STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555535	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Valley Care Center	9000 Larkin Road Live Oak, CA 95953

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, the facility failed to maintain a safe, clean, comfortable and homelike environment when 10 out of 21 resident rooms in the locked unit, and one courtyard in the locked unit had the following: 1. Resident rooms 131, 133, 134, 137, 138, and 140 were observed as undecorated and not personalized to individuals. 2. room [ROOM NUMBER] was found on multiple dates as having a foul, unpleasant urine-like smell. 3. room [ROOM NUMBER] and 141 were observed to have mismatched toilet parts covered in tape, as well as other broken parts. 4. rooms [ROOM NUMBER] were observed to have patchy, or scratched off paint visible to, and near resident beds. 5. Uncovered outlets with patchy paint were found near room [ROOM NUMBER]. 6. (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The outdoor courtyard for locked unit had uneven pavement, dead plants, no shade, and an unpleasant appearance. 7. Several resident rooms were found to have unpleasant, sewage-like smells in bathrooms. This failure placed Residents at risk for psychosocial harm when they had to live in an environment that was not homelike and in disrepair. Findings: During an observation on 6/17/25 at 10:00 am, rooms 131, 133, 134, 137, 138, and 140 were found to be plain and undecorated. Other rooms were found to be undecorated and lacking any individual belongings, wall decorations, and did not appear homelike. During an interview 6/19/25 at 8:20 am with Activities Director (AD) regarding the locked dementia unit, she stated I'd like to improve and decorate more rooms over there, it's a work in progress. During multiple observations on 6/17/25, 6/18/25, and 6/19/25, room [ROOM NUMBER] was found to have a severe, foul, urine-like smell inside, with sticky, unknown liquid stains on the floor. During a concurrent interview and observation with LN A on 6/20/25 9:04 am, she stated Yes, it smells like urine. She explained that Resident in 137B had urinary issues, and that housekeeping was aware of the problem. During multiple observations on 6/17/25 through 6/20/25, rooms [ROOM NUMBERS]'s shared bathroom was found to have broken, ill-fitting parts taped down, and a broken toilet paper dispenser. During an interview on 6/17/25 2:53 pm with CNA L, she verbally confirmed toilets in resident's rooms smell like sewage, and she wished maintenance would come around more to fix things. During multiple observations on 6/17/25 through 6/20/25 by multiple surveyors, rooms [ROOM NUMBER] were found to have peeling, scratched off, or patchy paint. Mismatched paint patches or drywall spackle were found in multiple areas. room [ROOM NUMBER] was found to have large patches of green paint scratched off, showing beige paint, directly next to the resident's bed. During multiple observations on 6/17/25 through 6/20/25, facility hallways were found to have patchy, mismatched paint or possibly drywall spackling in multiple spots. The facility hallways also had an uncovered electrical outlet near room [ROOM NUMBER] with paint patches surrounding it. During multiple observations on 6/17/25 through 6/20/25, the only outdoor recreation space for the locked unit was found to have uneven pavement, dead plants, tall, uncut weeds, dead grass, no shade, and the general appearance was not homelike. The courtyard appeared to have full sun exposure for most of the day. The courtyard was adjacent and visible to the smoking area of the facility, as well as the storage sheds along a driveway. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with CNA H on 6/20/25 at 9:13 am, when asked about the resident courtyard, CNA H stated, It could be improved. The facility policy and procedure titled Homelike Environment dated 2001, shows the facility staff shall provide, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. It also shows Residents are provided with a safe, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible or as practicable.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not accurately assess Resident 7 when the Minimum Data Set (MDS, a standardized, comprehensive assessment to evaluate resident's health status, functional abilities, and care needs) indicated Resident 7 required partial to moderate assistance with eating; however, the care plan (a document that outlines a resident's specific goals and needs) indicated Resident 7 required extensive assistance with eating. This failure had the potential to not accurately reflect Resident 7's status, which could cause a decline in the resident's status and ability to receive proper nutrition. Findings: A review of a facility policy titled, Resident Assessments, with a revised date of October 2024, indicated, The results of the assessments are used to develop, review, and revise the resident's comprehensive care plan. A review of a facility document titled, Job Description: MDS Nurse . with a date of August 2019, indicated the essential duties of an MDS nurse included, Responsible for the data entry function to assure accurate data entry and electronic submission of MDS assessments. Performs corrections when necessary and maintains appropriate records. Assists disciplines in formulating and revising care plans. Ensures that resident's present//potential problems are identified and prioritize; realistic goals are established, and nursing intervention is appropriate. Evaluates resident care plans for comprehensiveness and individuality. Ensures that the resident's care plan is reassessed and revised appropriately . A review of the facility's records indicated Resident 7 was admitted to the facility on [DATE], with diagnoses that included Alzheimer's Disease with late onset (a gradual decline in cognitive function, including memory loss, confusion, and difficulties with thinking, language, and judgment), Underweight, Vascular Dementia (problems with reasoning, planning, judgement, and memory), Unspecified Glaucoma (eye condition that can lead to vision loss or blindness), Blindness right eye, contracture left hand (hardening of muscles leading to deformity of joints), and Dysphagia (difficulty or discomfort during swallowing). A review of a facility document titled, MDS 3.0 Section GG - Functional Abilities, with a date of 4/3/25, indicated, Resident 7 required partial to moderate assistance with eating. A review of Resident 7's care plan with a revised date on 3/30/25, indicated, Resident 7 had an ADL Self Care Performance Deficit, due to diagnoses of Alzheimer's, dementia, contractures. Resident requires EXT (extensive) assist for . meals. She is unable to verbalize needs. All needs must be anticipated and met. During an observation on 6/17/25 at 12:22 pm, Resident 7 was observed sitting and eating her meal at the dining table with no help. Resident 7 was seen eating her pureed food with her hands as she could not see her food. At times, Resident 7 was sitting there not eating her food. After approximately 10 minutes, a staff member came over to help and helped direct Resident 7 as to where her utensils and food were. