STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555555	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eskaton Village Care Center	3939 Walnut Avenue Carmichael, CA 95608

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interviews and record reviews the facility failed to ensure care plans (CP, a detailed document outlining a person's healthcare needs, goals, and the specific care and support they will receive) were reviewed and revised in a timely manner, for two of 12 sampled residents (Resident 5 and Resident 2), when:Resident 5's urinary catheter (a flexible tube inserted into the bladder to drain urine into a drainage bag) care plan was not updated or revised after removal;Resident 2's urinary catheter care plan was not revised after removal; andResident 2's trazodone care plan had not been reviewed or revised after 21 days, as indicated.These failures had the potential for Resident 5 and Resident 2 to receive inaccurate care and interventions.3. A review of Resident 2's FS indicated he was admitted to the facility in February 2026 with diagnoses which included multiple lumbar fractures (a break or crack in bones of the lower back), lower back pain, lack of coordination and weakness. A review of Resident 2's POs indicated an order for trazodone (a psychotropic medication, drugs that affects brain activities associated with mental processes and behaviors) 50 milligrams (mg, a unit of measurement), give 1 tablet at bedtime for depression manifested by insomnia, dated 2/9/26.\ A review of Resident 2's CP dated 2/10/26 indicated, Goal(s): Resident will exhibit less than 1 episodes of target behavior daily. (Target behavior: inability to sleep). Target Date: 3/10/26. Approach: IDT (interdisciplinary team) will meet to discuss and review psychoactive medication use within 21 days of admission. During a concurrent interview and record review on 3/19/26 at 1:54 p.m. with the DON, Resident 2's CP for trazodone and IDT notes were reviewed. The DON confirmed the CP indicated the IDT was to review the use of trazodone within 21 days of Resident 2's admission, and stated there was no evidence in the medical record to indicate it had been completed. During a review of the facility's policy and procedure (P&P) titled, Interdisciplinary Team/Care Plan Process, revised 12/15/21, the P&P indicated, Policy Interpretation and Implementation.Care Plan Review and Management: 1. Care plans are reviewed and revised as needed.c. During the weekly summary process. During a review of the facility's policy and procedure (P&P) titled, Interdisciplinary Team/Care Plan Process, revised 12/15/21, the P&P indicated, Policy Interpretation and Implementation.Care Plan Review and Management: 1. Care plans are reviewed and revised as needed.c. During the weekly summary process. Findings: 1. A review of Resident 5's Face Sheet (FS) indicated Resident 5 was admitted to the facility in (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	December 2025 with diagnoses which included cerebral infarction (a serious medical emergency where blood flow to part of the brain is blocked, causing tissue death) and left sided hemiparesis (weakness on one side). A review of Resident 5's Physician's Order (PO), dated 12/14/25, indicated Resident 5 had an order for a urinary catheter. A review of Resident 5's CP, dated 12/14/25, indicated Resident 5 had urinary retention (the inability to fully or partially empty the bladder, causing pain, frequent urges, or an inability to urinate) and had a urinary catheter inserted. During an interview on 3/17/26 at 9:38 a.m. with Resident 5, Resident 5 confirmed the urinary catheter had been removed. 2. A review of Resident 2's FS indicated Resident 2 was admitted to the facility in February 2026 with diagnoses which included lumbar and thoracic fractures (serious injuries occurring in the mid-to-lower back) and muscle weakness. A review of Resident 2's PO, dated 2/9/26,indicated Resident 2 had an order for a urinary catheter. A review of Resident 2's CP, dated 2/10/26, indicated the potential for complications related to urinary catheter use. A review of Resident 2's Progress Notes (PN), dated 2/11/26 indicated a new PO had been received to discontinue Resident 2's urinary catheter. During an interview on 3/18/26 at 11:30 a.m. in Resident 2's room, Resident 2 confirmed the urinary catheter had been removed quite some time ago. During a concurrent interview and record review on 3/20/26 at 1:35 p.m. with LN (Licensed Nurse) 1, Resident 5's and Resident 2's POs and CPs were reviewed. LN 1 confirmed Resident 5 and Resident 2 had their urinary catheters discontinued and indicated the CPs had not been updated. LN 1 acknowledged CPs should be updated and revised when there are changes to the residents' treatments or health status. During a concurrent interview and record review on 3/20/26 at 2:36 p.m. with the Director of Nursing (DON), Resident 5's and Resident 2's POs and CPs were reviewed. The DON confirmed Resident 5's and Resident 2's urinary catheters had been discontinued by the physician, and their CPs should have been updated. The DON acknowledged CPs should be updated and revised when there are changes to the residents' care plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to provide care and services in