indicated there were 28 recommendations made in November 2025 and 17 recommendations in December 2025. 2. A review of the pending reports called Consultation Reports, from October 1, 2025 to December 31,2025, indicated there were 4 pending recommendations in November 2025, and 12 pending ones in December 2025. They included recommendations for the following sampled residents: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Resident 10 had a physician's order for aspirin 325 milligrams (mg, unit of measurement) 1 tablet one time a day for blood clot prevention since 8/1/25. A review of the CP's recommendation to the physician, dated 12/14/25, indicated: [Resident 10] receives aspirin at a daily dose regimen great than 100 mg which could increase the risk of bleeding complications . Please consider evaluation, and if continues, please document an assessment of risk vs benefit. During a concurrent interview and record review with the DON on 1/28/26 at 11:54 a.m., he acknowledged this recommendation has not been presented to the physician for a response yet (more than a month later). b. A review of Resident 1's clinical record indicated she was admitted to the facility with diagnoses including depression (mood disorder that causes a persistent feeling of sadness and loss of interest) and insomnia (inability to sleep). Resident 1 had a physician's order, dated 11/6/25, for trazodone (an antidepressant medication) 50 mg, give 1 tablet at bedtime for insomnia m/b [manifested by] inability to sleep. A review of Resident 1's care plan titled Resident is AT RISK for Side Effects from Psychotropic Medications. Trazodone, dated initiated 11/06/25, indicated Monitor every shift for side effects of psychotropic medications and notify physician if side effects are present. However, neither the care plan nor any place in the clinical records indicated the staff were monitoring for the side effects of trazodone. On 1/28/26, a review of the CP's recommendation, dated 12/14/25, indicated: [Resident 1's] medication administration record (MAR) or prescriber order sheets (POS) includes items that need clarification. Trazodone 50 mg hs [at bedtime] - antidepressant, please monitor side effects. During a concurrent interview and record review of Resident 1's clinical record with the DON on 1/28/26 at 12:48 p.m., he verified there was no documentation the staff had been monitoring for the side effects of trazodone. He also reviewed and acknowledged the CP had made the recommendation for trazodone side effect monitoring over a month ago, and it has not been acted upon. c. A review of Resident 38's clinical record indicated she was an over-[AGE] year-old resident admitted to the facility with diagnoses including unspecified atrial fibrillation (Afib, an irregular and often very rapid heart rhythm. AFib can lead to blood clots in the heart). The resident weighed 120 pounds (54.5 kilograms [kg], unit of weight) on 1/27/26. A review of Resident 38's physician's orders, on 1/28/26, indicated an order for Eliquis (apixaban, an anticoagulant to prevent blood clot) 5 milligrams (mg, unit of measurement), 1 tablet by mouth two times a day for DVT prophylaxis (prevention of deep vein thrombosis, a blood clot in a deep vein, usually in the legs), dated 12/12/25. A review of the manufacturer's Prescribing Information (detailed description of a drug's uses, dosage (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	range, side effects, drug-drug interactions, and contraindications that is available to clinicians) for apixaban, issued 4/2025, indicated the following under DOSAGE AND ADMINISTRATION: For atrial fibrillation, The recommended dose is 5 mg twice daily. In patients with at least 2 of the following characteristics: age greater than or equal to 80 years, body weight less than or equal to 60 kg, or serum creatinine [a measure of how well the kidneys are filtering waste from the blood] greater than or equal to 1.5 mg/dL, the recommended dose is 2.5 mg orally twice daily. Prophylaxis of DVT following hip or knee replacement surgery: The recommended dose is 2.5 mg orally twice daily. On 1/28/26 at 1:46 p.m., a review of the above Prescribing Information with the DON was conducted. He verified Resident 38 was over [AGE] years old and weighed less than 60 kilograms which indicated she should be on 2.5 mg twice daily instead of 5 mg twice daily. During a telephone interview with the CP on 1/28/26 at 3:56 p.m., she confirmed Resident 38 has afib and should be on the lower dose, at 2.5 mg twice daily. She stated the new admission pharmacist made a dose change recommendation to the physician on 12/15/25. She continued to explain, in doing the review in January 2026, I didn't see any change so I made recommendation on January 12th for consideration to lower the dose to 2.5 mg twice daily. The CP also stated she put a clinical priority on the recommendation. When asked what that meant, she stated means I would like them to get more attention but did not specify the timeline to act upon this type of