STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555583	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MacLay Healthcare Center	12831 MacLay Street Sylmar, CA 91342

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety 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 prepare food in a form designed to meet individual needs (requirements for a person's well-being, such as food) for:1. Three (3) of eight (8) sampled residents (Resident 14, Resident 96, and Resident 24) on pureed diet (a texture modified diet that consist of smooth, pudding-like consistencies that are easy to swallow) by not following the recipe for puree oatmeal and in accordance with the International Dysphagia Diet Standardization Initiative (IDDSI - a framework for categorizing food textures and drink thickness) Level Four (4) Standards (puree foods and extremely thick drinks) when on 1/13/2026, Resident 14, Resident 96, and Resident 24 were served regular oatmeal with lumps, grains, and was not pureed.2. Sixteen (16) of 16 residents on soft bite sized (SB6 - soft, tender foods that are appropriate for oral processing skills with no more than 15 millimeters [mm - a unit of length], for adults) were given pork mushroom and carrots that were finely chopped and minced.3. Eight (8) of 8 residents on puree diet were given puree pancakes that left a thick film during a spoon tilt test (method used to check the texture, stickiness, and ability to hold shape of foods for individuals with swallowing difficulties) and puree sausages that were flat and did not hold its shape on the plate on 1/13/2026.These deficient practices had potential to cause Resident 14, Resident 96, and Resident 24 to not be able to eat their food and/or choke (when food gets stuck in your airway, blocking the flow of the air to the lungs) and aspirate (when food or liquid enters your airway and lungs instead of your stomach) on their food. On 1/14/2026 at 9:10 a.m., while onsite at the facility, the State Survey Agency (SSA) called an Immediate Jeopardy (IJ - a situation in which the facility's non-compliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) in the presence of the Administrator (ADM) and Director of Nursing (DON), due to the facility's failure to provide food and drink prepared in a form designed to meet individual needs in accordance with S483.60(d)(3) by failing to ensure the facility staff followed the recipe for pureed diet and served pureed food to Resident 14, Resident 96, and Resident 24.On 1/16/2026 at 3:20 p.m., the ADM provided an IJ Removal Plan (a plan that identifies all actions the facility will take to immediately address the non-compliance that has resulted in IJ situation) which included the following summarized actions:1. On 1/14/2026, Resident 14, Resident 96, and Resident 24 were assessed by the Registered Nurse (RN) Supervisor. The residents showed no signs of respiratory distress (difficulty breathing where the body cannot get enough oxygen). The RN Supervisor notified each resident's primary care physician (PCP) and ordered a stat (immediate) chest x-radiation (x-ray - medical imaging test that uses a tiny amount of high-energy radiation to take pictures of the inside of the body) for each resident. Resident 14, Resident 96, and Resident 24's chest x-ray results showed the residents' lungs were clear.2. On 1/14/2026, the Registered Dietitian (RD) conducted a one-to-one (1:1) in-service (refers to individualized, one-on-one education provided to a single individual by a staff member or professional) and competency validation (the structured process of verifying that an individual possesses the required knowledge, skills, and behaviors to perform specific tasks or job roles to a defined standard) with [NAME] 1 regarding IDDSI Level 4 Standards, food preparation (continued on next page)

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

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	signs and symptoms of aspiration and to avoid difficulty with chewing and swallowing throughout the review period. The Care Plan interventions included explaining and reinforcing to the resident the importance of maintaining the prescribed diet, as well as monitoring, documenting, and reporting as needed any signs and symptoms of dysphagia including pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing and refusing to eat.During a review of Resident 24's, Speech Therapy Treatment Encounter Note, dated 1/2/2026, the Speech Therapy Treatment Encounter Note indicated Resident 24 to be on pureed diet texture consistency with thin liquids.During a review of Resident 24's Mini Nutritional Assessment, dated 12/26/2025, the Mini Nutritional Assessment indicated Resident 24 has a diet order of pureed thin liquid consistency.During a review of Resident 24's Order Summary Report, dated 11/3/2025, the Order Summary Report indicated a physician's order for CCHO diet, Pureed level 4 texture, with thin level consistency. During an observation on 1/13/2026 at 8 a.m. of Resident 24 and Resident 24's tray at bedside, observed CNA 3 arrange the breakfast tray on Resident 24's table. Resident 24 was then observed eating regular oatmeal. During a concurrent observation and interview on 1/13/2026 at 8:02 a.m., with CNA 3, observed Resident 24 eating regular oatmeal with CNA 3 at bedside and observed Resident 24 consumed 100% of the regular oatmeal. CNA 3 stated Resident 24's meal ticket indicated pureed pancakes, pureed meat, and pureed oatmeal. CNA 3 stated that the pancakes and meat served to Resident 24 were pureed however Resident 24's oatmeal was not pureed. CNA 3 stated the oatmeal that was served to Resident 24 contained liquid consistency, but the oatmeal was not pureed, as it was not smooth in consistency. During an interview on 1/13/2026 at 8:39 a.m., with the DS, the DS stated the oatmeal deliveries come every Thursday, but she (DS) did not order oatmeal and did not forecast the oatmeal usage well. The DS stated [NAME] 1 cooked the regular oatmeal on 1/13/2026, at around 6:30 a.m. and informed her (DS) that the facility had run out of oatmeal. The DS stated she (DS) instructed [NAME] 1 to substitute oatmeal with cream of wheat instead. The DS stated that the RD did not approve substituting oatmeal with cream of wheat. The DS stated that regular oatmeal needed to be pureed for residents on a pureed diet because pureed oatmeal was included in the residents' diet orders, and residents receiving regular oatmeal instead of pureed oatmeal could experience difficulty swallowing, resulting in choking.During an interview on 1/13/2026 at 10:11 a.m., with [NAME] 1, [NAME] 1 stated she (Cook 1) cooked the breakfast today and made a big pan of regular oatmeal. [NAME] 1 stated she (Cook 1) needed to separate oatmeal for residents on pureed diets, however, she (Cook 1) did not separate and puree the oatmeal because there was no oatmeal remaining. [NAME] 1 further stated that she (Cook 1) cooked cream of wheat.During an interview on 1/13/2026 at 10:20 a.m., with DA 1, DA 1 stated she (DA 1) was responsible for checking the meal trays prior to placing the trays in the carts. DA 1 stated that her responsibilities included verifying residents' allergies (a condition that causes illness when someone eats certain food), diet orders, likes and dislikes, tray accuracy, and tray completeness. DA 1 stated that if [NAME] 1 placed incorrect food items on a tray, she (DA 1) would return the tray to be corrected. DA 1 stated that residents on puree diet should have received cream of wheat for today's (1/13/2026) breakfast. DA 1 stated regular oatmeal is not appropriate for a pureed diet because regular oatmeal contains large particles that could become lodged in a resident's throat. DA 1 further stated that residents on a puree diet could potentially choke if served regular oatmeal. DA 1 stated that she does not give regular oatmeal to residents on a puree diet, as they usually blend the oatmeal, but sometimes, she (DA 1) makes mistakes. DA 1 stated she (DA 1) made a mistake today by placing regular oatmeal on trays designated for residents on a pureed diet. DA 1 also stated that there have been instances when nurses came to the kitchen and requested regular oatmeal instead of pureed oatmeal for residents (did not specify) on puree diets. During an interview on 1/13/2026 at 10:39 a.m., with LVN 1, LVN 1 stated she (LVN 1) checked the meal trays today (1/13/2026) before the meal trays were distributed to the residents. LVN 1 stated the process involves reading the diet list while another LN checks the trays for allergies, resident's likes and dislikes, diet texture and consistency, and tray accuracy. LVN (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1 stated the other LN checks the trays by opening the lids of the food items. LVN 1 stated that if a meal tray

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure the confidential personal information of residents were protected by failing to ensure documents (meal tickets) containing protected information (PHI - any health information that can be used to identify specific individual which must remain confidential to prevent harmful consequences) were not shredded prior to disposing in the waste container. This failure had the potential to violate 127 of 127 residents' rights for privacy and confidentiality of personal and medical records. Findings: During an observation on 1/14/2026 at 12:59 p.m., observed meal tickets in the trash by the dishwashing machine area. During an interview on 1/14/2026 at 1 p.m. with the Dietary Supervisor (DS), the DS stated the meal tickets come back to the kitchen after each meal and the meal tickets would be thrown out in the trash. The DS stated the meal tickets contained residents' name, diet, and room number and these are all protected information. The DS stated it was not appropriate for the staff to throw the meal tickets in the trash because it's a violation of Health Insurance Portability and Accountability Act (HIPPA - a law that sets national standard to protect sensitive health information, making sure it stays private and secure) law. The DS stated other people could get the residents' information and use it and they are not protecting the privacy rights of the residents. During a review of the facility's policies and procedures (P&P) titled, Meal Ticket Policy, dated 4/24/2025, the P&P indicated Meal ticket shall be generated based on the resident's current diet orders documented in the EHR. During a review of the facility's P&P titled, Resident Privacy and Confidentiality Policy, dated 4/24/2025, the P&P indicated Our facility will safeguard the confidentiality of all resident personal and medical records. Access to these records is limited to authorized staff members and approved business associates.