accordance with the professional standards of nursing practice for two out of 12 sampled residents (Resident 5 and Resident 2), when the physician's orders (PO) were not updated and the care plans (CP, a personalized document outlining a person's health conditions, care goals, and necessary services to maintain quality of life) were not revised after urinary catheters (a flexible tube inserted into the bladder to drain urine into a drainage bag) had been discontinued.This failure had the potential for Resident 5 and Resident 2 to receive inadequate and unnecessary care. Findings: A review of Resident 5's Face Sheet (FS) indicated Resident 5 was admitted to the facility in December 2025 with diagnoses which included cerebral infarction (a serious medical emergency where blood flow to part of the brain is blocked, causing tissue death) and left sided hemiparesis (weakness on one side).A review of Resident 5's PO, dated 12/14/25, indicated Resident 5 had an order for a urinary catheter.A review of Resident 5's CP, dated 12/14/25, indicated Resident 5 had urinary retention (the inability to fully or partially empty the bladder, causing pain, frequent urges, or an inability to urinate) and had a urinary catheter inserted.During an interview on 3/17/26 at 9:38 a.m. with Resident 5, Resident 5 confirmed the urinary catheter had been removed.A review of Resident 2's FS indicated Resident 2 was admitted to the facility in February 2026 with diagnoses which included lumbar and thoracic fractures (serious injuries occurring in the mid-to-lower back) and muscle weakness.A review of Resident 2's PO, dated 2/9/26,indicated Resident 2 had an order for a urinary catheter.A review of Resident 2's CP, dated 2/10/26, indicated the potential for complications related to urinary catheter use.A review of Resident 2's Progress Notes (PN), dated 2/11/26 indicated a new PO had been received to discontinue Resident 2's urinary catheter.During a concurrent observation and interview on 3/17/26 at 9:38 a.m. at the nursing station, Resident 5's urinary catheter drainage bag was not observed and Resident 5 confirmed the urinary catheter had been removed.During an interview on 3/18/26 at 11:30 a.m. in Resident 2's room, Resident 2 confirmed the urinary catheter had been removed quite some time ago.During a concurrent interview and record review on 3/20/26 at 1:35 p.m. with LN (Licensed Nurse) 1, Resident 5's and Resident 2's Pos and CPs were reviewed. LN 1 confirmed Resident 5 and Resident 2 had their urinary catheters discontinued and indicated the POs had not been updated. LN 1 acknowledged the physician's order should be discontinued.During a concurrent interview and record review on 3/20/26 at 2:36 p.m. with the Director of Nursing (DON), Resident 5's and Resident 2's POs and CPs were reviewed. The DON confirmed Resident 5's and Resident 2's urinary catheters had been discontinued by the physician, and the POs should have been updated. The DON acknowledged resident orders should be initiated, updated or discontinued when received and followed per physician instructions.A review of the facility's policy and procedure (P&P) titled, Orders - Physician, revised 2/28/24, the P&P indicated, The nursing staff shall place the order for all prescribed medications and treatments.The nursing staff shall note and verify orders when orders are received by provider.

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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. Based on observation, interview, and record review, the facility failed to ensure medications with discontinued orders were removed from facility drug supply and destroyed in a timely manner. This failure had the potential to result in medication errors and adverse events from residents receiving discontinued medications and the potential for diversion (the illegal transfer, theft, or misuse of medications) from medications not being disposed of.Findings: During an inspection of the Medication Storage Room on 3/17/26 at 9:58 a.m. with the Director of Nursing (DON), a three-drawer cart positioned immediately to the right of the entrance filled with medications was observed. Additional medications were stored in a plastic drawer situated on top of the cart and to the left of it, an orange bucket was found overflowing with more medications. On the shelves were multiple plastic bins and one soft maroon insulated bag, all filled with medications. One intravenous (IV, into the vein) bag sodium chloride (used for rehydration) 0.9% with a pharmacy label was comingled with the facility's stock of the same IV solution. The DON confirmed the findings and stated they were all discontinued medications that needed to be separated from facility stock and destroyed. The DON stated discontinued medications were destroyed every Friday with another nurse as witness; if a second nurse was unavailable, destruction would be delayed by a week.During the same inspection of the Medication Storage Room, two randomly selected discontinued medications were identified for further review. The sample included Resident 22's Benadryl (a medication to treat allergies) and Resident 20's hyoscyamine (a medication to treat excessive secretions in the mouth).During a concurrent interview and record review on 3/17/26 at 10:17 a.m. with