recommendation. A review of the above-mentioned recommendation by the new admission pharmacist, dated 12/15/25, indicated: [Resident 38] receives Eliquis (apixaban) 5 mg BID [twice daily] (dx? [diagnosis] afib?) and has 2 or more of the following dose limiting characteristics: 1) age greater than or equal to 80 years, 2) boy weight 60 kg or less; 3) serum creatinine greater than or equal to 1.5 mg/dL. Recommendation: If Apixaban indication use is afib, please consider decreasing Eliquis to 2.5 mg BID when the start date is clarified (12/24/2025?). A review of the recommendation by the CP, dated 1/12/26, indicated: Comment: ***CLINICAL PRIORITY RECOMMENDATION: PROMPT RESPONSE REQUESTED*** [Resident 38] receives Eliquis (apixaban) 5 mg BID (dx afib) and has 2 or more of the following dose limiting characteristics: 1) age greater than or equal to 80 years . 2) body weight 60 kg or less -- wt [weight] 57 kg (125 lb) 3) serum creatinine greater than or equal to 1.5 mg/dL -- ok . Recommendation: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	If Apixaban indication for use is a fib, please consider decreasing Eliquis to 2.5 mg BID. During an interview on 1/28/26 at 4:12 p.m., the DON confirmed he had received the recommendations by the pharmacists, but they had not been provided to the physician and hence not acted upon yet. He stated the facility policy does not address the timeline to act upon the pharmacist's recommendations, but the expectation is within 2 weeks but would also depend on the nature of the recommendations. He said he has no excuse for it, except he had many things to do, and the recommendations were not done. d. Review of Resident 29's admission Record indicated he was admitted to the facility on [DATE] with pain in left knee and gout (characterized by sudden, severe attacks of pain, swelling, redness and tenderness in one or more joints, most often in the big toe) diagnoses. Review of Resident 29's physician order, dated 2/11/25, indicated he had an order for acetaminophen (a drug that reduces pain and fever) 325 milligrams (mg, a metric unit of mass) 2 tablets every 4 hours as needed for mild pain. Review of Resident 29's Consultation Report, dated 11/11/25, indicated the pharmacist reported that Resident 29 frequently received acetaminophen as needed for pain, at night around 8 p.m. and recommended the physician to consider initiating routine acetaminophen 650 mg at 8 p.m. However, there was no indication that the Consultation Report was presented to the physician. During an interview with the director of nursing (DON) on 1/28/26, at 4 p.m., he reviewed Resident 29's 11/11/25 Consultation Report and confirmed that it had not been presented to the physician. A review of the facility's policy and procedures titled Medication Regimen Review, effective 11/28/16, indicated: 6. The pharmacist will address copies of the residents' MRRs to the Director of Nursing and/or the attending physician and to the Medical Director. Facility staff should ensure that the attending physician, Medical Director, and Director of nursing are provided with copies of the MRRs. 7. Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MRR and the Director of Nursing to act upon the recommendations contained in the MRR . 9. When the Consultant Pharmacist identifies an urgent medication irregularity during MRR that requires immediate action, the consultant pharmacist will notify the nurse and request the facility to contact the attending physician to communicate the issue and obtain direction or new orders.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 2 out of 14 sampled residents (Residents 7 and 38) were free from unnecessary medications when:1. Resident 38 received apixaban (Eliquis, an anticoagulant - or blood thinner- to prevent blood clots) at a dose higher than manufacturer's recommendation for her diagnosis, age, and weight without the risk/benefit assessment from the physician. This had the potential for the resident to suffer from adverse effects (such as bruising, bleeding) from anticoagulant use.2. The nursing staff did not monitor for signs and symptoms of related to apixaban use for Resident 38. This had the potential for untimely recognition and interventions for adverse effects from anticoagulant use.3. Resident 7 received torsemide (a medication to lower blood pressure and treat fluid retention) without hold parameters (such as to hold when blood pressure is low). This had the potential for the medication to be administered when the resident's blood pressure is low, leading to severely low blood pressure for the resident. 