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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, and record review, the facilityˆfailed toˆprovide a safe, comfortable, and homelike environment for fiveˆ(5)ˆof five (5)ˆsampled residents (Residentsˆ65, 55, 33, 39 and 72) byˆfailing to: 1. Maintainˆthe cleanliness of Resident 65'sˆelectric stand fan.ˆ 2. Ensureˆ Resident 55`s electric fan was free from dust buildup on the fan blades and the front and back safety enclosure grill of the fan.ˆ These deficient practices had the potential to negatively affect Resident 65 and Resident 55's quality of life and had violated the residents' right to a safe, clean,ˆcomfortableˆand homelike environment.ˆ 3. Provide Residentsˆ33, ˆ39, andˆˆ72ˆwith aˆhomelikeˆenvironment when their room was damaged due to water leaks.ˆˆ Thisˆdeficientˆpracticeˆhad the potential toˆpreventˆresidentsˆfromˆenjoying the rightˆtoˆa cleanˆdry andˆhomelike environment free from water damaged floors and closet space.ˆ Cross-reference F880 and F921.ˆ Findings:ˆ 1) During a review of Resident 65's admission Record, the admission Record indicated the facilityˆoriginallyˆadmitted the resident onˆ10/8/2012, and readmitted in the facility on 6/9/2025,ˆwith diagnoses includingˆdependence on supplemental oxygen,ˆpneumonitis (swelling of the lung tissue), pulmonary hypertension (a type of high blood pressure that affects the arteries in the lungs and the right side of the heart),ˆand generalized muscle weakness.ˆ During a review of Resident 65's History and Physical (H&P) datedˆ6/19/2025, the H&PˆindicatedˆthatResident 65ˆhadˆthe capacity to understand and make decisions.ˆ During a review of Resident 65's Minimum Data Set (MDS, a standardized assessment and care screening tool), datedˆ12/26/2025, the MDS indicatedˆResident 65ˆhad severely impaired cognition (mental action or process of acquiring knowledge and understanding) and requiredˆsupervision or touching assistance with eating; partial or moderate assistance with oral and personalˆhygiene; substantial/maximal assistanceˆwith upper body dressing and rolling to left and right;ˆtotal assistance from staff with allˆotherˆactivities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive).ˆˆ Duringˆan observationˆon 1/12/2026ˆat 10:31ˆa.m., inside Resident 65's room,ˆobservedˆan electric stand fan facing the resident and wasˆturned on had strips ofˆgrayˆpowder like material lining the outward front and back panel and the blades.ˆˆ During a concurrent observation and interview on 1/12/2026 atˆ10:40 a.m.ˆinside Resident 65's room with Certified Nursing Assistant (CNA)ˆ8, CNA 8 stated Resident 65's electric stand fanˆhad a lot of gray colored dusts in the front and back panel. CNA 8 statedˆshe (CNA 8) is not sure who is responsible on cleaning the electric fans. CNA 8ˆstatedˆif the electric fan was blowing andˆfull of dusts, Resident 65 can inhale the dust particles andˆthe resident can get sick.ˆResident 65's electric fanˆshould have been cleaned regularlyˆas it does not provide a homelike environment to the resident as the facility is already their home.ˆ During a concurrent observation and interview on 1/12/2026 at 10:45 a.m. inside Resident 65's room with Licensed Vocational Nurse (LVN)ˆ10, LVN 10 states Resident 65's electric stand fan that was blowing and facing the resident had a lot of gray colored dusts in the front and back. LVN 10ˆstatedˆthe maintenance department was responsible in making sure the electric fans or any resident equipment is cleanˆto provide a homelike environment to the residents. LVN 10ˆstatedˆthe (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Maintenance staff shall prioritize requests based on safety and urgency.ˆ During a review of the facility's P&P titled, Air Filter and Electric Fan Cleaning Policy, last reviewed on 4/24/2025, the P&P indicatedˆthe facility ensures air filters and electric fans are cleaned routinely to reduce dust build up, improve air circulation, maintain equipment function, and support infection prevention standards.ˆThe P&P furtherˆindicated:ˆ - The facility willˆmaintainˆair filters and electric fans in clean working condition. Filters and fans will be inspected, cleaned, or replaced on a routine schedule and anytime visible dust build up isˆobserved.ˆ - All portable and fixed electric fans will be cleaned routinely to prevent dust accumulation and reduce the spread of particles. Fans used in resident rooms must be cleaned on a routineˆschedule, when visibly soiled, and between resident use if reassigned.ˆ - Nursing staff must report visibly dirty fans in resident rooms and report equipment concerns to maintenance orˆenvironmentalˆservices department. 2) During a review of Resident 55's admission Record (AR), the AR indicated the facility admitted the resident on 9/12/2018, and readmitted the resident on 11/13/2025, with diagnoses including cellulitisˆ(a skin infection that causes swelling and redness)ˆof the left and right lower limb and lymphedemaˆ(tissue swelling caused by an accumulation of protein-rich fluid that's usually drained through the body's lymphatic system).ˆ During a review of Resident 55's History and Physical (H&P), dated 11/14/2025, the H&PˆindicatedˆthE resident had the ability to understand and make decisions.ˆ During a review of Resident 55's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognitionˆ(a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment).ˆˆˆ During a review of Resident 55's Order Summary Report (OSR), dated 12/3/2025, the OSR indicated an order for enhanced barrier precautionsˆ(gown and glove use duringˆhigh-contact resident care activities for residents known to be colonized or infected with aˆmultidrug-resistant organism [MDRO,ˆbacteria or germs that have developed resistance to multiple, commonly used antibiotics]ˆas well as those at increased risk of MDRO acquisition)- staff to utilize gowns and gloves for high-contact resident care activities related to deviceˆperipherally inserted central catheterˆ(PICC,ˆa long, thin, flexible tube inserted through a vein in the upper arm and passed through the venous system until the tip rests in a large vein near the heart)ˆline,ˆleft lower leg (LLL)ˆvenous woundˆ(can occur when the veins inˆtheˆlegs do not push blood back up toˆtheˆheart as well as they should),ˆright lower leg (RLL)ˆvenous wound.ˆ During a review of Resident 55's Care Plan (CP) Report titled, The resident will be staying long-term in the facility, last revised on 11/14/2025, the CPˆindicatedˆa goal of the resident will be comfortable in their environment.ˆ During an observation and interview on 1/12/2026, at 10:13 a.m.,ˆwith Resident 55, inside Resident 55's room,ˆobservedˆResident 55's electric fan with dust buildup on the fan blades and the front and (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	back grill enclosure of the fan. Resident 55ˆstatedˆshe (Resident 55) has spoken to the Maintenance Department about it but has not cleaned the fan yet.ˆˆ During an observation and interview on 1/12/2026, at 3:30 p.m., with theˆRespiratory Therapist Supervisor (RTS), inside Resident 55's room,ˆobservedˆthe electric fan with dust buildup on the fan blades and the front and back grill enclosure of the fan. The RTS stated the fan was dirty and needed to be cleaned to prevent the resident from getting respiratory infection. The RTS stated she will report them to the Maintenance Department to clean them right away.ˆ During an interview and record review on 1/14/2026, at 2:59 p.m.,ˆwith the Minimum Data Set Coordinator (MDSC),ˆreviewed the photo taken of the electric fanˆof Resident 55ˆon 1/12/2026, at 10:13 a.m.ˆThe MDSC stated Resident 55's fan was dirty and should have been cleaned by the housekeeper. The MDSC stated everybody in the facility is mandated to report them to the housekeepers when they see the electric fans of the resident dirty covered with dust. The MDSC stated the failure of the facility to report and clean the dirty electric fan covered with dust on the fan blade and back and front grill can cause respiratory infections to the resident and does not promote a homelike environment.ˆ During an interview on 1/16/2026, at 10:06 a.m., with theˆDirector of Nursing (DON), the DONˆstatedˆthe housekeepingˆis in charge ofˆcleaning the electric fans in the facility. The DONˆstatedˆResident 55's electric fan should have been cleaned by the housekeeperˆto prevent the dust from being introduced to the resident causing the resident to get sick.ˆ During a review of the facility's recent policy and procedureˆ(P&P)ˆtitled, Air Filter and Electric fan Cleaning Policy, last reviewed onˆ4/24/2025, the P&P indicated to ensure air filters and electric fans are cleaned routinely to reduce dust buildup, improve air circulation, maintain equipment function, and support infection prevention standards atˆthe facility.ˆ PROCEDUREˆ 2.ˆElectric Fan Cleaningˆ All portable and fixed electric fans will be cleaned routinely to prevent dust accumulation and reduce the spread of particles.