DON, Resident 22's medical record was reviewed. Resident 22's medical record indicated a physician's order for Benadryl (a medication to treat allergies) 25 milligrams (mg, a unit of measurement), give 1/2 tablet every 6 hours as needed, dated 1/22/25 to 8/13/25. DON confirmed the medication had been long discontinued and should have been destroyed.During a concurrent interview and record review on 3/17/26 at 10:21 a.m. with DON, Resident 20's medical record was reviewed. Resident 20's medical record indicated a physician's order for hyoscyamine 0.125 mg sublingual (under the tongue) tablet, give 1 tablet twice a day, dated 4/4/25 to 5/28/25. DON confirmed the medication order was discontinued and should have been destroyed.During a telephone interview with the Consultant Pharmacist (CP) on 3/18/26 at 1:21 p.m., the CP stated he expected the Medication Storage Room to be clean of discontinued medications and facility staff were aware they were to be destroyed within 90 days.During a review of the facility's policy and procedure (P&P) titled, Medication Storage, Storage of Medication, undated, the P&P indicated, Procedures. 14. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal. 15. Medications awaiting destruction. These medications should be stored in a secured area separate from active orders. 16. Medication storage areas should be kept clean, well lit, organized and free of clutter.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, the facility failed to ensure food textures and preferences were accommodated for four of 12 sampled residents (Resident 2, Resident 50, Resident 51, Resident 38) when:1. Resident 2's food texture was not accommodated; 2. Resident 50 did not receive food items indicated on the daily menu;3. Resident 51's food preferences were not followed when she received food items that were identified as disliked; and,4. Resident 38's did not receive her preference of biscuit listed on the meal ticket. This failure had the potential to negatively impact Resident 2's, Resident 38's, Resident 50's, and Resident 51's nutritional status.Findings: 1. A review of Resident 2's Face Sheet(FS) indicated Resident 2 was admitted to the facility in February 2026 with diagnoses which included lumbar and thoracic fractures (serious injuries occurring in the mid-to-lower back) and muscle weakness. A review of Resident 2's diet orders indicated the following: a. Regular diet with International Dysphagia Diet Standardization Initiative (IDDSI, a global framework that standardizes terminology and methods for texture-modified foods) Level 7 Texture (soft, tender foods), dated 2/9/26; b. Regular diet with IDDSI Level 5 (MM5, minced, moist foods), dated 2/27/26; and c. Regular diet with IDDSI Level 6 (SB6, soft, bite sized foods) dated 3/17/26. A review of Resident 2's Progress Notes (PN), dated 2/12/26, by the Registered Dietician (RD), indicated Resident 2 was not meeting his estimated nutrition needs to promote wound healing. A review of Resident 2's Nutritional Care Plan (NCP), created on 2/17/26 by the Registered Dietitian (RD), indicated Resident 2 was at risk for altered nutritional status related to gout (a painful, inflammatory form of arthritis), acute kidney failure (a sudden decrease in kidney function occurring over hours or days, causing waste buildup, fluid retention, and electrolyte imbalances) and to provide diet changes as appropriate, diet as ordered and liberalize as desired, offer substitutes as needed and review food preferences. During a concurrent observation and interview on 3/18/26 at 11:54 a.m. in Resident 2's room, Resident 2's lunch tray was delivered. Resident 2 stated, Most of the time I can't eat what they are serving because the food is pureed and if it's pureed again today, I can't eat it. Resident 2's lunch tray and meal ticket, which indicated the texture consistency of the diet,, were observed and reviewed. The meal ticket indicated the following food items: pureed salmon and potato chowder, soft and bite sized meatloaf, pureed seasoned broccoli florets, pureed cornbread, and pureed Dutch apple pie. Resident 2 stated, I don't know why they [kitchen staff] keep serving me pureed foods, I've never been on a pureed diet. 2. A review of Resident 50's FS indicated Resident 50 was admitted to the facility in March 2026 with diagnoses which included a left hemiarthroplasty (a surgical procedure, a partial hip replacement, after a fracture) and major depressive disorder (a serious mental health condition characterized by persistent sadness, low mood, and loss of interest in activities). (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 50's diet order, dated 3/10/26, indicated Resident 50 was on a No Added Salt (NAS)/Low Fat diet. A review of Resident 50'sNCP created on 3/18/26 by the RD indicated Resident 50 was at risk for altered nutritional status related to the left femur (thigh bone) fracture and to provide interventions which included: diet changes as appropriate, liberalize as desired, offer substitutes as needed and review food preferences. A review of the Week 4 Wednesday Therapeutic Spreadsheets Low Fat diet on 3/18/26 indicated the lunch menu was salmon and potato chowder, meatloaf, seasoned broccoli florets, cornbread and Dutch apple pie. During a concurrent observation