1. A review of Resident 38's clinical record indicated she was an over-[AGE] year-old resident admitted to the facility with diagnoses including unspecified atrial fibrillation (Afib, an irregular and often very rapid heart rhythm. AFib can lead to blood clots in the heart). The resident weighed 120 pounds (54.5 kilograms [kg], unit of weight) on 1/27/26. A review of Resident 38's physician's orders indicated an order for apixaban 5 milligrams (mg, unit of measurement), 1 tablet by mouth two times a day for DVT prophylaxis (prevention of deep vein thrombosis, a blood clot in a deep vein, usually in the legs), dated 12/12/25, A review of the manufacturer's Prescribing Information (detailed description of a drug's uses, dosage range, side effects, drug-drug interactions, and contraindications that is available to clinicians) for apixaban, issued 4/2025, indicated the following under DOSAGE AND ADMINISTRATION: For atrial fibrillation, The recommended dose is 5 mg twice daily. In patients with at least 2 of the following characteristics: age greater than or equal to 80 years, body weight less than or equal to 60 kg, or serum creatinine [a measure of how well the kidneys are filtering waste from the blood] greater than or equal to 1.5 mg/dL, the recommended dose is 2.5 mg orally twice daily. Prophylaxis of DVT following hip or knee replacement surgery: The recommended dose is 2.5 mg orally twice daily. On 1/28/26 at 1:46 p.m., a review of the above Prescribing Information with the DON was conducted. He verified Resident 38 was over [AGE] years old and weighed less than 60 kilograms which indicated she should be on 2.5 mg twice daily instead of 5 mg twice daily. A review of Resident 38's clinical record indicated there was no risk/benefit assessment statement or rationale for why Resident 38 should be on a higher dose than the manufacturer's recommended dose for apixaban. During a telephone interview with the Consultant Pharmacist (CP) on 1/28/26 at 3:56 p.m., she confirmed Resident 38 has afib and should be on the lower dose, at 2.5 mg twice daily. She stated the new admission pharmacist (pharmacist who reviews the drug regimen for newly admitted residents) made a recommendation to the physician on 12/15/25; and she made another recommendation on 1/12/26, for consideration to lower the dose to 2.5 mg twice daily. During an interview on 1/28/26 at 4:12 p.m., the DON acknowledged he had received the recommendations by the pharmacists, but they had not been acted upon, hence the reason the dose had not been changed. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Medication Utilization and Prescribing - Clinical Protocol, revision date 4/2018, indicated, When a medication is prescribed for any reason, the physician and staff will identify the indications (condition or problem for which it is being given .) considering the resident's age .risks, health status, and medication regimen . The consultant pharmacist should use the monthly and interim drug regimen review to help identify potentially problematic medications, including medication regimens that are not supported based on clinical signs or symptoms .The physician will provide and/or document a rationale when the indication, dose, duration, or frequency of a prescribed medication is greater than commonly accepted practice or the manufacturer's recommendations . 2. During a review of Resident 38's clinical record indicated Resident 38 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation (is an irregular and often very rapid heart rhythm) and other osteoporosis (a bone disease causing weak, brittle bones due to decreased bone mass) without current pathological fracture (a bone break caused by an underlying disease or condition). A review of Resident 38's physician's orders indicated an order for apixaban oral tablet 5 mg (milligram) Give 1 tablet by mouth two times a day for DVT prophylaxis (prevention of deep vein thrombosis, a blood clot in a deep vein, usually in the legs), dated 12/12/25. During a review of Resident 38's January 2026 medication administration record (MAR, a record of medications given) and physician's order, indicated the nursing staff did not monitor the side effects related to use of apixaban. During a concurrent interview and record review on 1/28/26 at 1:30 p.m., with the DON, the DON reviewed Resident 38's clinical records, the DON stated did not see the see the order for side effects monitoring. The DON further stated usually the monitor for side effects and it's missing in this case. During a review of facility's policy and procedure (P&P) titled Anticoagulation - Clinical Protocol, dated 3/2025, indicated, Monitoring and Follow-Up.5. The staff and physician will monitor for possible complications in individuals who are being anticoagulated, and will manage related problems. a. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis; or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant . During a review of facility's policy and procedure (P&P) titled Medication Utilization and Prescribing -Clinical Protocol, dated 3/2025, indicated, Monitoring: 1.The staff and physician will periodically re-evaluate the conditions and symptoms for which each resident is receiving medications to determine if the medication and doses are still relevant and are not causing undesired complications.2.The staff and physician will monitor the progress of anyone with a probable adverse drug reaction and anyone for whom medications have been adjusted because of the possibility of an adverse drug reaction. 