ˆ 3a) During a review Resident 33's admission Record (AR), the AR indicated the facility admitted Resident 33 on 1/19/2023, with diagnoses including congestive heart failure (CHF – a heart disorder which causes the heart not to pump the blood efficiently sometimes resulting in leg swelling) and depression (a serious, common mood disorder causing persistent sadness, loss of interest, and affecting how you think, feel, and handle daily activities).ˆˆˆ During a review of Resident 33's H&P dated 3/5/2025, the H&Pˆindicatedˆ Resident 33 did not have the capacity to understand or make decisions.ˆ During a review of Resident 33's MDS dated [DATE], the MDS indicated Resident 33 was dependent upon staff for all activities of daily living (ADLs- activities such as bathing, dressing, and toileting) requiring maximumˆassistanceˆof staff to complete daily tasks.ˆ During a review of Resident 33's plan of care revised onˆ2/16/2025, the plan of (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room was observed. There were two wash basins on the laundry room floor placed under leaking pipes. One pipe leaked water into a wash basin. Another pipe leaked soap suds into the other wash basin. There was a water puddle in front of the washing machines. The DOM stated the water had been leaking for several weeks. A bath blanket was present on the laundry room floor. The DOM stated the blanket was placed on the floor to absorb the leaking water. The DOM stated the leaking pipes in the laundry room caused water damage to Resident 33, Resident 39, and Resident 72's room. The DOM stated the water damage in Resident 33, Resident 39, and Resident 72's room included loose and damp laminate floor tiles, warped wood on the drawers and closet panels, and wall damage. The DOM stated the leaking water was a safety and infection control risk.^^ During a review of the facility's policy and procedure^(P&P)^undated, titled, Homelike Environment,^the P&P^indicated^(facility name) provides and^maintains^a^homelike,^noninstitutional environment that supports resident dignity,^choice,^privacy,^and quality of life.^The facility shall^maintain^clean,^safe,^and comfortable^resident rooms^ ^and a pleasant^décor.^A homelike environment shall be^maintained^without compromising^infection prevention and control. The homelike environment is^monitored^through resident feedback,^quality assurance activities,^and regulatory^inspections.^^^^ During a review of the facility's policy and procedure (P&P) undated, titled General Maintenance and Plant Operations, the P&P^indicated^maintaining a safe,^clean^and functional physical environment for resident. All facility systems, equipment and structures shall be^maintained^in good working order.^Preventive maintenance schedules shall be^established^equipment inspected may include plumbing .^^^^

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) for one (1) of 1 sampled resident (Resident 57) reviewed for physical restraints by failing to obtain a physician's order, informed consent, and complete a restraint assessment prior to placement of bed pad alarm (a pad with sensors that will alarm when a resident stands up unassisted to help prevent falls by alerting staff). These deficient practices had the potential to result in the restriction of Resident 57's freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from entrapment, and possibly death. Findings: During a review of Resident 57's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility originally admitted Resident 57 on 11/18/2025 and readmitted in the facility on 11/21/2025 with diagnoses hemiplegia (total paralysis [the loss of muscle function in a part of the body] of the arm, leg, and trunk on the same side of the body) and hemiparesis (paralysis of the arm, leg, and trunk on one side of the body) following cerebral infarction (also known as stroke, loss of blood flow to a part of the brain) affecting right non-dominant side, congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and cognitive communication deficit (difficulty in talking, listening, or understanding, and participating in conversations). During a review of Resident 57's History and Physical (H&P), dated 11/19/2025, the H&P indicated Resident 57 did not have the capacity to understand and make decisions. During a review of Resident 57's Minimum Data Set (MDS - a resident assessment tool), dated 11/27/2025, the MDS indicated Resident 57 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was able to understand and able to make his needs known. The MDS further indicated Resident 57 required partial or moderate assistance with eating, oral hygiene, and upper body dressing; total assistance with toileting hygiene, bathing, and lower body dressing; substantial or maximal assistance from staff with all other activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 57 had a fall incident prior to admission to the facility. During a review of Resident 57's Order Summary Report, dated 1/16/2026, the Order Summary Report did not indicate a physician's order for the use of bed pad alarm. During a review of Resident 57's paper and electronic health records, dated as of 1/16/2026, the paper and electronic health records did not indicate a consent was obtained from the resident or responsible party for the use of the bed pad alarm. During a review of Resident 57's fall risk evaluation forms, dated 11/18/2025, 11/20/2025, 12/4/2025, and 12/9/2025, the fall risk evaluations indicated that Resident 57 was at a high risk for falls. During a review of Resident 57's care plan (CP) on risk for falls, initiated on 11/18/2025 and actual fall incidents on 12/4/2025 and 12/9/2025, the CP indicated interventions including bed alarm in place and continue with fall precautions such as nonskid socks and bed in lowest position so the resident will remain free from falls and complications from falls. During a concurrent observation and interview on 1/12/2026 at 11:14 a.m. inside Resident 57's room with Licensed Vocational Nurse (LVN) 10, observed Resident 57 sitting at the edge of the bed. LVN 10 stated Resident 57's bed alarm box was hanging on the wall with the cord wrapped around the bed control cord closest to the plug and was not functioning properly. LVN 10 stated Resident 57 was at a high risk for falls and one of the interventions to prevent falls or injury is the bed alarm due to multiple fall incidents since admission. During a concurrent interview and record review on 1/16/2026 at 9:36 a.m. with the Minimum Data Set Coordinator (MDSC), Resident 57's physician's order, CPs, fall risk evaluations, and paper and electronic health records were reviewed. The MDSC stated there was no (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician's order, informed consent obtained, and a restraint assessment completed prior to application of the bed alarm. The MDSC stated if Resident 57 had a bed alarm as part of the fall management program, the staff should have obtained a physician's order, obtained a signed informed consent, and completed a restraint assessment prior to the application of a bed alarm to Resident 57. The MDSC stated that restraint assessments are completed prior to application of the restraint, quarterly, and as needed with any significant change in condition. The MDSC stated the bed alarm is considered a restraint as it restricts the resident from getting up and moving freely and should have a physician's order so the physician would be aware of the proper device Resident 57 needed for his safety. The MDSC stated an informed consent should have been obtained to ensure the resident and/or resident representative understands the risks and consequences of having the bed alarm and gives them the opportunity to decline or accept the treatment. The MDSC stated a restraint or device use assessment should have been completed prior to use of the bed alarm to ensure the use of bed alarm is appropriate. During a review of the facility's policy and procedure (P&P) titled, Bed and Chair Alarm Monitoring Policy, last reviewed on 4/24/2025, the P&P indicated the facility utilizes bed and chair alarm monitoring systems as part of a comprehensive fall prevention and resident safety program. Bed and chair alarms are implemented based on individual residents' assessment, clinical need, and interdisciplinary care planning. The P&P further indicated: - Bed/chair alarms are monitoring device designed to alert staff when a resident attempts to rise from a bed or wheelchair. - Residents are assessed for fall risk on admission, quarterly, after a fall, and with any significant change in condition. - Resident and/or responsible representative shall be informed of alarm use as appropriate. During a review of the facility's P&P titled, Restraint-Free environment, last reviewed on 4/24/2025, the P&P indicated the facility is committed to maintaining a restraint free environment for all residents. Physical or chemical restraints are used only when medically necessary to protect the resident or others and only after all alternatives have been attempted. The P&P further indicated: - Residents are assessed for risk of harm to self or others upon admission and continuously thereafter. - Restraint use is documented and justified only when alternatives fail. - Restraints are used only with a physician's order specifying the type of restraint, reason for use, and duration and monitoring requirements. - Residents and/or responsible parties are informed about restraint use, alternatives, and potential risks. - Consent must be documented in the medical record.