and interview on 3/18/26 at 12:09 p.m. in Resident 50's room, Resident 50's lunch tray and meal ticket were observed. Resident 50's lunch tray and meal ticket included chicken, brown rice and seasoned broccoli florets. Resident 50 indicated she did not request chicken or brown rice for lunch and was disappointed she did not receive the meatloaf, which was indicated on the lunch menu. Resident 50 stated, I haven't received a dessert in several days either. During an interview on 3/18/26 at 2:16 p.m. with the Director of Culinary Experience (DCE), the DCE confirmed Resident 50's disappointment from not receiving meatloaf for lunch or a dessert item. The DCE indicated he expected menus and food preferences to be followed to increase the resident's overall experience and healing process while at the facility. 3. A review of Resident 51's FS indicated Resident 51 was admitted to the facility in March 2026 with diagnoses which included right knee replacement surgery and major depressive disorder. A review of Resident 51's diet order, dated 3/9/26 indicated Resident 51 was on a Consistent Carbohydrate Diet (CCHO, diabetes management plan diet designed to stabilize blood sugar by consuming a consistent, set amount of carbohydrates at the same meals each day). A review of Resident 51's N CP created on 3/18/26 by the RD, indicated Resident 51 was at risk for altered nutritional status related to anxiety disorder and morbid obesity (a complex chronic disease which typically involves being greater than 100 pounds over ideal body weight) and provide interventions which included: diet changes as appropriate, provide diet as ordered and liberalize as desired and review food preferences. A review of Resident 51's Nutritional Observation (NO), dated 3/11/26, indicated Resident 51 dislikes fish, spinach, broccoli and pies. A review of the Week 4 Wednesday Therapeutic Spreadsheets the CC (Controlled Carbohydrates) diet on 3/18/26 indicated the lunch menu was salmon and potato chowder, meatloaf, seasoned broccoli florets, cornbread and dutch apple pie. During a concurrent observation and interview on 3/18/26 at 12:08 p.m. in Resident 51's room, Resident 51's lunch tray and meal ticket were observed. Resident 51's lunch tray and meal ticket included salmon and potato chowder, meatloaf, cornbread, and sugar free chocolate pudding. Resident 51 stated, I don't eat fish or seafood, and today I received salmon and potato soup. Resident 51 further indicated a vegetable item had not been served. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/19/26 at 12:57 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 indicated dietary staff, or the RD, interviewed residents about their food preferences and stated alternatives are available if a resident did not like the meal that was served. CNA 1 confirmed residents were expected to receive the meal indicated on their meal ticket. CNA 1 acknowledged when residents do not enjoy the meals provided, they do not eat well which can lead to unintentional weight loss. During a concurrent interview and record review on 3/19/26 at 2:32 p.m. with the RD, Resident 2's, Resident 50's and Resident 51's diet orders and preferences were reviewed. The RD indicated residents' food preferences were documented on the initial NO and periodic updates would be documented under the dietary progress note and stated CNAs checked in with residents during mealtimes and should offer alternatives for residents with minimal intake or if they disliked the meal provided. The RD stated the pureed items served to Resident 2 were predetermined on the diet spreadsheet, and stated, The spreadsheet must be followed. The RD confirmed that therapeutic diets should include a dessert item and resident's food preferences should be followed and the expectation was for a resident's diet order, lunch tray and meal ticket to match. During an interview on 3/19/26 at 3:35 p.m. with the Food Services Manager (FSM) the FSM stated he expected the diet order, food tray and meal ticket to match. The FSM stated foods with an altered texture were identified on the menu spreadsheet and dietary staff were to always follow what's on the spreadsheet. A review of the facility's policy and procedure (P&P) titled, Therapeutic Diets/Texture Alterations, revised 10/29/18, the P&P indicated, Liberalize diets whenever possible per RD. Therapeutic diets are planned by a dietician and prepared per recipes an production guides. A review of the facility's P&P titled, Menus and Recipes, revised 3/18/26, the P&P indicated, Menus are approved by a Registered Dietician and are purchased and written by [Diet Manual].A copy of menus shall be posted in at least two (2) resident areas. Menus shall be posted low enough and in print large enough for residents to read them. 4. A review of Resident 38's FS indicated Resident 38 was admitted to the facility in Fall 2025 with a diagnosis of weakness. A review or Resident 38's MDS (a federally mandated resident assessment tool) indicated that Resident 38 had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 14 indicated Resident 38 had no memory impairment. A review of Resident 38's dietary notes indicated [Resident 38's] preferences are noted on the tray ticket to individualize her diet as much as possible. A review of Resident 