3. During a review of Resident 7's clinical record indicated Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including unspecified atrial fibrillation and other osteoporosis without current pathological fracture. A review of Resident 7's physician's order indicated an order for torsemide oral tablet 20 give 2 tablet by mouth one time a day for HTN (hypertension, known as high blood pressure), dated 3/19/24. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 7's January 2026 MAR and physician's order, it indicated there were no holding parameters for torsemide, such as to hold when the blood pressure is low. During a concurrent interview and record review on 1/30/26 at 9:23 a.m., with the DON, the DON reviewed Resident 7's clinical records and confirmed that there were no holding parameters for torsemide. The DON further stated there should be a parameter. During a review of facility's policy and procedure (P&P) titled Medication Utilization and Prescribing -Clinical Protocol, dated 3/2025, indicated, Monitoring: 1.The staff and physician will periodically re-evaluate the conditions and symptoms for which each resident is receiving medications to determine if the medication and doses are still relevant and are not causing undesired complications.2.The staff and physician will monitor the progress of anyone with a probable adverse drug reaction and anyone for whom medications have been adjusted because of the possibility of an adverse drug reaction.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure food served to the residents were at acceptable temperature. This failure had the potential to impact on the residents' nutritional status and not meet the residents' desires.Findings:During an interview with Resident 61 on 1/26/26, at 11:14 a.m., she stated the hot food was not hot.During an observation and interview with the director of hospitality and nutrition (DHN) on the test tray on 1/28/26, at 12:35 p.m., the brisket, the macaroni and cheese, and the burger were at 117.9 Fahrenheit (F, a scale of temperature), 121F, and 116.9F. The DHN confirmed these hot food temperatures.During an interview with the DHN on 1/30/26, at 11:15 a.m., he stated the facility did not have the policy on food temperature served at the residents' tables.During an interview with Resident 60 on 1/30/26, at 1:04 p.m., he stated the food was cold; the hot food was not hot; the coffee in the morning was cold; the eggs, bacon, and sausages were cold when they came to his room.Review of the facility's Food and Nutrition: Test Tray Evaluation Logs indicated that the food temperatures were taken on the facility's test trays, but there was no benchmark to determine what temperature was acceptable.

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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 ensure proper infection prevention techniques were followed when:1. The Licensed Vocational Nurse (LVN) A failed to wear Personal Protective Equipment (PPE, equipment worn to minimize exposure to hazards that cause serious workplace injuries and illness) when he entered the room of a Covid-19 (highly contagious respiratory illness caused by the SARS-CoV-2 virus) positive resident (Resident 51);2. The Registered Nurse (RN) B failed to change gloves during tube feeding (liquid nutrients given through a tube inserted in the stomach) for Resident 2;3. Licensed Vocational Nurse (LVN) C used the same tissue to wipe excess liquid from both eyes during the administration of three different eye medications for Resident 4; and4. Certified Nursing Assistant F (CNA F) did not perform hand washing or hand hygiene before feeding Resident 18.These deficient practices had the potential for contamination and spread of infection.Findings: 1. Review of Resident 51's admission Record indicated he was admitted to the facility on [DATE] with a diagnosis of Covid-19. Review of Resident 51's Physician's order, dated 1/25/26, indicated utilize airborne precautions (a type of isolation used to prevent the spread of infectious agents transmitted through the air) due to Covid positive every shift for 10 days. During an observation on 1/26/26 at 9:48 a.m., the LVN A was inside Resident 51's room with the door open. The LVN A was not wearing the proper PPE which includes N-95 (a respiratory protective device) mask, gown, gloves and goggles (protective eyewear). During a concurrent observation and interview with the Director of Staff Development Coordinator (SDC), on 1/26/26 at 10:02 a.m., the DSD confirmed the LVN A was not wearing the proper PPE. The DSD stated the LVN A should have worn the N-95 mask and gown. During an interview with LVN A, on 1/26/26 at 12:49 p.m., the LVN A confirmed he was not wearing the proper PPE when he entered Resident 51's room. The LVN A stated he should have worn N-95 mask, protective gown, gloves and goggles. During an interview with the Infection Preventionist (IP), on 1/30/26 at 10:15 a.m., the IP stated