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/19/25 at 9:48 am with the Director of Nursing (DON), stated that Resident 7, sometimes needs a lot of queuing (verbal direction), while eating. DON confirmed that Resident 7's care plan indicated extensive assistance and is still current. DON confirmed that due to this care plan, Resident 7 would be a one on one for feeding. During an interview on 6/19/25 at 1:35 pm with MDS, confirmed that the care plan indicated Resident 7 required extensive assistance with meals, even though the MDS indicated Resident 7 required partial to moderate assistance with eating. MDS confirmed that both of the assessments (MDS and care plan) did not state the same level of help required, leading to an inaccurate assessment of Resident 7.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on observation, interview and record review, the facility failed to develop a baseline care plan for one resident out of three (Resident 238) within 48 hours after admission for respiratory care issues and oxygen needs. This failure had the potential for Resident 238 to not receive effective and person-centered care when no respiratory goals or interventions were included in the baseline care plan. Findings: During a review of the facility's policy and procedure titled, Care Plans - Baseline, revised October 2024, indicated, a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight hours of admission. During an observation on 6/17/25 at 11:17 am, in Resident 238's room, there was an oxygen concentrator administering oxygen to Resident 238 via nasal cannula (a thin, flexible tube that wraps around your head, typically hooking around your ears. On one end, it has two prongs that sit in your nose and deliver oxygen. The other end of the tube connects to an oxygen supply). Resident 238 was observed to be laying flat and having a difficult time breathing. During a review of Resident 238's physician orders dated on 6/15/25, indicated Resident 238 was to receive continuous oxygen support via nasal cannula at 2 liters per minute. During a review of Resident 238's medical records on 6/18/25, indicated Resident 238 was admitted to facility on 6/15/25 from an acute care hospital with acute respiratory failure, heart failure, pneumonia, and chronic obstructive pulmonary disease (a progressive lung disease that makes it difficult to breathe). Resident 238 was able to make own healthcare decisions. During a review of Resident 238's baseline care plan on 6/18/25, the care plan did not indicate the patient was on oxygen or had any respiratory problems. During a concurrent interview and record review on 6/19/25 at 3 pm, with the Director of Nursing (DON), the DON confirmed Resident 238's baseline care plan should have included respiratory goals and interventions including oxygen therapy.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a person-center care plan for one of four residents (Resident 26) sampled for care plans, to reflect Resident 26's required need of the assistance of two helpers with Activity of Daily Living (ADL's, which included turning resident in bed, bathing, and changing her brief [incontinent underwear that absorb urine and feces]). This failure had the potential to lead to inaccurate provision of care and adverse health outcomes for Resident 26. Findings: A review of the facility's policy titled Care Plans, Comprehensive reviewed 9/2024, indicated A comprehensive 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. 1. The care plan interventions are derived from analysis of the information gathered as part of the comprehensive assessment. The comprehensive care plan will: .b. Describe the services that are to be furnished. d. Describe any specialized services to be provided. A review of Resident 26's admission record indicated, Resident 26 was readmitted to the facility on [DATE] after a hospital stay, with diagnoses that included respiratory failure with hypoxia (lack of oxygen to the brain), pneumonitis (lung infection) due to inhalation of food and vomit, Dysphagia (difficulty with swallowing), aphasia (unable to talk), Alzheimer's (progressive brain disease which causes a decline in thinking, reasoning, and memory), and diabetes (high sugar in the blood). Resident 26 was unable to make her own health care decisions. A review of Resident 26's Significant Change in Status Minimum Data Set (MDS, a comprehensive assessment to determine a resident's care plan) dated 5/30/25, indicated that Resident 26's ability to think, reason, and remember, was severely impaired. Resident 26 was dependent (requiring the assistance of two or more helpers to complete the activity) on staff for toileting hygiene (changing her brief and cleaning up afterwards), bathing, upper and lower body dressing, and rolling from left to right or right to left. During an observation on 6/18/25 at 10:22 am, Certified Nursing Assistant (CNA) F was observed turning Resident 26 on her left side and removing a soiled brief and replacing it with a clean one. CNA F rolled Resident 26 on her left side by pushing on Resident 26's right shoulder and right hip. CNA F then removed her right hand from Resident 26's hip and kept pushing on Resident 26's right shoulder to keep Resident 26 from rolling on her back while she cleaned Resident 26's bottom and place a new brief. Resident 26 was grabbing at CNA F, pushing against CNA F and moaning during the event. During an interview on 6/18/25 at 11:06 am, CNA F indicated she usually changed Resident 26's brief by herself. CNA F stated, I do not know if she (Resident 26) needs two people. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 26's comprehensive care plan revised 11/20/23, showed a focus area titled ADL Self Care Performance Deficit. Resident is unable to make needs known. All needs must be anticipated. She requires extensive to total assist with ADLS . There were no interventions to indicate number of helpers needed for the ADL tasks. During a concurrent interview and record review with the Director of Nursing (DON) on 6/18/25 at 11:10 am, Resident 26's MDS and Care Plans were reviewed. The DON indicated that Resident 26 was dependent with her ADL's and required two helpers with turning in bed and brief change. The DON indicated that Resident 26 was unable to help with these activities and there should be two helpers to prevent injury and provide comfort for Resident 26. The DON confirmed that Resident 26's care plan did not specify the need for two helpers, but it should have.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not provide Resident 7 with extensive assistance while eating her lunch, as deemed necessary by her care plan (a document that outlines a resident's specific goals and needs). This failure had the potential to foster a decrease in the resident's participation in her activities of daily living (ADLs) to maintain good nutrition. Findings: A review of a facility policy titled, Activities of Daily Living (ADL), Supporting, with a revised date of August 2024, indicated, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs) as practicable as possible. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition A review of a facility policy titled, Care Plans, Comprehensive, with a reviewed date of September 2024, indicated, A comprehensive care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive care plan will: aid in preventing or reducing decline in the resident's functional status and/or functional levels A review of the facility's records indicated Resident 7 was admitted to the facility on [DATE], with diagnoses that included Alzheimer's Disease with late onset (a gradual decline in cognitive function, including memory loss, confusion, and difficulties with thinking, language, and judgment), Underweight, Vascular Dementia (problems with reasoning, planning, judgement, and memory), Unspecified Glaucoma (eye condition that can lead to vision loss or blindness), Blindness right eye, contracture left hand (hardening of muscles leading to deformity of joints), and Dysphagia (difficulty or discomfort during swallowing). A review of Resident 7's care plan with an initiated date on 10/25/2022, indicated, Resident 7 had an ADL Self Care Performance Deficit, due to diagnoses of Alzheimer's, Dementia, contractures. Resident requires EXT (extensive) assist for . meals. She is unable to verbalize needs. All needs must be anticipated and met. A review of a facility progress note dated 5/16/25 at 3:57 pm by Infection Preventionist (IP), indicated Resident 7, Was spitting out her vegetables and carbs. She uses her tongue to flatten her food. During an observation on 6/17/25 at 12:22 pm, Resident 7 was observed sitting and eating her meal at the dining table with no help. Resident 7 was seen eating her puree food with her hands as she could not see her food. At times, Resident 7 was sitting there not eating her food. After approximately 10 minutes, a staff member came over and helped direct Resident 7 as to where her utensils and food were. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/19/25 at 8:45 am with IP, confirmed that an individual can not eat pureed foods with their hands. IP stated she remembered watching Resident 7 try to chew her carrots and she was smashing them and would spit them out. During an interview on 6/19/25 at 9:48 am with the Director of Nursing (DON), stated that Resident 7, sometimes needs a lot of queuing (verbal direction), while eating. DON confirmed that Resident 7's care plan indicated extensive assistance and is still current. DON confirmed that due to this care plan, Resident 7 would be a one on one for feeding.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an evaluation and documentation, of a red area, was completed for one of two residents (Resident 26) sampled for skin conditions, when Resident 26 was identified to have a red area on her bottom on admission but there was no further documentation about the red area for the next three weeks. This failure had the potential for Resident 26's skin condition to become worse and cause significant pain and negative clinical outcomes. Findings: A review of the facility's policy titled Prevention of Pressure Ulcers/Injuries revised September 2024, indicated Monitoring 1. Evaluate, report and document potential changes in the skin. A review of Resident 26's admission record indicated, Resident 26 was readmitted to the facility on [DATE] after a hospital stay, with diagnoses that included respiratory failure with hypoxia (lack of oxygen to the brain), pneumonitis (lung infection) due to inhalation of food and vomit, Dysphagia (difficulty with swallowing), aphasia (unable to talk), Alzheimer's (progressive brain disease which causes a decline in thinking, reasoning, and memory), and diabetes (high sugar in the blood). Resident 26 was unable to make her own health care decisions. A review of Resident 26's Significant Change in Status Minimum Data Set (MDS, a comprehensive assessment to determine a resident's care plan) dated 5/30/25, indicated that Resident 26's ability to think, reason, and remember was severely impaired. Resident 26 was dependent (requiring the assistant of two or more helpers to complete the activity) on staff for toileting hygiene (changing her brief and cleaning up afterwards), bathing, upper and lower body dressing, and rolling from left to right or right to left. Resident 26 was always incontinent of urine and bowel (feces) movements. During an observation on 6/18/25 at 10:22 am, Certified Nursing Assistant (CNA) F was observed turning Resident 26 on her left side, removing a soiled brief (disposable underwear to catch urine and feces), and wiping urine and feces off of her bottom. Resident 26 was observed to have a wound dressing on her bottom. CNA F stated the dressing was to cover a red area on Resident 26's bottom. A review of Resident 26's weekly skin assessments dated 6/8/25 and 6/15/25 indicated Resident 26's skin had no new skin issues and skin was clear and intact. A review of the admission Comprehensive Skin Evaluation/Assessment dated 5/28/25, indicated Resident 26 had redness to the sacrum (an area on Resident 26's bottom at the end her spine). There was no documented measurements or cause for the redness. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview with Licensed Nurse (LN) B and record review on 6/19/25 at 12:59 pm, Resident 26's admission Comprehensive Skin Evaluation/Assessment dated 5/28/25, was reviewed. LN B indicated the redness that was identified on Resident 26's bottom during admission was due to moisture associated skin damage (MASD, when the skin gets inflamed/irritated due to urine or feces on the skin). LN B confirmed that the reason for the redness was not identified or measured on the assessment evaluation, and it should have been. LN B indicated that Resident 26 continued to have redness on her bottom, and that there was a daily treatment for this area. Resident 26's 6/8/25 and 6/15/25 weekly skin assessments was also reviewed and LN B confirmed that there was no follow-up or evaluations of the redness for Resident 26 and there should have been. During an interview on 6/19/25 at 1:25 pm, the Treatment Nurse (TN) indicated that she was doing daily treatments for Resident 26's redness on her bottom but said the redness had never been measured or evaluated to determine how it was progressing (if it was getting better or worse) and there should have been documentation on this. During an observation on 6/20/25 at 9:30 am, TN and LN B were observed changing the dressing on Resident 26's bottom. Resident 26's bottom presented with a large egg-shaped, fist size, purple/red area, with pealing skin, that spread to both sides of Resident 26's bottom. TN confirmed the wound's size, shape, color, and that the skin was peeling off of Resident 26's bottom.