38's diet orders, dated 11/6/25, indicated that Resident 38 was on a regular diet with thin liquids. A review of Resident 38's breakfast meal ticket, dated 2/17/26, indicated the morning meal was prune juice, orange juice, water, oatmeal, sausage gravy, biscuit, fruit, fried egg, and wheat toast. During an interview on 3/17/26 at 8:49 a.m. with CCNA 1, the CNA 1 confirmed resident 38 was (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	missing her biscuit, and stated, It was needed for her weight gain. During a concurrent observation and interview on 2/17/26 at a.m., with Resident 38 in Resident 38's room, Resident 38's breakfast tray was observed served by staff. Resident 38 indicated she was missing her biscuit and she would like to have the biscuit. Resident 38 stated, I do not need to lose any more weight. During a concurrent interview and record review on 3/19/26 at 2:40 p.m., with the RD, the RD reviewed the weekly menu and confirmed Resident 38 should have received a biscuit for her preference and that it was the expectation what was on the menu to be on the residents meal tray unless it expressed otherwise. The RD stated that if residents did not have their preferences, that could lead to weight loss and loss of eating enjoyment. During an interview on 3/20/26 at 2:58 p.m. with the Director of Nursing (DON), the DON stated the expectation was Resident 38's meal ticket should have reflected the food choices in the meal tray. A review of the facility's policy titled, Nutritional Care, Screening and assessment, dated 2/9/2017, indicated, Food Preferences will be maintained in the tray card system.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food was stored and prepared in accordance with professional standards for food service safety in a census of 33 residents, when: The interior dispenser of ice machine had black, brown, and white substances on its surfaces in the facility kitchen; One kitchen staff touched the prepped food area with solid gloves after touching multiple surfaces in the kitchen;Ice buildup was found on the edge and frame of the doors of freezer in the main kitchen; andWet, dirty pans were found stored on the ready-to-use rack next to cooking area in the main kitchen. These failures had the potential risk for the spread of food-borne illnesses in a vulnerable population.Findings: 1. During a concurrent observation and interview on 2/17/26 at 3:10 a.m. with the Food Service Manager (FSM), the interior dispenser of ice machine in the kitchen was observed. The surface of the interior ice dispenser was found covered with black and brown substances. The FSM confirmed the interior dispenser of ice machine was dirty and ice was exposed to its dirty surfaces. The FSM stated the debris was not expected to be in the ice machine and that it was not good for the residents. During an interview on 2/20/26 at 9:19 a.m. with the Director of Maintenance (DOM), the DOM stated it was the expectation that the kitchen outside contracted technicians completed quarterly full cleaning that included the interior of the ice machine and it was the expectation for the ice machine to be clean to ensure the health and safety of vulnerable residents within the facility. During an interview on 3/20/26 on 3/20/26 at 1:46 p.m. with Director of Nursing (DON), the DON stated it was the expectation that ice machines were cleaned for infection control reasons and residents' health. During a review of the facility's policy and procedure (P&P) titled, Sanitation and Cleaning, dated 10/29/18, the P&P indicated,.All equipment shall be kept clean. 2. During a concurrent observation and interview on 3/17/26 with [NAME] 1 and the FSM in the kitchen, [NAME] 1 was observed wearing single use gloves in the cooking area. [NAME] 1 touched the food prep area with soiled gloves after touching hot holding food door handle. [NAME] 1 confirmed he touched multiple surfaces and stated he should had removed his gloves before handling the resident's food. The FSM confirmed the handle of the hot holding food door handle was soiled with visible debris and that it was the expectation to change gloves after touching dirty surfaces. During a concurrent record review and interview on 3/19/26 with the Infection Prevention Nurse (IPN), the handwashing training facility record was reviewed. The IP Nurse confirmed all kitchen staff completed recent hand washing training and were expected to follow the practice of handwashing. During a review of the facility's P&P titled Personal Sanitary and Dress Standards, dated 3/24/24, the P&P indicated, .Gloves are not to be used as a replacement for frequent, proper hand washing and gloves must be changed when going from dirty to clean operations.3. During a concurrent observation and interview on 3/19/26 at 7:34 a.m. with the Executive Chef (EC), ice buildup was found on the rubber seals of the freezers holding ice cream in the main kitchen. The EC confirmed there was ice buildup on the edges and frames of the holding freezers and could pose a health risk for residents. During a interview with Director of Nursing (DON) on 3/20/26 on 3/20/26 at 1:46 p.m. with the DON, the DON stated it was the expectation that freezers were properly cleaned and did not have ice buildup to avoid contamination of food served to the residents. During a review of the facility's P&P titled, Sanitation and Cleaning, dated 10/29/18, the P&P indicated, All kitchens, kitchen areas .shall be kept clean, maintained in good repairs .freezers to be cleaned monthly . 