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure residents were free from unnecessary psychotropic medication (medications that affect the mind, emotions, and behavior) and the use of chemical restraints (any drug that is used for discipline or staff convenience and not required to treat medical symptoms) for two of five sampled residents (Residents 15 and 14) reviewed for unnecessary medications by failing to: 1. Ensure quetiapine fumarate (medication to treat symptoms of psychosis [occurs when a person becomes disconnected from reality]) and sertraline (medication used to treat depression [persistent feelings of sadness and loss of interest that can interfere with daily living]) was prescribed and monitored for specific, measurable behavioral manifestation for Resident 15. 2. Monitor for adverse effect (a harmful, unexpected, or unintended result of a medical treatment, such as a drug, surgery, or procedure) on the use of Depakote (a prescription drug used to control seizures, prevent migraine headaches, and stabilize mood swings in bipolar disorder, working by affecting brain chemicals to calm electrical activity) and Rexulti (a prescription medication, specifically an atypical antipsychotic, used to treat major depressive disorder) on Resident 14. This deficient practice had the potential to result in the administration of unnecessary psychotropic medication and placed residents at increased risk for adverse effects related to psychotropic medication therapy, such as drowsiness, dizziness, or increased risk of fall, possibly leading to impairment or decline in their mental or physical condition or functional or psychosocial status. Findings: 1. During a review of Resident 15's admission Record (AR), the AR indicated the facility admitted the resident on 9/19/2016, and most recently readmitted the resident on 6/6/2025, with diagnoses that included major depressive disorder (persistent feelings of sadness and loss of interest that can interfere with daily living), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and unspecified dementia (a progressive state of decline in mental abilities). During a review of Resident 15's Minimum Data Set (MDS – resident assessment tool) dated 11/11/2025, the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated that the resident required partial / moderate assistance from staff for bathing, and supervision from staff for dressing and personal / oral hygiene. The MDS indicated that the resident was administered the following high-risk medications (drugs that can cause significant patient harm if used incorrectly): antipsychotics (medication to treat psychosis) and antidepressants (medication to treat depression). During a review of Resident 15's Physician's Order, the Physician's Orders indicated the following orders: - Quetiapine fumarate tablet 25 milligrams (mg, a unit of measurement) give one tablet by mouth at bedtime for mood stabilizer manifested by feelings of highs and lows, dated 6/6/2025 - Sertraline HCl oral tablet 25 mg, give one tablet by mouth one time a day for depression manifested by feelings of hopelessness. sadness. Loneliness. During a review of Resident 15's Care Plan (CP) titled, The resident uses antidepressant medication – sertraline HCL oral tablet 50 mg for depression manifested by feelings of hopelessness, sadness, loneliness, initiated 12/3/2024, the CP indicated an intervention of behavior monitoring for antidepressant medication. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 15's CP titled, The resident uses anti-psychotic medication quetiapine for the symptoms / behaviors associated with the diagnosis of schizophrenia, bipolar type., initiated 12/3/2024, the CP indicated a goal that the resident would reduce the use of psychotropic medication with interventions that included behavior monitoring for anti-psychotic medication. During a concurrent interview and record review on 1/14/2026 at 11:55 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 reviewed Resident 15's physician orders and medication administration record (MAR- a record of all medications taken by a resident on a day-to-day basis) for 1/2026. LVN 1 stated antipsychotic and antidepressant medications are high-risk medications that can cause adverse effects like dizziness and increased confusion resulting in resident falls. LVN 1 stated the goal for psychotropic medication administration is to gradually reduce the dose (GDR - structured process of slowly lowering a patient's medication dose) of psychotropic medications administered to reduce the potential for adverse effects. LVN 1 stated the facility process for psychotropic medication administration is the resident's behaviors are monitored by facility staff and the physician to determine if psychotropic medications are appropriate or not. LVN 1 stated behavioral manifestations are included in the physician's order and the behaviors are tallied in the MAR each shift by the LN. LVN 1 stated if the resident has decreased behaviors, then a GDR is attempted. LVN 1 stated Resident 15 received quetiapine fumarate and sertraline for behavioral manifestations of feelings of hopelessness. sadness. loneliness, and highs and lows. LVN 1 stated feelings can be verbalized and expressed in different ways like facial expressions. LVN 1 stated Resident 15 can verbalize his feelings. During a follow up interview with LVN 1 on 1/14/2026 at 2:57 p.m., LVN 1 stated that feelings are emotions that manifest in behaviors. LVN 1 stated feelings are not a specific measurable behavior. LVN 1 stated Resident 15's orders and monitoring for quetiapine fumarate and sertraline should have included specific behaviors like the resident verbalizes his feelings, but they did not. LVN 1 stated when Resident 15 was not monitored for specific behaviors it could lead to ineffective behavior medication management potentially resulting in harm to the resident from the administration of unnecessary medication. During a concurrent interview and record review on 1/16/2026 at 1:30 p.m. with the Director of Nursing (DON), the DON reviewed the facility policy and procedure (P&P) regarding psychotropic medication. The DON stated psychotropic medications are high risk medications that control resident behaviors. The DON stated psychotropic medications are not recommended for long term use in the elderly and can cause adverse effects like dizziness and falls. The DON stated the facility process for psychotropic medication is the LN monitors and tallies resident's specific measurable behaviors that are communicated with the physician in the MAR. The DON stated the physician then attempts a GDR with a goal to discontinue the medication. The DON stated feelings are not measurable behaviors because feelings are emotions and different staff may have different interpretations of the resident's expression of his feelings resulting in the resident not being properly monitored for their specific behaviors. The DON stated the facility P&P was not followed when Resident 15's quetiapine fumarate and sertraline was not monitored for resident specific behavioral manifestations potentially resulting in the administration of unnecessary psychotropic medications leading to unsteadiness and falls with injuries. During a review of the facility P&P titled, Psychotropic Medication Management, last reviewed 4/24/2025, the P&P indicated, Policy Statement: .(facility name) ensures that psychotropic medications are prescribed, administered, monitored, and (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discontinued in accordance with resident-specific needs, physician orders, and regulatory guidelines. These medications are used only when clinically indicated, and the facility actively monitors for . efficacy, and reduction attempts. Purpose: To ensure safe, appropriate, and effective use of psychotropic medications while protecting resident rights and minimizing unnecessary use. Procedure: . 1. Assessment and Prescription. Medication orders must include: . Indication and expected outcome. 4. Monitoring and Review. Residents on psychotropic medications are reviewed at least quarterly by the IDT.Monitor for: Effectiveness. Need for dose adjustment or tapering. 5. Reduction and Discontinuation.The facility attempts to reduce or discontinue psychotropic medications when clinically appropriate. During a review of the facility P&P titled, Psychoactive Drug Monitoring last reviewed 4/24/2025, the P&P indicated, Policy: 1). Residents who receive antidepressant. antipsychotic medications are monitored to evaluate the effectiveness of the medication . 