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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 observation, interview and record review, the facility failed to ensure the safety of one of nine sampled residents (Resident 79) reviewed for accidents and hazards when Resident 79 was found to have nine razors and one pair of tweezers in her room. This failure had the potential for Resident 79 to cause physical and psychosocial harm to herself and to other residents in the secured unit. Findings: During a record review of facility policy titled Safety and Supervision of Residents dated October 2024, indicated employees shall be trained in potential accident hazards, how to identify and report accident hazards, and try to prevent avoidable accidents. Facility policy further indicated that resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. During a record review of Resident 79's admission record, Resident 79 was admitted to the facility on [DATE] with diagnoses that included dementia (a decline in mental ability severe enough to interfere with daily life) with psychotic disturbance (the presence of hallucinations and/or delusions), visual hallucinations (perceptions of visual stimuli that are not present), and anxiety disorder (excessive fear, worry, or unease). During a concurrent observation and interview on 6/17/25 at 9:16 am, Resident 79 stood in the doorway of her room and held a brush in her hands. Resident 79 stated she liked to tweeze the hairs of her upper lip. Resident 79 was observed with upper lip redness, inflammation and three red scabs. Resident 79 called a passing resident a thief and stated she had to stand in her doorway to keep people out and protect her belongings. Resident 79 stated she had to use her brush to defend herself against intruders. During a concurrent observation and interview on 6/18/25 at 3:01 pm, Resident 79 sat on her bed. Resident 79 opened her bedside table and produced nine double-bladed disposable razors and one pair of tweezers. Resident 79 stated the razors were to shave her face and legs. Resident 79 stated staff were aware she had them in her room. During an interview on 6/18/25 at 3:17 pm, with Registered Nurse (RN) D, RN D stated she knew Resident 79 had tweezers in her room and used them on her face. RN D stated she did not know there were nine disposable razors in Resident 79's room. RN D stated it was possible a family member brought them to Resident 79. RN D stated staff would call a family member to come remove the razors from Resident 79. RN D stated staff was not comfortable going into Resident 79's room because she had a tendency to be combative. RN D confirmed that Resident 79 should not have disposable razors in her room due to safety concerns for herself and other residents. During a concurrent observation and interview on 6/18/25 at 3:40 pm, there were no razors or tweezers observed in Resident 79's room. RN D confirmed items had been removed by staff. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/19/25 at 9:21 am, with Director of Nursing (DON), DON stated she was surprised staff knew about the tweezers in Resident 79's room. DON confirmed disposable razors and tweezers were a safety concern and Resident 79 should not have them.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to maintain a medication error rate below 5%, as 10 medication errors were observed out of 28 opportunities. The error rate was calculated by dividing 10 by 28 and multiplying by 100, resulting in an error rate of 35.7%. This failure led to inaccurate dosing and multiple medication errors. Findings: 1. During a record review of facility policy titled Administering Medications dated 2001, indicated medications are administered in accordance with prescriber orders. Facility policy further indicated staff would check the label three times to verify the right resident, right medication, right dosage, right time and right method of administration before giving the medication. Facility policy also indicated the expiration/beyond use date on the medication label is checked prior to administering. During a record review of Resident 46's Medication Administration Record (MAR) dated 6/4/25, indicated Resident 46 was prescribed Hydrocodone-Acetaminophen (Norco - a pain medication) 5-325 milligrams (mg) by mouth two times a day for chronic pain. During a record review of Resident 46's MAR dated 6/19/25, indicated Licensed Nurse (LN) A documented Resident 46's pain level as a seven out of ten (indicated severe pain on a zero to ten pain scale). During an observation on 6/18/25 at 8:12 am, LN A failed to accurately document medication administration for Resident 46. Resident 46 refused to take a crushed Norco 5-325 mg in applesauce. LN A asked Resident 46 if it was the applesauce that she did not like. Resident 46 nodded her head yes. LN A did not offer Norco 5-325 mg to Resident 46 in another food item. LN A documented the pain medication as refused on Resident 46's MAR. During a record review of Resident 288's physician orders dated 5/22/25, indicated Resident 288's medications crushed unless contraindicated. During an observation on 6/18/25 at 8:25 am, LN A failed to crush Resident 288's cranberry 450 mg and Lexapro 20 mg per physician orders. During an observation on 6/18/25 at 8:25 am, LN A failed to check medication expiration dates per facility policy prior to administration for Resident 288. During an interview with LN A on 6/18/25 at 8:39 am, LN A confirmed she incorrectly documented Resident 46's refusal of the applesauce as a refusal of the Norco 5-325 mg. LN A stated she knew Resident 46 did not like applesauce, but her medication cart was out of pudding. LN A stated she should have put a pudding on her medication cart when she noted there was none prior to medication administration. LN A also confirmed Resident 288's cranberry 450 mg and Lexapro 20 mg were not completely crushed per physician orders. LN A further confirmed she did not check the expiration dates of Resident 288's medications prior to administration. 2. During a record review of Resident 59's physician orders dated 3/30/25, indicated Resident 59 was prescribed Ascorbic acid (vitamin C) tablet 500 mg, give 1000 mg by mouth once daily. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 6/18/25 at 8:41 am, LN B failed to follow physician medication orders for Resident 59 when he gave Resident 59 four Vitamin C 250 mg tablets instead of two Vitamin C 500 mg tablets per physician orders. During an observation on 6/18/25 at 8:41 am, LN B failed to check Resident 59's medications against the MAR three times per facility policy. During an interview with LN B on 6/18/25 at 8:51 am, LN B confirmed he did not check Resident 59's medications against the MAR three times. LN B confirmed facility policy stated staff were to check medications against the resident's MAR three times prior to administration. LN B stated he should not have given Resident 59 four Vitamin C 250 mg tablets because that was not what the provider ordered. LN B stated he should have contacted the provider prior to administration for a new medication order. 