4.During a concurrent observation and interview on 3/19/26 at 7:56 a.m., with the EC, a cooking pan and six hotel pans were found stored wet. The EC confirmed wet kitchen wares were stored on the ready-to-use rack next to the main kitchen's cooking area. During a interview on 3/20/26 on 3/20/26 at 1:46 p.m. with the DON, the DON stated she expected ready-to-use items to be dry and ready to use to avoid risk of infection to residents. During a review of the facility's P&P titled, Ware Washing, dated 7/7/15, the P&P indicated, .pans.washed.rinsed.sanitized.inverted on drain board. Let air dry.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview, record review, the facility failed to ensure one out of 12 sampled residents (Resident 2) was free from unnecessary psychotropic medication (drugs that affects brain activities associated with mental processes and behaviors) when Resident 2 received trazodone (an antidepressant) for insomnia without adequate indication for use and without adequate monitoring for efficacy. This failure had the potential to result in the unnecessary use of psychotropic medication and increased risk of exposure to side effects such as drowsiness, dizziness, headache, dry mouth, nausea, and lightheadedness upon standing.A review of Resident 2's medical record indicated he was admitted to the facility in February 2026 with diagnoses which included multiple lumbar fractures (a break or crack in bones of the lower back), lower back pain, lack of coordination and weakness. A review of Resident 2's physician's orders indicated an order for trazodone (an antidepressant also used to treat insomnia) 50 milligrams (mg, a unit of measurement), give 1 tablet at bedtime for depression manifested by insomnia, dated 2/9/26. During a concurrent interview and record review on 3/19/26 at 12:12 p.m. with Licensed Nurse 1 (LN 1), Resident 2's physician's orders, and behavior monitoring related to trazodone were reviewed. LN 1 reviewed the physician's order for trazodone and stated it was indicated for Resident 2's depression and insomnia. LN 1 stated the efficacy of the medication was assessed by asking the resident how they were feeling, assessing their mood, and seeing if they were getting out of bed. LN 1 reviewed Resident 2's record and confirmed it was documented that the resident was sleeping but the number of hours were not documented. She agreed it would have been useful to know how many hours the resident slept per day to assess if medication was effective for his insomnia. She stated she expected to see a monitoring parameter for hours of sleep in a resident's chart if a medication was given for insomnia. During a concurrent interview and record review on 3/19/26 at 12:24 p.m. with the Director of Nursing (DON), Resident 2's diagnoses, physician's orders, and behavior monitoring related to trazodone were reviewed. DON reviewed Resident 2's order for trazodone and confirmed it indicated for depression manifested by insomnia. She reviewed Resident 2's record and confirmed there was no documentation to support the clinical diagnosis of depression. She stated the order indicated it was for depression because Medical Records had given guidance that since trazodone was an antidepressant the order needed to include a diagnosis of depression even though it was given to Resident 2 to treat insomnia. DON agreed the physician's order should not have read for depression without a clinical diagnosis. DON confirmed Resident 2 was not monitored for hours of sleep but should have been to assess the efficacy of the medication. During a concurrent telephone interview and record review on 3/19/26 at 1:10 p.m. with the Consultant Pharmacist (CP), the CP agreed all elements of a prescriber's order must be accurate. He stated without a depression assessment the resident could not be diagnosed with depression. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, revised 5/16/20, the P&P indicated, Policy Interpretation and Implementation. 2. Residents on psychotropic medications will be monitored for appropriate use, effectiveness, side effects and possible dose reduction. 4. The physician order for psychotropic medications will include the name of the medication, dose, route, frequency, diagnosis, and the specific behavior manifestation to be treated. 6. Monthly, the licensed nurse will evaluate the resident for overall effectiveness of the psychotropic medication and record side effects noted. 7. Based on a comprehensive assessment of a resident, the community will ensure that: a. residents who have not used psychotropic drugs are not given those drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the residents record.