2). Every effort is made to ensure that residents receiving these medications obtain the maximum benefit with the minimum of untoward effects. Procedure: . Unless medically contraindicated, periodic dosage reductions are attempted and the results documented. Antidepressants. The resident's subjective, objective improvement, and/or maintenance of function is documented. The resident is evaluated periodically for continued need for the antidepressant medication, which may include a dosage reduction trial. Anti-psychotics. Residents receive anti-psychotic medication only for behaviors that are quantitatively and objectively documented through the use of behavioral monitoring charts or a similar mechanism. 2. During a review of Resident 14's admission Record (AR), the AR indicated the facility admitted the resident on 4/18/2023, and readmitted the resident on 12/22/2025, with diagnoses including depressive episodes (a period, typically lasting at least two weeks, marked by a persistently sad mood and/or loss of interest in activities, accompanied by several other symptoms like fatigue, sleep/appetite changes, feelings of worthlessness, poor concentration, and sometimes suicidal thoughts, significantly impairing daily life) and anxiety disorders (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness). During a review of Resident 14's History and Physical (H&P), dated 12/24/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 14's Minimum Data Set (MDS, a resident assessment tool), dated 10/31/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had severe cognitive impairment (a major loss in mental abilities like memory, thinking, and decision-making, so significant that a person can't live independently and needs help with daily tasks like eating, dressing, or managing medications, similar to advanced dementia). During a review of Resident 14's Order Summary Report (OSR), the OSR indicated an order for: 12/23/2025 Depakote Oral Tablet Delayed Release 250 milligrams (mg, a unit of weight) (Divalproex Sodium). Give one tablet orally three times a day for bipolar disorder monitor for behavior (m/b) mood swing. 12/24/2025 Rexulti Oral Tablet one mg (Brexpiprazole). Give one tablet by mouth one time a day for psychosis (a mental state where a person loses touch with reality and has trouble distinguishing what is real from what is not) m/b screaming and aggression secondary to dementia (a progressive state of decline in mental abilities). (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 14's Care Plan (CP) Report titled, The resident with behavioral history such as: history of physical aggression towards roommate., last revised on 9/18/2024, the CP indicated an intervention to administer medications as ordered. Monitor/document for side effects and effectiveness. Depakote Oral Tablet Delayed Release 250 mg (Divalproex Sodium). Give one tablet orally three times a day for bipolar disorder m/b mood swing and Depakote Oral Tablet Delayed Release 250 mg. Black Box Warning (is the strictest, most serious warning the U.S. Food and Drug Administration (FDA) requires for prescription drugs). During a concurrent interview and record review on 1/14/2026, at 1:10 p.m., with the Minimum Data Set Coordinator (MDSC), reviewed Resident 14's Medical Diagnosis, OSR, Medication Administration Record (MAR), and CP. The MDSC stated there was no order for monitoring for adverse effect on the use of psychotropic medications Depakote and Rexulti and the MAR does not have any form of monitoring for its adverse effects. The MDSC also stated the behaviors to be monitored on the use of Depakote was not specific. The MDSC stated that it was important to monitor for specific behaviors on the use of psychotropic medications to know if the medication was working and to help in the gradual dose reduction of the drug. The MDSC also stated it was important to monitor for adverse effects of the psychotropic drugs so the licensed nurse can report to the PMD the adverse reactions of the drug for the PMD to intervene appropriately in a timely manner to prevent undue harm and stress to the resident. During an interview on 1/16/2026, at 10:06 a.m., with the Director of Nursing (DON), the DON stated it was important to monitor for the adverse effects of Depakote and Rexulti on Resident 14 every shift to see if there is any reaction from the medication being both medications have Blackbox warning. The DON stated Blackbox warning tells the nurses the changes to watch for and other severe adverse reaction that can even cause death to residents. During a review of the facility's recent policy and procedure (P&P) titled, Psychotropic Medication Management, last reviewed on 4/24/2025, the P&P indicated the facility ensures that psychotropic medications are prescribed, administered, monitored, and discontinued in accordance with resident-specific needs, physician orders, and regulatory guidelines. These medications are used only when clinically indicated, and the facility actively monitors for side effects, efficacy, and reduction attempts. Procedure 1.Assessment and Prescription - Medication orders must include: Indication and expected outcome 3. Administration -Licensed staff must monitor for adverse reactions and document administration and resident response. 4. Monitoring and Review - Monitor for: (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Side effects and adverse reactions Need for dose adjustment or tapering

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's licensed nursing staff failed to provide care in accordance with professional standards of care for two of two sampled residents (Residents 4 and 35) reviewed for insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) use by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (sq, beneath the skin) insulin administration sites. The deficient practice had the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross reference F760. Findings: 1. During a review of Resident 4's admission Record (AR), the AR indicated the facility admitted the resident on 3/13/2017, and readmitted the resident on 11/17/2025, with diagnoses including type two diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic chronic kidney disease (diabetes has damaged the kidneys' tiny filters over time, making them less able to clean waste and extra fluid from the blood, causing these to build up, and potentially leading to kidney failure if not managed) and mild protein-calorie malnutrition (a condition where a person is not getting enough protein and total calories to meet their body's basic needs, leading to the very early stages of muscle loss or body fat depletion). During a review of Resident 4's History and Physical (H&P), dated 5/8/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 11/12/2025, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severe cognitive impairment (have a very hard time remembering things, making decisions, concentrating, or learning). The MDS indicated the resident was on a high-risk drug class hypoglycemic medication (a group of drugs used to help reduce the amount of sugar present in the blood). During a review of Resident 4's Order Summary Report (OSR), the OSR indicated an order for: 11/17/2025 Insulin Glargine Subcutaneous Solution 100 units per milliliter (unit/ml, theˆconcentrationˆor strength of the insulin) (Insulin Glargine). Inject 15 units subcutaneously at bedtime for type two diabetes mellitus. Rotate Site. 12/11/2025 Novolog Injection Solution 100 unit/ml (Insulin Aspart). Inject as per sliding scale (extra units of insulin to be administered when a person's blood sugar gets high): if 70 - 150 = 0 units. If blood sugar (BS) less than (<)70, give eight (8) ounces (oz, a small unit for measuring weight or volume) of orange juice and call MD; 151 - 200 = two (2) units; 201 - 250 = 4 units; 251 - 300 = six (6) units; 301 - 350 = eight (8) units; 351 - 400 = 10 units if BS greater than (>) 400, give 12 units and call MD, subcutaneously before meals and at bedtime for type two diabetes mellitus. May rotate injection site. During a review of Resident 4' Location of Administration (LAR) of insulin for 12/2025 until 1/2026, the LAR indicated: - Insulin Glargine Subcutaneous Solution 100 unit/ml was given on: 12/14/2025 at 8:50 p.m. on the Abdomen - Left Lower Quadrant (LLQ) 12/16/2025 at 9:51 p.m. on the Abdomen - LLQ - Novolog Injection Solution 100 unit/ml was given on: 12/2/2025 at 4:35 p.m. on the Abdomen - LLQ 12/3/2025 at 4:26 p.m. on the Abdomen - LLQ 12/4/2025 at 12:25 p.m. on the Arm - left 12/5/2025 at 5:40 a.m. on the Arm - left 12/5/2025 at 5:27 p.m. on the Abdomen - LLQ 12/5/2025 at 9:14 p.m. on the Abdomen - LLQ 12/8/2025 at 8:43 p.m. on the Abdomen - Right Lower Quadrant (RLQ) 12/9/2025 at 12:15 p.m. on the Abdomen - RLQ 12/14/2025 at 8:49 p.m. on the Abdomen - RLQ 12/15/2025 at 12:49 p.m. on the Abdomen - RLQ 12/25/2025 at 4:13 p.m. on the Abdomen - RLQ 12/25/2025 at 8:42 p.m. on the Abdomen - RLQ 12/31/2025 at 5:49 a.m. on the Arm - left 12/31/2025 at 11:53 a.m. on the Arm - left During a review