3.During a record review of a manufacturer's insert for Breo Ellipta (a corticosteroid inhaler commonly prescribed for Chronic Obstructive Pulmonary Disease (COPD - a condition caused by damage to the airways or other parts of the lungs) dated May 2023, indicated the following steps as part of a six-step instructive guide for patient use: 1. While holding the inhaler away from your mouth, breath out fully. 2. Take one long, steady, deep breath in through your mouth. Do not breathe in through your nose. 3. Remove the inhaler from your mouth and hold your breath for about three to four seconds. 4. Breathe out slowly and gently. 5. Do not swallow water after you rinse your mouth. Spit it out. During an observation on 6/18/25 at 8:55 am, Registered Nurse (RN) E did not instruct Resident 45 to empty her lungs completely. RN E did not instruct Resident 45 to take one long and steady breath through her mouth, and Resident 45 breathed in through her nose. RN E did not instruct Resident 45 to hold her breath for three to four seconds after the medication was administered. Resident 45 swallowed the water after she rinsed her mouth and did not spit it out. During an interview with RN E on 6/18/25 at 9:02 am, RN E confirmed she did not follow manufacturer guidelines to administer the Breo Ellipta inhaler to Resident 45. RN E could not confirm the difference between a steroid and non-steroid inhaler. RN E could not confirm why spitting the water out after an administered steroid inhaler was necessary. RN E confirmed there were five Breo Ellipta inhalers in her medication cart, and only two contained manufacturer's inserts. RN E stated she did not know where the other three manufacturer's inserts were. RN E stated facility expectation was for staff to know how to administer inhalers to facility residents per manufacturer's guidelines found on the box or box inserts. During an interview with Director of Nursing (DON) on 6/19/25 at 9:21 am, DON stated facility expectation was for staff to follow facility's medication administration policy and for staff to understand how to administer different inhalers. DON stated facility expectation was for staff to read the outside of the inhaler box or the manufacturer's insert prior to administration.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to properly store supplies in a medication room. This was evident in one out of two sampled medication storage rooms where unorganized products were found. Additionally, resident care supplies were found under the sink, which further indicated improper storage practices. The facility also failed to properly label resident medications in two out of four sampled medication carts. Disorganized storage of supplies and products in a nursing home can lead to medication errors, delays in treatment, and potential adverse health effects. Failing to properly label resident medications has the potential to put residents at risk for harm from receiving incorrect, expired, and potentially contaminated or ineffective medications. Findings: 1. During a record review of facility policy titled Medication Labeling dated [DATE], indicated the medication label included the expiration date as determined by the manufacturer, and resident's name. During a concurrent observation and interview of the medication cart 2B on Station 2 on [DATE] at 8:17 am, nicotine patches were found unlabeled in a drawer without the resident's name and expiration date. Registered Nurse (RN) E confirmed nicotine patches were not labeled with the resident's name and expiration date and should have been. During a concurrent observation and interview of the medication cart 1 on Station 1 on [DATE] at 8:47 am, D-Mannose (a simple sugar that can help prevent bacteria from sticking to the urinary tract walls) 500 milligrams (mg) was not labeled with the resident's name and expiration date and 30 Restasis single use artificial tears vials 0.4 milliliters (mL) were not labeled with the resident's name and expiration date. Licensed Nurse (LN) A confirmed both resident medications were not properly labeled with resident name and expiration date and should have been. 2. During a record review of facility policy titled Storage of Medications dated [DATE], indicated that nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. During an observation on [DATE] at 10:43 am, medication room number two on station two was inspected. Medication room number two's upper cabinets had a variety of syringes and intravenous (IV) supplies scattered in unlabeled boxes, unorganized, and improperly placed on the shelves. A resident's heart monitor was observed under the sink amongst cleaning supplies. The wound supply cabinet had supplies scattered in unlabeled boxes, and unorganized. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Licensed Nurse (LN) B on [DATE] at 10:50 am, LN B confirmed he was the unit manager. LN B confirmed the unit manager was responsible for the organization and accessibility of the medication room. LN B confirmed medication room number two was unorganized and inaccessible to staff. LN B confirmed there was a resident's heart monitor under the sink and confirmed that it needed to be picked up by the manufacturer and should not be under the sink with cleaning supplies.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure three dietary aides (responsible for dishwashing) was competent on the use of the three-compartment sink (used in food services to properly wash, rinse, and sanitize dishes and utensils) procedure for manual dish washing in the kitchen. This failure placed all residents at risk for cross contamination and acquiring food-borne illnesses. Findings: A review of the facility policy titled Manual Warewashing [dishes and utensils], revised 10/2022, indicated all cookware, dishware, and serviceware that is not processed through the dish machine will be manually washed and sanitized (using chemicals to kill bacteria). The dining service staff will be knowledgeable in proper technique including: - Soap dispensing. - Wash temperature at no less then 110 degrees Fahrenheit. - Chemical sanitizing dispensing. - Chemical sanitizer testing and concentration. Appropriate test strips will be utilized to measure the concentration of the sanitizer solution. Results will be recorded on the Three-Compartment Sink Log. All serviceware and cookware will be air dried prior to storage. During a concurrent observation and interview, on 6/17/25 at 9:11 am, Dietary Aide (DA) J was using the dishwasher to wash and sanitize the post breakfast dishes. DA J was asked to test the level of chemicals in the dishwasher used for sanitization with test strips. The test strip indicated that the sanitizing solution was at a level of 10 parts per million (ppm) and it should have been at 200ppm per the manufacture instructions on the test strip. DA J repeated the test a second time and got the same result. DA J checked the test strips expiration date, and they were expired as of 3/2025. DA J and DA K continued to wash dishes and did not inform the Dietary Service Supervisor (DSS) or start three-compartment manual dish washing. A review of a dish machine report, dated 6/17/25, indicated an emergency service for machine sanitizer for the dishwasher occurred. Service technician found a hole in the tube that delivered sanitizer to the dishwasher and replaced the tube. During a concurrent observation and interview, on 6/17/25 at 11:10 am, three-compartment manual dish washing was taking place in the kitchen. DA I stated that dishes needed to be left in the sanitizing solution for three to five minutes. DA I confirmed that there was no policy regarding dwell time for the three-compartment sink close by for them to reference to ensure the correct dwell time. DA I stated they would need to go and ask the DSS to confirm the dwell time. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During review of manufacture guidelines for [NAME] Chemicals Sani Tech, indicated when used surfaces need to remain visibly wet for at least 60 seconds. During an interview with the Registered Dietitian (RD) on 6/17/25 at 11:10 am, the RD confirmed that dietary staff should not be using test trips that are expired, and they should have immediately started the three-compartment sink procedure, and dietary staff should know the dwell time for sanitization for manual dishwashing. During an interview with the Director of Maintenance (DOM) on 6/17/25 at 12:33 pm, the DOM stated they were unaware of any issues with the dishwasher.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that food was in the appropriate form for one of three residents (Resident 7) to meet her dietary needs. This failure had the potential for Resident 7 to aspirate (ingestion of food or fluid into the airway or lungs), choke, and have weight loss. Findings: During review of Resident 7's medical record revealed Resident 7 was admitted on [DATE] with diagnoses of Alzheimer's, underweight, blindness, contracture (deformity and rigidity of joints) of the left hand, and dysphagia (difficulty swallowing). A review of Dietary Note dated 12/18/24, at 1:00 pm, indicated that Resident 7 had a food intake range of 51-75% with meals being mechanical soft (foods that are easy to chew and swallow), pureed (a creamy paste or thick liquid made from cooked food) meat, and fortified (extra calories). A review of a Dietary Note dated 4/2/25, at 10:33 am, indicated that Resident 7's food intake was 0-26% with meals being mechanical soft, pureed meat, and fortified. A review of a Dietary Note dated 5/16/25 at 3:57 pm, indicated that the Infection Preventionist (IP) was assisting Resident 7 with lunch and noted that Resident 7 was spitting out the vegetables and carbohydrates. Resident 7 would use her tongue to flatten the food in their mouth. Resident 7 does not have any teeth. The IP indicated that Resident 7 did good eating the pureed fish and ice cream and downgraded (to pureed for swallowing safety) Resident 7's diet order. At 4:23 pm, IP informed the Physician and Resident 7's Responsible Party of the diet change. IP stated speech therapy was not needed. IP noted this was a food texture issue not a chocking issue for Resident 7. Charge nurse notified and dietary staff given diet change. A review of Clinical Physician Orders dated 5/16/25 at 4:01 pm, indicated a change in the diet order to a fortified diet, pureed textures. During an observation, on 6/17/24 at 12:22 pm, Resident 7 was sitting in the dinning room eating her meal with no help. She was eating pureed food with her hands and feeling around for the food. At times, Resident 7 was just sitting there and not eating. After 10 minutes, the Director of Staff Development (DSD) came over to help Resident 7 by directing the resident to where the utensils were. Resident 7's tray card indicated a dislike for green salad. On the plate was pureed meat, chopped tomatoes with lettuce, tater tots, and a tomato basil salad. During an interview, on 6/18/24 at 11:50 am, the Registered Dietitian (RD) stated that on 5/16/25 there was an order to change the diet for Resident 7's meals to be all pureed, but that information was not communicated to the RD. Resident 7 had been receiving the discontinued diet of pureed meats only for 33 days. RD updated the diet order for the dietary staff. RD confirmed that having the wrong diet put Resident 7 at risk for choking and weight loss. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Rehab Dysphagia Screening Form, dated 8/29/24 for Resident 7, this was the last time Resident 7 had speech therapy evaluate her swallowing ability.

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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. Based on observation, interview, and record review, the facility failed to ensure the kitchen was sanitary and food was stored, prepared, and distributed in accordance with food safety when: 1. The low temp dishwasher sanitizing solution did not meet manufacturer guidelines. 2. Primary handwashing skink for dietary staff was low flow and not warm. 3. Tortillas were not dated once received and were expired. 4. Dirty dishes were found placed under kitchen preparation area. 5. The lid for the dry powder thickener was kept open when not in use. 6. Thickened milk in the fridge was not dated when created. These failures had the potential to result in cross contamination and place residents at risk for developing a foodborne illness. Findings: 1. During a concurrent observation and interview, on 6/17/25 at 9:11 am, Dietary Aide (DA) J was using the dishwasher to wash and sanitize the post breakfast dishes. DA J was asked to test the level of chemicals used for sanitization in the dishwasher with test strips. The test strip indicated that the sanitizing solution was at a level of 10 parts per million (ppm) and it should have been at 200 ppm per the manufacture instructions on the test strip. DA J repeated the test a second time and they got the same result. DA J checked the test strips expiration date, and they were expired as of 3/2025. DA J and DA K continued to wash dishes and did not inform the Dietary Service Supervisor (DSS) or start three-compartment manual dish washing. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview, on 6/17/25 at 11:10 am, three-compartment manual dish washing was taking place in the kitchen. DA I stated that dishes needed to be left in the sanitizing solution for three to five minutes. DA I confirmed that there was no policy regarding dwell time for the three-compartment sink close by for them to reference to ensure the correct dwell time. DA I stated they would need to go and ask the DSS to confirm the dwell time. During an interview with the Director of Maintenance (DOM) on 6/17/25 at 12:33 pm, the DOM stated they were unaware of any issues with the dishwasher. 