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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. Based on observation, interview, and record review, the facility failed to develop and implement a person-centered care plan (CP, a personalized document outlining a person's health conditions, care goals, and necessary services to maintain quality of life) for one of 12 sampled residents (Resident 7), when Resident 7's nutritional status CP was not individualized to meet Resident 7's specific medical needs.This failure had the potential for Resident 7 to receive inappropriate and inaccurate nutritional and dietary interventions.Findings:A review of Resident 7's Face Sheet (FS) indicated Resident 7 was admitted to the facility in January 2026 with diagnoses which included pneumonitis (lung inflammation) due to inhalation of food and vomit, and gastronomy placement (GT, a feeding tube placed through the abdominal wall directly into the stomach, providing nutrition for people unable to eat normally).A review of Resident 7's Nutritional Observation, dated 2/10/25, indicated Resident 7 was NPO (nothing by mouth, no food or fluid intake) and received tube feedings (liquid nutrients delivered directly into the stomach or small intestine when oral intake is impossible or insufficient).A review of Resident 7's diet order, dated 2/25/26, indicated Resident 7's diet as NPO.A review of Resident 7's CP, dated 1/20/26, indicated Resident 7 required a feeding tube related to oropharyngeal dysphagia (difficulty swallowing or moving food from the mouth to the throat, often causing coughing and choking), and to check the placement and patency of the feeding tube every shift and before each feeding.A review of Resident 7's Nutritional CP (NCP), dated 1/22/26, indicated Resident 7 was at risk for altered nutritional status related to pneumonitis, dysphagia and use of a feeding tube. Two goals were identified: ?no significant weight changes in 1 and 6 months' and ?will consume at least 70% of meals daily.' Interventions for Resident 7 to meet these goals included: offer bedtime snacks daily, diet as ordered and liberalize as desired, encourage oral intake, offer food substitutes as needed and review Resident 7's food preferences.During an interview on 3/17/26 at 2:23 p.m. in Resident 7's room, Resident 7 confirmed he received tube feeding for nutrition, and stated, I do the feedings myself, through the [GT] tube, unfortunately I can't eat regular food yet.During an interview on 3/20/26 at 11:27 a.m. with the Director of Staff Development (DSD) the DSD indicated CPs should be personalized for each resident and coordinated with physician's orders and the medical diagnoses identified. The CP should also include preventative measures for potential problems which include goals, interventions used and a time frame for the expected outcome. The DSD confirmed that NPO residents should not have interventions that encourage oral intake on the CP. The DSD stated if a NPO resident received food or fluids by mouth they were at risk for aspiration (the accidental breathing in of foods or liquids into the airway and lungs) or choking.During an interview on 3/20/26 at 1:50 p.m. with Licensed Nurse (LN) 2, LN 2 confirmed Resident 7 was NPO and received tube feedings for nutrition. LN 2 stated Resident 7's CP should not include interventions to encourage food, fluids or to provide a bedtime snack. LN 2 stated if Resident 7 was provided with food or fluids as indicated on his CP it could have a drastic negative outcome for the resident such as choking, respiratory distress or even death.During a concurrent interview and record review on 3/20/26 at 2:36 p.m. with the Director of Nursing (DON), Resident 7's diet order and CP were reviewed. The DON confirmed Resident 7 was not to receive food or fluids by mouth and interventions on the CP which included the encouragement of oral intake or to provide a snack at bedtime was inappropriate and unsafe. The DON stated Resident 7 has an increased risk for choking which could lead to death, due to his inability to swallow food and fluids safely.During a review of the facility's policy and procedure (P&P) titled Interdisciplinary Team/Care Plan Process revised 12/15/21, the P&P indicated, Each resident will have a care plan that is initiated upon admission. Nursing participates in the interdisciplinary assessment process by initiating an assessment of the resident, reviewing the physician's orders (e.g., diet.) and other transferring information.The care plan is developed by an interdisciplinary team which includes, but is not limited to: b. Licensed nurse who has responsibility (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for the resident, d. Dietary manager/Registered Dietician.The comprehensive care plan has been designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported to the facility irregularities related to the medication regimen for one of 12 sampled residents (Resident 2) during the medication regimen review (MRR). This failure resulted in inadequate monitoring and indication for use of psychotropic medication (drugs that affects brain activities associated with mental processes and behaviors) for Resident 2.Findings: A review of Resident 2's medical record indicated he was admitted to the facility in February 2026 with diagnoses which included multiple lumbar fractures (a break or crack in bones of the lower back), lower back pain, lack of coordination and weakness. A review of Resident 2's physician's orders, dated 2/9/26, indicated an order for trazodone (an antidepressant also used to treat insomnia) 50 milligrams (mg, a unit of measurement), give 1 tablet at bedtime