of Resident 4's Care Plan (CP) Report indicating the resident has diabetes mellitus, last revised on 12/8/2025, the CP indicated an intervention of diabetes medication as ordered by the doctor. Monitor/document for side effects and effectiveness and insulin glargine (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	subcutaneous solution 100 unit/ml (Insulin Glargine). Inject 15 units subcutaneously at bedtime for type two diabetes mellitus, rotate site. During a concurrent interview and record review on 1/14/2026, at 1:43 p.m., with the Minimum Data Set Coordinator (MDSC), reviewed Resident 4's Medical Diagnosis, OSR, LAR, and CP. The MDSC stated there were multiple instances that the licensed nurses did not rotate the insulin administration on Resident 4. The MDSC stated the purpose of rotating insulin administration sites is to prevent discomfort to residents and prevent skin injury to the resident such as lipodystrophy. The MDSC stated if the licensed staff continuously administer the medication on the lipodystrophy sites of the resident, the medication will not be absorbed properly and can cause hyper/hypoglycemia to residents. During an interview on 1/16/2026, at 10:06 a.m., with the Director of Nursing (DON), the DON stated the licensed staff should have rotated the sites of insulin administration to Resident 4, unless it is the resident's preference. The DON stated they rotate insulin administration sites to prevent injury to the skin such as lipodystrophy. The DON stated insulin will not be absorbed properly if injected at the sites of lipodystrophy that can cause hypo or hyperglycemia to residents. During a review of the facility's recent policy and procedure (P&P) titled, Insulin Administration, last reviewed on4/24/2025, the P&P indicated the facility ensures that insulin is administered safely, accurately, and timely in accordance with physician orders, facility protocols, and accepted standards of nursing practice. Insulin is classified as a high-alert medication and requires strict adherence to medication administration procedures to prevent adverse events. POLICY GUIDELINES 1. Physician Orders All insulin administration requires a current physician or authorized practitioner order. 4. Insulin Administration Injection sites must be rotated to prevent tissue damage. During a review of the facility-provided Highlights of Prescribing Information (HPI) on the use of Lantus (insulin glargine injection) for subcutaneous injection, with initial U.S. approval in 2000, the HPI indicated to rotate injection sites to reduce the risk of lipodystrophy. 2. During a review of Resident 35's AR, the AR indicated the facility admitted the resident on 7/13/2010, and readmitted the resident on 12/23/2023, with diagnoses including type 2 diabetes mellitus with chronic kidney disease (a long-term condition where the kidneys do not work as well as they should), retinopathy (an eye disease often caused by diabetes), and neuropathy (when nerve damage leads to pain, weakness, numbness or tingling in one or more parts of your body). During a review of Resident 35's H&P, dated 11/1/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 35's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). The MDS indicated the resident was on a high-risk drug class hypoglycemic medication. During a review of Resident 35's OSR, the OSR indicated an order for: - 12/11/2025 Humulin R Injection Solution 100 unit/ml (Insulin Regular (Human)). Inject as per sliding scale: if 0 - 80 If conscious, give 4 oz of juice. If unconscious, give glucagon (a hormone that your pancreas makes to help regulate your blood glucose (sugar) levels) one milligram (mg, a unit of weight) intramuscular (IM, a shot of medicine given into a muscle) x 1. Notify MD; 81 - 199 = 0 No coverage; 200 - 250 = two (2) units; 251 - 300 = four (4) units; 301 - 350 = six (6) units; 351 - 400 = eight (8) units; 401+ = 10 units Notify MD, subcutaneously before meals and at bedtime for DM. May Rotate Injection Site. - 12/12/2025 Insulin NPH Isophane & Regular Suspension (70-30) 100 unit/ml. Inject 12 unit subcutaneously two times a day for DM. May rotate injection site. During a review of Resident 35's LAR of insulin for 12/2025 until 1/2026, the LAR indicated: - Insulin NPH Isophane & Regular Suspension (70-30) 100 unit/ml was given on: 12/8/2025 at 8:16 a.m. on the Abdomen - RLQ 12/9/2025 at 9:18 a.m. on the Abdomen - RLQ 12/14/2025 at 8:22 a.m. on the Deltoid - right 12/15/2025 at 8:19 a.m. on the Deltoid - right - Humulin R Injection Solution 100 unit/ml was given on: 12/5/2025 at 11:50 a.m. on the Abdomen - Left Upper Quadrant (LUQ)^ 12/6/2025 at 12:25 p.m. on the Abdomen - LUQ 12/9/2025 at 12:04 p.m. on the Abdomen - LLQ 12/15/2025 at 11:33 a.m. on the Abdomen - LLQ 12/24/2025 at 12:01 p.m. on the Abdomen - LLQ 12/25/2025 at 11:39 a.m. on the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Abdomen - LLQ During a review of Resident 35's CP Report titled, The resident has diabetes mellitus, last revised on 12/8/2025, the CP indicated an intervention to administer medication as ordered by the physician. Monitor for side effects and effectiveness and inject as per sliding scale: if 0 - 80 If conscious, give 4 oz of juice. If unconscious, give glucagon 1mg IM x 1. Notify MD; 81 - 199 = 0 No coverage; 200 - 250 = two (2) units; 251 - 300 = four (4) units; 301 - 350 = six (6) units; 351 - 400 = eight (8) units; 401+ = 10 units Notify MD, subcutaneously before meals and at bedtime for DM. Rotate Site. During a concurrent interview and record review on 1/14/2026, at 1:43 p.m., with the MDSC, reviewed Resident 35's Medical Diagnosis, OSR, LAR, and CP. The MDSC stated there were multiple instances that the licensed nurses did not rotate the insulin administration on Resident 35. The MDSC stated the purpose of rotating insulin administration sites is to prevent discomfort to residents and prevent skin injury to the resident such as lipodystrophy. The MDSC stated if the licensed staff continuously administer the medication on the lipodystrophy sites of the resident, the medication will not be absorbed properly and can cause hyper/hypoglycemia to residents. During an interview on 1/16/2026, at 10:06 a.m., with the DON, the DON stated the licensed staff should have rotated the sites of insulin administration to Resident 35, unless it is the resident's preference. The DON stated they rotate insulin administration sites to prevent injury to the skin such as lipodystrophy. The DON stated insulin will not be absorbed properly if injected at the sites of lipodystrophy that can cause hypo or hyperglycemia to residents. During a review of the facility's recent P&P titled, Insulin Administration, last reviewed on4/24/2025, the P&P indicated the facility ensures that insulin is administered safely, accurately, and timely in accordance with physician orders, facility protocols, and accepted standards of nursing practice. Insulin is classified as a high-alert medication and requires strict adherence to medication administration procedures to prevent adverse events. POLICY GUIDELINES 1. Physician Orders All insulin administration requires a current physician or authorized practitioner order. 4.Insulin Administration Injection sites must be rotated to prevent tissue damage. During a review of the facility-provided HPI on the use of Humulin R (insulin human) injection, for subcutaneous or intravenous use, with initial U.S. approval in 1982, the HPI indicated subcutaneous injection: inject subcutaneously 30 minutes before a meal into the thigh, upper arm, abdomen, or buttocks. Rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis. During a review of the facility-provided Patient Information (PI) for Novolin N, the PI indicated skin thickens or pits at the injection site (lipodystrophy). Change (rotate) where you inject your insulin to help prevent these skin changes from happening. DO not inject insulin onto this type of skin.