2. During a concurrent observation an interview, on 6/17/25 at 9:10 am, the hand washing station (also used as an eye washing station) in the kitchen had low flow and it took several minutes to have hot water. [NAME] stated that management had been informed that the sink has had a low flow and slow to get hot water. During an interview with the DSS on 6/17/25 at 9:38 am, the DSS stated, I am sure maintenance is aware of the issues with the handwashing sink it has been like that for a while. The DSS stated that the sink should have higher flow and warmer water. During an interview with the DOM on 6/17/25 at 12:33 pm, the DOM stated they are aware of the issues with the handwashing sink in the kitchen and have known about it since June or July of 2024. DOM stated that the Administrator has been informed of the issue as well. DOM stated that there is an issue with the plumbing in the whole building and DOM is wanting to do a large project for the whole facility which would fix the issue with the kitchen handwashing sink. 3. During a concurrent observation and interview on 6/17/25, at 9:25 am, in the dry storage room six packages of flour tortillas were expired on 6/15/25, and two packages of corn tortillas did not have a received date and were expired as of 2/14/25. During an interview with the DSS, at 9:38 am, the DSS confirmed that the tortillas were expired. A review of the facility policy and procedure titled Labeling and Dating of Foods, dated 2023, indicates food delivered to facility needs to be marked with a received date. A review of the facility Dry Goods Storage Guidelines, dated 2023, indicates that corn and flour tortillas are good for one month unopened on the shelf. This guideline is to be followed if there is no manufacturer recommendation indicating otherwise. 4. During a concurrent interview and observation on 6/17/25, at 9:20 am, two dirty dishes were sitting under the kitchen preparation table next to other clean dishes. During an interview with the DSS, at 9:38 am, the DSS confirmed that there should not be any dirty dishes under the kitchen preparation table. 5. During a concurrent observation and interview on 6/17/25, at 9:19 am and 11:06 am, the lid to the large container of dry powder thickener was left open when not in use by dietary staff. During an interview with the DSS, at 9:38 am, the DSS confirmed that the lid to the thickener should be closed when not in use. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. During a concurrent observation and interview on 6/17/25, at 9:19 am, there was a container of nectar thick milk that had been mixed and placed into the fridge with no date. At 9:38 am, the DSS confirmed that the milk should have a date on it once it has been made. The DSS then asked a staff member to put a date on the nectar thick milk that was already in the fridge. A review of the facility policy and procedure titled Labeling and Dating of Foods dated 2023, indicates all prepared foods need to be covered, labeled, and dated.

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	555535	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Valley Care Center	9000 Larkin Road Live Oak, CA 95953

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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 an infection control program was implemented by staff to reduce the spread of infection in the facility when: 1. A COVID outbreak was not reported timely to the Department of Public Health. 2. Certified Nursing Assistant (CNA) F did not perform hand hygiene when doing patient cares. These failures had the potential to result in the development and transmission of infectious diseases to residents, staff, and visitors. Findings: 1. A review of a facility policy titled, Unusual Occurrence Reporting, with a revised date of October 2024, indicated, Our facility will report the following events to appropriate agencies: An outbreak of any communicable disease . This policy further indicated, Unusual occurrences shall be reported . to appropriate agencies as required . Within twenty-four (24) hours of such incident . A review of a facility policy titled, Infection Prevention and Control Program, with a revised date of October 2024, indicated, The medical staff will help the facility comply with pertinent state and local regulations concerning the reporting and management of those with reportable communicable diseases. During an interview on 6/19/25 at 10:00 am with Infection Preventionist (IP), stated the COVID outbreak was reported to the local public health office on 6/11/25, but it was not reported to The California Department of Public Health (CDPH). IP stated, I wasn't sure if I needed to report it to CDPH, so I didn't report it. 2. A review of the facility's policy titled Handwashing/Hand Hygiene (undated), indicated this facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections [infections that happen in the nursing home]. Indications for Hand Hygiene F. Before moving from a work on a soiled body site to a clean body site on the same resident: and after glove removal. A review of Resident 26's admission record indicated, Resident 26 was readmitted to the facility on [DATE] after a hospital stay, with diagnoses that included respiratory failure with hypoxia (lack of oxygen to the brain), pneumonitis (lung infection) due to inhalation of food and vomit, dysphagia (difficulty with swallowing), aphasia (unable to talk), Alzheimer's (progressive brain disease which causes a decline in thinking, reasoning, and memory), and diabetes (high sugar in the blood). Resident 26 was unable to make her own health care decisions. A review of Resident 26's Significant Change in Status Minimum Data Set (a comprehensive assessment to determine a resident's care plan) dated 5/30/25, indicated that Resident 26's ability to think, reason, and remember was severely impaired. Resident 26 was dependent (requiring the assistant of two or more helpers to complete the activity) on staff for toileting hygiene (changing her brief and cleaning up afterword), bathing, upper and lower body dressing, and rolling from left to right or right to left. Resident 26 was incontinent of bowel and bladder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 6/18/25 at 10:22 am, CNA F was observed changing a soiled brief for Resident 26. CNA F applied alcohol hand rub onto her hands, entered Resident 26's room and donned (put on) gloves. Resident 26 was lying in bed and CNA F rolled Resident 26 over and removed the soiled brief. CNA F used wipes to wipe Resident 26's bottom that had feces and urine on it. Resident 26 continued to expel feces and CNA F continued to wipe her bottom until it was clean of feces. CNA F threw the soiled brief and wipes in the garbage then with the same soiled gloved hands, CNA F picked up a clean brief and put it on Resident 26, adjusted Resident 26 in bed with her soiled gloves, and touching the bed controllers. CNA F then removed the soiled gloves and without doing hand hygiene she put on new gloves and applied a draw sheet under the resident and a new gown on the resident. During an interview on 6/18/25 at 10:40 am, CNA F confirmed that she did not remove her soiled gloves or do hand hygiene after contact with Resident 26's soiled body site and before touching a clean brief and a clean body site and she should have. CNA F confirmed that she did not perform hand hygiene after she removed her soiled gloves and before putting on new clean gloves and she should have. During an interview on 6/18/25 11:06 am, the IP indicated that it was their policy to do hand hygiene and change gloves when going from a soiled site to clean site and hand hygiene should be done when gloves are removed.