for depression manifested by insomnia. During a concurrent interview and record review on 3/19/26 at 12:12 p.m. with Licensed Nurse 1 (LN 1), Resident 2's physician's orders, and behavior monitoring related to trazodone were reviewed. LN 1 reviewed the physician's order for trazodone and stated it was indicated for Resident 2's depression and insomnia. LN 1 stated the efficacy of the medication was assessed by asking the residents how they were feeling, assessing their mood, and seeing if they were getting out of bed. LN 1 reviewed Resident 2's record and confirmed it was documented that the resident was sleeping but the number of hours were not documented. She agreed it would be useful to know hours of sleep to assess if medication was working or not. She stated she would normally expect to see a monitoring parameter for hours of sleep in a resident's chart if a medication was being given for sleep. During a concurrent interview and record review on 3/19/26 at 12:24 p.m. with the Director of Nursing (DON), Resident 2's diagnoses, physician's orders, and behavior monitoring related to trazodone were reviewed. The DON reviewed Resident 2's order for trazodone and confirmed it indicated depression manifested by insomnia. She reviewed Resident 2's record and confirmed there was no documentation to support the clinical diagnosis of depression. She stated the order indicated it was for depression because Medical Records had given guidance that since trazodone was in the drug category of antidepressants the order needed to include that even though it was being given to treat insomnia. The DON agreed the physician's order should not have read for depression without a clinical diagnosis. The DON confirmed Resident 2 was not monitored for hours of sleep but should have been to assess the efficacy of the medication. During a telephone interview on 3/19/26 at 1:10 p.m. with the CP, the CP agreed all elements of a prescriber's order must be accurate. He stated without a depression assessment the resident could not be diagnosed with depression. A review of the Consultant Pharmacist's Medication Regimen Review: Listing of Residents Reviewed with No Recommendations. For Recommendations Created Between 2/1/2026 and 2/23/2026, indicated the CP did not identify or report that there was no documentation to support the clinical diagnosis of depression for Resident 2. The report also indicated CP did not identify that Resident 2 was not being adequately monitored for the efficacy of trazodone. During a second telephone interview and record review on 3/19/26 at 2:40 p.m. with the CP, Resident 2's recommendations and diagnosis were reviewed. CP confirmed he did not identify or report any irregularities for either the diagnoses or monitoring related to trazodone for Resident 2's. CP confirmed he did not see clinical justification documented for the use of trazodone for depression in Resident 2's record. CP stated he did not typically evaluate the diagnostic criteria used by a physician to diagnose a resident for new psychotropic medication orders. CP stated for new psychotropic medication orders he reviewed the list of diagnoses in a resident's medical record to confirm a diagnosis was listed for the medication ordered. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, revised 5/16/20, the P&P indicated, Policy Interpretation and Implementation. 2. Residents on psychotropic medications will be monitored for appropriate use, effectiveness, side effects and possible dose reduction. 4. The physician order for (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychotropic medications will include the name of the medication, dose, route, frequency, diagnosis, and the specific behavior manifestation to be treated. 7. Based on a comprehensive assessment of a resident, the community will ensure that: a. residents who have not used psychotropic drugs are not given those drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the resident's record. During a review of the facility's policy and procedure (P&P) titled, Medication Monitoring Medication Regimen Review and Reporting, undated, the P&P indicated, Policy: ?Medication Regiment Review (MRR)' or Drug Regimen Review is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes a review of the medical record in order to prevent, identify, report and resolve medication related problems, medication errors, or other irregularities. Procedures. 2. The consultant pharmacist reviews the medication regimen and medical chart of each resident at least monthly to appropriately monitor the medication regimen and ensure that the medications each resident receives are clinically indicated. Identification of irregularities may occur by the consultant pharmacist utilizing a variety of sources including medication administration records (MAR), prescriber's orders, progress notes, nurse's notes, the Resident Assessment Instrument (RAI), Minimum Data Set (MDS), laboratory and diagnostic test results, behavior monitoring information and information from the nursing care center staff and other health professionals involved in the resident's care. 3. In performing medication regimen review, the consultant pharmacist incorporates federally mandated standards of care, in addition to other applicable professional standards.