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to provide treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plans by failing to notify the physician when the resident's blood pressure measured higher than the established parameters of systolic blood pressure (SBP - measures the pressure in your arteries [pathway that carries blood away from the heart]) greater than (>) 140 millimeters of mercury (mmHg - measurement of pressure) on multiple shifts in 1/2026 for one of one sampled resident (Resident 5). This deficient practice had the potential to result in further decline of the resident's kidney (body part that filters blood) function. Findings: During a review of Resident 5's admission Record (AR), the AR indicated the facility admitted the resident on 4/7/2022 and most recently readmitted the resident on 9/14/2025 with hypertensive heart disease with heart failure (refers to heart problems that occur because of high blood pressure [HTN]), acute on chronic congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), chronic kidney disease (condition in which the kidneys are damaged and cannot filter blood as well as they should) stage three (3) (kidneys are moderately damaged), and hemiplegia (total paralysis [the loss of muscle function in a part of the body] of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial paralysis or weakness on one side of the body) following cerebral infarction (stroke - loss of blood flow to a part of the brain). During a review of Resident 5's Minimum Data Set (MDS - resident assessment tool), dated 10/9/2025, the MDS indicated the resident was able to understand others and make himself understood. The MDS further indicated the resident was dependent on staff for bathing, toileting, rolling left to right, and lower body dressing. During a review of Resident 5's Care Plan (CP) titled, The Resident has altered cardiovascular status related to HTN., initiated 4/7/2022, the CP indicated a goal that the resident would be free from cardiac complications with an intervention that included resident / family / caregiver teaching including risk factors such as HTN. During a review of Resident 5's CP titled, The resident has chronic renal failure related to kidney disease ., initiated 7/29/2024, the CP indicated interventions that included monitor vital signs (measurements of the body's most basic, essential functions - body temperature, pulse (heart rate), respiratory (breathing) rate, and blood pressure [BP]) and notify the physician of significant abnormalities. During a review of Resident 5's Kidney Medical Group (KMG) notes, dated 11/18/2025, the KMG notes indicated, Chronic Kidney Disease, Stage 3 . has improved . The goal is to maintain function and prevent further decline . Management will focus on blood pressure control. Blood pressure control is essential to protect kidney function. Target systolic blood pressure should be maintained below 140 mmHg. During a review of Resident 5's Order Summary Report, dated 11/19/2025, the Order Summary Report indicated a physician's orders to check BP two times a day and notify the physician if SBP > 140 mmHg. During a concurrent interview and record review on 1/14/2026 at 3:24 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 5's physician orders, medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), for 1/2026, and Progress Notes, for 1/2026, were reviewed. LVN 1 stated Resident 5 had an outside appointment on 11/18/2025 at KMG and a new physician's order was carried out on 11/19/2025 to check the resident's SBP two times a day and notify the physician if the SBP >140 mmHg. LVN 1 stated the MAR indicated to check the BP at the routine times of 9 a.m. and 5 p.m. daily and the physician should be notified when the SBP is > 140 mmHg during those routine checks. LVN 1 stated if the physician was notified regarding Resident 5's SBP, then there should be documentation as proof that the order was carried out and the physician was notified. LVN 1 reviewed Resident 5's MAR and Progress Notes for 1/2026 and noted the following: - On 1/2/2026 at 5 p.m., there was no documented evidence that the physician was notified when the SBP measured 151 mmHg. - On 1/3/2026 at 9 a.m., there was no documented evidence that the physician was notified when the SBP measured 145 mmHg. - On 1/3/2026 at 5 p.m., (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there was no documented evidence that the physician was notified when the SBP measured 157 mmHg. - On 1/4/2026 at 9 a.m., there was no documented evidence that the physician was notified when the SBP measured 152 mmHg. - On 1/5/2026 at 5 p.m., there was no documented evidence that the physician was notified when the SBP measured 157 mmHg. - On 1/6/2026 at 9 a.m., there was no documented evidence that the physician was notified when the SBP measured 145 mmHg. - On 1/6/2026 at 5 p.m., there was no documented evidence that the physician was notified when the SBP measured 154 mmHg. - On 1/9/2026 at 5 p.m., there was no documented evidence that the physician was notified when the SBP measured 144 mmHg. - On 1/10/2026 at 5 p.m., there was no documented evidence that the physician was notified when the SBP measured 147 mmHg. - On 1/11/2026 at 9 a.m., there was no documented evidence that the physician was notified when the SBP measured 147 mmHg. LVN 1 further stated when the licensed nurses (LN) did not follow the physician's order for notification when the SBP was >140 mmHg, there was the potential that the staff would not know of any needed treatments for the increased BP leading to worsening kidney issues in Resident 5. During a concurrent interview and record review on 1/15/2026 at 2:13 p.m. with LVN 11, Resident 5's physician orders, MAR, for 1/2026, and Progress Notes, for 1/2026, were reviewed. LVN 11 stated Resident 5 had a history of CHF and takes many BP medications. LVN 11 stated Resident 5's physician placed an order to take the resident's BP at 9 a.m. and 5 p.m. and to notify if the SBP was >140 because the physician wanted the resident's SBP to be below 140 mmHg. LVN 11 stated LVN 11 notified the physician on 11/24/2025 when the resident's SBP was >140 and the physician ordered additional medication. LVN 11 stated she regularly cares for Resident 5 and has not notified the physician regarding an SBP >140 since 11/2025. LVN 11 reviewed Resident 5's MAR and noted on 1/3/2026 at 9 a.m., the SBP measured 145, but LVN 11 did not remember what happened. LVN 11 stated she did not follow the physician's order to notify the physician when the SBP was >140, but she should have. During a concurrent interview and record review on 1/16/2026 at 2 p.m. with the Director of Nursing (DON), the facility's policy and procedures (P&P) titled, Quality of Care Policy, last reviewed 4/24/2025, and Change of Condition, last reviewed 4/24/2025, were reviewed. The DON stated physician orders include instructions to the LN for providing resident care. The DON stated if there is a physician's order to notify the physician when the resident's BP is out of the parameter, then the physician should be notified, and the notification should be documented. The DON stated it was important to notify Resident 5's physician when the SBP was >140 mmHg to implement interventions to lower the BP and to prevent the resident from having another stroke or further loss of kidney function, but it was not done. The DON stated the facility P&Ps were not followed when the physician was not notified. During a review of the facility P&P titled, Quality of Care Policy, last reviewed 4/24/2025, the P&P indicated, Purpose: .To ensure that all residents receive safe, effective, and resident-centered care in accordance with physician orders, care plans, and regulatory requirements.Policy: . The facility is committed to providing high-quality care that meets professional standards and promotes the health, safety, and well-being of all residents.Procedures: . I. Assessment and Monitoring: . a. All residents will have care plans based on comprehensive assessments.b. Ongoing monitoring of care delivery, including . nursing interventions will be conducted daily or as indicated. During a review of the facility P&P titled, Change of Condition, last reviewed 4/24/2025, the P&P indicated, Policy Statement . The facility will promptly recognize, assess, and respond to any change in a resident's physical. condition to ensure timely medical intervention and maintain resident safety. Purpose . 1. Recognition . a. All staff must observe and report any changes in resident status, including but not limited to: . 1. Vital signs. 2. Immediate Action. b. Notify the physician or authorized practitioner according to severity and facility protocol. 3. Documentation . a. Document . provider notifications in the EHR or medical record

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents` environment was free of accident hazards for eight (8) of nine (9) sampled residents (Residents 43, 53, 73, 18, 68, 111, 3, and 57) reviewed for accidents by failing to ensure: 1. Resident 43 did not have a furniture or equipment on top of the floor mat (specially designed mats provide cushioning and support to patients who are at risk of falling, helping to prevent serious injuries). 2. Resident 53 did not have frayed (torn) wires on the resident's bed remote control. This deficient practice increases the risk of accidents such as electrocution (the injury or killing of someone by electric shock) and falls with injuries on residents. 3. The facility followed the policy and procedure (P&P) to conduct Interdisciplinary Team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of their resident) meetings after Resident 73 fell on [DATE] and 12/19/2025. This deficient practice had the potential to result in recurrent, preventable falls with injury to Resident 73. 4. Residents 18, 68, and 111's self-administered medications were not left unattended at their bedside without a physician's order. This deficient practice had the potential to result in ongoing unauthorized medication administration, and medication errors. 