the expectation was to follow the policy for airborne precautions to wear PPE including gown, N-95 respirator, gloves and goggles. According to Centers for Disease Control and Prevention's (CDC, a public health agency that protect public health by preventing and controlling disease, injury and disability) Infection Control Guidance: SARS-CoV-2, dated 7/24/24, indicated HCP (Healthcare Provider) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). Review of the facility's policy and procedure (P&P), titles Isolation-Categories of Transmission-Based Precautions, revised date 9/22, indicated When a resident is placed on transmission-based precautions.The signage informs the staff of the type of CDC precaution(s), instructions for the use of PPE.Airborne Precautions.4. Any individuals who enter the room of a resident placed on airborne (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	precautions must wear approved respiratory protection. Review of the facility's P&P, titled Standard Precautions, revised date 9/22, indicated Standard precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard precautions presume all blood, body fluid, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. 2. Review of Resident 2's admission Record indicated she was admitted on [DATE] with diagnoses including hemiplegia (loss of strength in the arm, leg, and sometimes face on one side of the body) and hemiparesis (a relatively mild loss of strength in the arm, leg, and sometimes face on one side of the body) following cerebral infarction (stroke; a result of disrupted blood flow to the brain), dysphagia (difficulty swallowing), type II diabetes mellitus (high levels of sugar in the blood). Review of Resident 2's Physician's order, dated 1/26/26, indicated [NAME] Farms 1.2 Glucose Support (plant-based, organic nutrition formula) bolus (a method of delivering nutrition directly into the stomach) of 250 milliliter (ml, unit of measurement) five times a day for enteral feeding (tube feeding). During a concurrent observation and interview with RN B, on 1/28/26 at 10:38 a.m., RN B was observed to put on the PPE before entering Resident 2's room. RN B moved the trash bin closer to the resident and checked the residual (the volume of fluid remaining in the stomach at a point in time during enteral nutrition feeding) of the G-tube (gastrostomy tube, a soft plastic tube inserted through the stomach to deliver nutrients, fluids, and medications). RN B then went to the bathroom to discard the residual amount. RN B then started to flush the G-tube (a process of pushing water into the _tube to prevent clogging). RN B then proceeded to insert the syringe and poured the formula until it was empty. RN B went to the bathroom to get more water to flush the G-tube after the giving the formula. RN B confirmed that she did not change gloves after she moved the trash bin which was contaminated and after she went to the bathroom. RN B stated she should have changed gloves in between pouring the formula and flushing. During an interview with the Infection Preventionist (IP), on 1/30/26 at 10:19 a.m., the IP stated the nurse should change gloves, sanitize hand and put on new gloves every time the nurse touch anything dirty to clean. During a review of the facility's P&P, titled Standard Precautions, revised date 9/22, indicated Gloves are changed and hand hygiene performed before moving from a contaminated-body site to a clean-body site during resident care. Gloves are changed as necessary, during the care of a resident to prevent cross-contamination from one body site to another (when moving from a dirty site to a clean site). During a review of the facility's P&P, titled Enteral Feedings – Safety Precautions, indicated Maintain strict aseptic technique at all times when working with enteral nutrition systems and formulas. 3. During a medication administration observation on 1/26/26 starting at 4:18 p.m., Licensed Vocational Nurse C (LVN C) was observed preparing 7 medications for Resident 4. Included in the medications were 3 different eye medications to treat high eye pressure in the eye (glaucoma): Brimonidine 0.1% eye solution, latanoprost 0.005% eye solution, and dorzolamide-timolol 2-0.5 % eye (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	solution. On 1/26/26 at 4:29 p.m., LVN C was observed instilling 1 drop of the brimonidine 0.1% eye solution into each of the resident's eyes. He then obtained a tissue and wiped the dripping off her eyes with one single tissue. On 1/26/26 at 4:36 p.m., LVN C was observed instilling 1 drop of latanoprost eye solution into each of the resident's eyes. Again, he obtained a new tissue and wiped both of her eyes with it after the eye drop instillation. On 1/26/26 at 4:42 p.m., LVN C did the same with the dorzolamide-timolol eye solution. He stilled 1 drop into each of the resident's eyes, then obtained a new tissue to wipe both of her eyes after the eye drop instillation. During an interview on 1/26/26 at 4:44 p.m., LVN C confirmed he used 1 tissue to wipe the resident's eyes after each eye drop administration; and acknowledged he should have used one tissue for each eye to prevent cross-contamination, such as bringing bacteria from one eye to the other. During an interview with the Infection Preventionist (IP) on 1/27/26 at 10:15 a.m., she stated, when administering eye drops, the staff needs to use a new clean tissue for each eye to avoid cross-contamination. A review of the facility's policy and procedures titled Instillation of Eye Drops, revised January 2014, indicated in part, Gently dry the eyelid with cotton ball if dripping occurs. (Note: Use only one cotton ball per wipe). 