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the communication call light system (a communication system which relays the call directly to a staff member or to a centralized staff work area) was working for five of seven residents (Residents 21, 55, 69, 81 and 440) sampled for working call lights, when these residents had been given hand bells when their call light cord broke and the Director of Maintenance (DOM) indicated she did not have time to fix their call light cords. This failure had the potential for Resident 21, 55, 69, 81, and 440, to be at risk for accidents and their care needs not being met. Findings: A review of the facility's policy titled Maintenance Service revised 12/2023, indicated The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner in a practicable timeframe. A review of the DOM job description dated 2/2024, indicated Make periodic rounds to check equipment and to assure the necessary equipment is available and working properly. A review of Resident 81's admission record indicated that Resident 81 was admitted to the facility on [DATE] with diagnoses that included heart disease, muscle weakness, and unsteadiness of feet. Resident 81 was placed in room [ROOM NUMBER]-B on 5/21/25. A review of Resident 81's At Risk for Falls care plan dated 3/14/25, included an intervention to Be sure the resident's call light is within reach The resident needs prompt response to all requests for assistance. A review of Resident 21's admission record indicated that Resident 21 was admitted to the facility on [DATE] into room [ROOM NUMBER]-A with diagnoses that included heart disease, difficulty walking, and pain in right lower leg. A review of Resident 21's At Risk for Falls care plan dated 4/30/25, included an intervention to Be sure the resident's call light is within reach The resident needs prompt response to all requests for assistance. During a concurrent observation on station two in room [ROOM NUMBER] bed A and bed B, and an interview on 6/17/25 from 2:30 pm thru 2:56 pm, Resident 81 and Resident 21 were observed lying in their respected beds. They both had hand bells sitting on their overbed tables. At 2:30 pm, Resident 81 demonstrated the use of the hand bell by picking up the bell and ringing it a couple of times then setting it back down. From 2:30 pm thru 2:56 pm, staff never responded to the bell. Resident 81 indicated that he had to keep ringing the hand bell to get assistance from staff. Resident 21 indicated that he did not want to wake his roommate during the night, so he did not like to ring the bell at night. Both residents indicated that the call light cord that was in their room had not worked for a couple of weeks, so they were supposed to use hand bells. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation in the hallway, on station two outside of room [ROOM NUMBER], and interview on 6/17/25 at 2:57 pm, Registered Nurse (RN) E was observed walking down the hallway and confirmed that she did not hear a hand bell ring and was unaware that the residents in room [ROOM NUMBER] had hand bells instead of a working call light. During a concurrent observation in the hallway, on station two outside of room [ROOM NUMBER], and interview on 6/17/25 at 2:59 pm, Certified Nursing Assistant (CNA) G, indicated the residents in room [ROOM NUMBER] had hand bells as their call light system but that she was unable to hear the bell when she was in another resident's room or when she was at the nurse's station. During an interview on 6/20/25 at 8:38 am, Social Service Assistant (SSA) stated sometimes residents get ruff with the call lights, so we give them hand bells. SSA continued to say, staff will tie the cords to the side rales and then when the residents pull on them the wires will separate. A review of Resident 55's admission record indicated Resident 55 was admitted on [DATE] with diagnoses that included dementia, depression, and vertigo (dizziness). Resident 55 was placed in room [ROOM NUMBER]-A on 5/9/25. A review of Resident 55's admission Minimum Data Set (MDS, a comprehensive assessment) dated 4/9/25, indicated that Resident 55 required maximum assistance from staff with personal hygiene, toileting, and dressing. A review of Resident 69's admission record indicated Resident 69 was admitted on [DATE] with the diagnoses that included stroke (brain damage), muscle weakness, muscle spasms, and dysphagia (difficulty swallowing). Resident 69 was placed in room [ROOM NUMBER]-B on1/22/25. A review of Resident 69's Quarterly MDS dated [DATE], indicated Resident 69 was dependent on staff for transfers in and out of bed, toileting, and bed mobility. A review of Resident 440's admission record indicated Resident 440 was admitted to the facility on [DATE] with diagnoses that included lung disease, difficulty in walking, muscle weakness, and dementia. Resident 440 was placed in room [ROOM NUMBER]-B on 6/7/25. A review of Resident 440's At Risk for Falls care plan dated 6/7/25 indicated an intervention to keep call light within reach. A review of the maintenance logbook for station two identified documentation that included: *6/1/25 room [ROOM NUMBER] A&B (Residents 55 & 69) call light not working; can't find replacement both beds given bells. *6/10/25 room [ROOM NUMBER]B (Resident 440) Need [call] light replaced requested also on 5/28/25 Parts ordered. *6/15/25 room [ROOM NUMBER] A&B (Resident 21 & 81) Call light broken on both Call lights ordered. A review of the facility's invoice from a call light company indicated 12-10ft (foot) double call cords were ordered on 5/1/25 and were shipped out to the facility on 6/11/25. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Durning an interview on 6/20/25 at 9:54 am, DOM showed me a large pile of broken call light cords. DOM indicated that residents drop them or pull the wiring apart and then we have to re-wire them. DOM indicated that she had ordered new call lights on 5/1/25 but was told that they were back ordered and would take a while for them to come in. DOM indicated they ran out of working call light cords around 6/1/25 and because she had not had time to fix the broken call lights the residents had to use the hand bells until the new shipment came in. DOM confirmed that room [ROOM NUMBER]-A&B had hand bells since 6/1/25, room [ROOM NUMBER]-B had a hand bell since 5/28/25, and room [ROOM NUMBER]-A&B had hand bells since 6/15/25. DOM stated We did not rewire them right then [when they broke] because we did not have time to do it. Giving them a hand bell was our way to resolve the issue. If a resident breaks their call light it is going to be a minute (a while) before they will get a new one. DOM indicated that on the evening of 6/17/25 (after the first day of the recertification survey), she and her assistant re-wired 12 broken call lights and then placed them in the rooms that had hand bells. On 6/20/25 at 10:00 am, DOM indicated that the shipment of 12-10ft call lights were delivered to the facility on 6/18/25.