4. During a dining observation on 1/26/26, at 12:38 p.m., CNA F pushed Resident 36's wheelchair from one location to another at the nurse station, then went into the dining room, sat down, and fed Resident 18 without cleansing her hands. During a concurrent interview with CNA F, she stated she should wash or sanitize her hands before feeding Resident 18. During an interview with the IP on 1/30/26, at 10:24 a.m., she stated staff should cleanse their hands before feeding the residents. Review of the facility's policy, Handwashing/Hand Hygiene, dated 8/2019, indicated . 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: . p. Before and after assisting a resident with meals; .

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and policy review, the facility failed to treat one of 14 residents (23) with respect and dignity when certified nursing assistant D (CNA D) was standing while feeding Resident 23 in his room. This failure had the potential to cause Resident 23 feeling low self-esteem.Findings:During a dining observation on 1/26/26, at 12:57 p.m., CNA D was standing while feeding lunch to Resident 23 in his room.During a concurrent interview with CNA D, she stated she was standing and feeding Resident 23 because she was short. CNA D acknowledged that she could position Resident 23's bed lower, so that she could sit on a chair and feed the resident.Review of the facility's policy, Assistance with Meals, dated 3/2022, indicated . 3. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: a. Not standing over residents while assisting them with meals; .

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F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise and implement comprehensive care plan that included measurable objectives and interventions for one out of 14 sampled residents (Resident 33) when Resident 33's foley catheter (a device inserted into the bladder [organ that collects urine] to drain urine, made of a semi-flexible plastic tube) care plan was not revised or updated after the intervention failed. The failure had the potential for Resident 33 not attaining the highest practicable physical, mental, and psychosocial well-being.During a review of Resident 33's clinical record indicated Resident 33 was admitted to the facility on [DATE] with diagnosis including urinary retention. A review of Resident 33's physician's order dated, 1/1/26 indicated an order for Foley Catheter 16Fr (French, size is comparable to the circumference of the catheter in millimeters) due to diagnosis of urinary retention change per MD (Medical Doctor) schedule and prn (as needed) obstruction. A review of Resident 33's care plan, dated 12/15/25 Problem: Resident has ACTUAL Altered Bladder Elimination- on Foley cath (catheter) for urinary retention. The intervention indicated, 3 day voiding diary to establish pattern and need for bladder training/toileting programs, dated 12/15/25. There was only one intervention for Resident 33's foley catheter care plan. During a concurrent interview and record review on 1/28/26 at 1:28 p.m., with the Director of Nursing (DON), the DON reviewed Resident 33's foley catheter care plan. The DON confirmed there was only one intervention in the care plan. The DON further stated the 3-day voiding trial failed and should have updated the care plan. During a review of facility's policy and procedure (P&P) titled Care plan, Comprehensive, Person-Centered dated 3/2022, indicated, Policy Statement: 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. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the care plan: .b. when the desired outcome is not met.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure necessary care and services were provided to one of three residents (41) when Resident 41's pacemaker (a small battery-operated device that helps the heart beats in a regular rhythm) information was not in his medical records. This failure had the potential for not preventing Resident 41 from experiencing serious health conditions.Findings:Review of Resident 41's admission Record indicated he was admitted to the facility on [DATE] with heart failure (a condition in which the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen), atrial fibrillation (an irregular heartbeat that can lead to blood clots, heart failure, and other heart-related complications), and presence of cardiac pacemaker diagnoses.Review of Resident 41's clinical record indicated that his pacemaker information such as manufacturer, model, serial number, date implanted, name of cardiologist, etc. was not found.During an interview with the director of nursing (DON) on 1/30/26, at 12 p.m., he reviewed Resident 41's medical records and was unable to locate Resident 41's pacemaker information. The DON stated Resident 41's pacemaker information should be available in his medical records.Review of the facility's policy, Pacemaker, Care of a Resident with a, dated 12/2015, indicated . Documentation: 1. For each resident with a pacemaker, document the following in the medical record and on a pacemaker identification card upon admission: a. The name, address, and telephone number of the cardiologist; b. Type of pacemaker; c. Type of leads; d. Manufacturer and model; e. Serial number; f. Date of implant; and g. Paced rate.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview and record review, the facility failed to assess fall risk for one of three residents (36) when Resident 36 had not had quarterly fall risk assessment since after 5/28/25. This failure had the potential to result in Resident 36's fall risk and fall intervention were not up to date to prevent her from falling and getting injury.Findings:Review of Resident 36's admission Record indicated she was admitted to the facility on [DATE] with abnormalities of gait and mobility diagnosis.Review of Resident 36's Nursing Progress Note, dated 5/28/25, at 9:50 p.m., indicated on 5/28/25, at 4:30 p.m., Resident 36 went from her wheelchair to stand and transfer to the walker in the dining room. Resident 36 lost balance and fell onto her left side.Review of Resident 36's clinical records indicated Resident 36 was assessed for fall risk when she fell on 5/28/25. However, there were no fall risk assessments done for Resident 36 after 5/28/25.During an interview with the director of nursing (DON) on 1/30/26, at 11:43 a.m., he reviewed Resident 36's medical records and confirmed that Resident 36 had not been assessed for fall risk since after 5/28/25. The DON stated the residents should be assessed for fall risk on their admissions, every quarter, and after they fell.Review of the facility's policy, Fall Risk Assessment, dated 3/2018, indicated The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the proper use of bed rails (side rails, adjustable rigid bars attached to the side of a bed) for one of nine residents (Resident 2) with side rails when there was no documented evidence that the bed rail entrapment risk assessment was completed.This failure had the potential to place the residents at risk of entrapment and serious injury.Findings:Review of Resident 2's admission Record indicated she was admitted on [DATE] with diagnoses including hemiplegia (loss of strength in the arm, leg, and sometimes face on one side of the body) and hemiparesis (a relatively mild loss of strength in the arm, leg, and sometimes face on one side of the body) following cerebral infarction (stroke; a result of disrupted blood flow to the brain), dysphagia (difficulty swallowing), type II diabetes mellitus (high levels of sugar in the blood).During a concurrent observation and interview with the Director of Nursing (DON), on 1/29/26 at 9:00 a.m., in Resident 2's room, the DON confirmed Resident 2 had bilateral (both) upper bed rails. The DON also stated the entrapment risk assessment was done by maintenance staff.Review of Resident 2's Physician's order, dated 12/9/25, indicated use of bed rails authorized per bed rail assessment for 2 transfer bar related to resident's hemiplegia and hemiparesis following cerebral infarction affecting left dominant side.During a concurrent interview and record review with the Associate Director Plant Ops (ADPO), on 1/30/26 at 2:18 p.m., the ADPO stated entrapment risk assessment for bed rails were done upon admission and quarterly. The ADPO was not able to provide documentation that Resident 2's entrapment risk assessment was completed.During a concurrent interview and record review with the DON, on 1/30/26 at 2:32 p.m., the DON confirmed the ADPO was not able to provide documentation that Resident 2's bed rail entrapment risk assessment was completed.Review of the facility's policy and procedure, titled Bed Safety and Bed Rails, dated 5/1/23, indicated 5. Regardless of mattress type, width, length, and/or depth, the bed frame, bed rail and mattress will leave no gap wide enough to entrap a resident's head or body. Any gaps in the bed system are within the safety dimensions established by the FDA. A bed rail gap evaluation will be completed by the maintenance department in collaboration with the licensed nurses. This evaluation will be documented. 6. Maintenance staff routinely inspects all beds and related equipment to identify risks and problems including potential entrapment risks. 10. Additional safety measures are implemented for residents who have been identified as having a higher than usual risk for injury including bed entrapment.