5. Resident 3`s physician's order to place the bed pad alarm (a pad with sensors that will alarm when a resident stands up unassisted to help prevent falls by alerting staff) was implemented. 6. Resident 57's bed alarm was functioning properly. These deficient practices placed the residents at risk for recurrent, preventable falls and incurred injuries which may lead to hospitalization. Findings: 1. During a review of Resident 43's admission Record (AR), the AR indicated the facility admitted the resident on 4/20/2009, and readmitted the resident on 11/7/2025, with diagnoses including abnormalities of gait (the way a person or animal walks or moves on foot, involving the coordinated pattern of steps, balance, and rhythm) and mobility, muscle weakness, and repeated falls. During a review of Resident 43's History and Physical (H&P), dated 11/8/2025, the H&P indicated the resident had fluctuating capacity to understand and make decisions. During a review of Resident 43's Minimum Data Set (MDS, a resident assessment tool), dated 10/24/2025, the MDS indicated the resident usually make self-understood and sometimes understand others and had severe cognitive impairment (inability to plan and carry out regular tasks (Activities of daily living/instrumental activities of daily living) and apply judgment). The MDS indicated the resident required substantial to supervision assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 43's Order Summary Report (OSR), dated 12/14/2023, the OSR indicated an order for yellow arm band on the resident for fall prevention. Monitor for presence. During a review of Resident 43's Fall Risk Evaluation (FRE), dated 11/7/2025, the FRE indicated the resident was at high risk for falls. During a review of Resident 43's Care Plan (CP) Report titled, The resident has a communication problem related to metabolic encephalopathy (a problem in the brain) ., last revised on 11/19/2025, the CP indicated an intervention to ensure/provide a safe environment. During a concurrent observation and interview on 1/12/2026, at 10:36 a.m., with Licensed Vocational Nurse (LVN) 6, inside Resident 43's room, observed Resident 43 in bed with upper side rails up, pad (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	alarm (is a safety or training device consisting of a pressure-sensitive mat (pad) placed under a person in bed or a chair, connected to a monitor that sounds an alarm when pressure is removed) was on, and there were floor mats placed on both sides of the bed. The left fall mat had a side table on top of them. LVN 6 stated there should be no furniture or equipment on top of the fall mat as it defeats the purpose of having a soft-landing surface for the resident to land on when the resident rolls/falls down from the bed. LVN 6 stated if there is a furniture or equipment on top of the floor mat, the resident will land on the hard objects that is on top of the floor mat that can cause injuries to residents such as bumps, laceration (a torn or jagged cut in the skin and underlying soft tissue), bruising and even fracture (break in bone). During an interview on 1/14/2026, at 1:09 p.m., with the Minimum Data Set Coordinator (MDSC), the MDSC stated the purpose of the floor mat was to prevent injury when Resident 43 rolls/falls down from the bed. The MDSC stated the interdisciplinary team (IDT, a group of professionals from different specialties who come together to create and manage a single, unified care plan for a resident) decides if the resident needs a floor mat, they notify the MD for order, and get consent from the resident representative (RP), and then they do the notes. The MDSC stated there should be no objects on top of the floor mat because the purpose of the floor mat is to prevent injury, if there is an object on top of the floor mat it is not safe, they will hit the object that is on top of the mat increasing the risk of injury. The MDSC stated they did not follow the P&P on Floor Mat Use for Safety of Residents. During an interview on 1/16/2026, at 10:06 a.m., with the Director of Nursing (DON), the DON stated they need to assess the resident for fall risk and inform the doctor to obtain an order. The DON stated the floor mat of Resident 43 should be free from equipment and furniture on top of them because the purpose of the floor mat is to provide a soft-landing surface and if there is an object on top they are more at risk for injury because they will hit the hard surface on top of the mat. The DON stated the resident can sustain injury such as cuts, bruises, and possible fractures. During a review of the facility's recent policy and procedure (P&P) titled, Floor Mat Use for Resident Safety, last reviewed on 4/24/2025, the P&P indicated the facility uses floor mats as a safety intervention for residents at risk for falls when exiting the bed. Floor mats are considered a fall prevention tool, not a restraint, and are applied based on individual resident assessment and care plan. Procedure 2.Floor Mat Placement Place floor mats on the floor next to the bed for residents identified at risk for falls. Mats should be flat, stable, and positioned to cover the area, most likely to be used when the resident exits the bed. Ensure mats are clean, dry, and free from obstacles. During a review of the facility-provided Floor Mat (FM) 1, undated, indicated the FM 1 reduces the impact of a fall from bed. Never leave heavy materials on the mat for an extended amount of time and they may cause a permanent indentation. During a review of the facility's recent P&P titled, Accident Reporting and Management Policy, last reviewed on 4/24/2025, the P&P indicated the facility is committed to maintaining a safe environment for residents, staff, and visitors. All accidents, incidents, or injuries occurring within the facility must be promptly reported, documented, investigated, and managed to ensure safety, regulatory compliance, and continuous quality improvement. 2. During a review of Resident 53's AR, the AR indicated the facility admitted the resident on 4/1/2025, and readmitted the resident on 10/14/2025, with diagnoses including dementia (a progressive state of decline in mental abilities), depression (a serious mood illness making you feel persistently sad, empty, or losing interest in things you once enjoyed, making daily life difficult), and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness). During a review of Resident 53's H&P, dated 4/1/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 53's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). The MDS indicated the resident required substantial to set up assistance on mobility and ADLs. During a review of Resident 53's CP Report titled, Resident is high risk for falls related to impaired mobility., last revised on 1/7/2026, the CP indicated an intervention to ensure all safety equipment is functioning properly and check alarms for each shift. During a concurrent observation and interview on 1/12/2026, at 10:11 a.m., with LVN 5, inside Resident 53's room, observed Resident 53's bed remote control with frayed wires on them. LVN 5 stated there should be no frayed wires on Resident 53's bed remote control because it can predispose the resident to accident such as electrocution. LVN 5 stated all staff are responsible for reporting environmental hazards to the Maintenance Department. During an interview on 1/14/2026, at 2:15 p.m., with the MDSC, the MDSC stated there should be no frayed wires on Resident 53's bed remote control because it can predispose the resident to injuries such as electrocution. The MDSC stated all staff are responsible to report all unsafe environmental conditions observed in the facility to the Maintenance Department. During an interview on 1/16/2026, at 10;06 a.m., with the DON, the DON stated there should be no open wires/frayed wires on Resident 53 bed remote control as it can cause accidents to the resident such as electrocution. During a review of the facility's recent P&P titled, General Maintenance and Plant Operations Policy, last reviewed on 4/24/2025, the P&P indicated the facility is committed to maintaining a safe clean, and functional physical environment for residents, staff, and visitors. All facility systems, equipment, and structures shall be maintained in good working order in compliance with federal, state, and local regulations. POLICY GUIDELINES 3.Preventive Maintenance Program - Preventive maintenance schedules shall be established and followed - Equipment inspected may include: Medical equipment (as applicable) 5. Environmental Safety - Maintain hallways, rooms, and common areas free of hazards. 9.Staff Responsibilities - All staff are responsible for reporting maintenance concerns promptly. 3. During a review of Resident 73's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], and most recently admitted the resident on 12/25/2025, with diagnoses that included aftercare following joint replacement surgery, history of falling, spinal stenosis (narrowing of one or more spaces within the spinal canal) of the cervical region (neck area), and post laminectomy syndrome (any lingering pain of unknown origin following back surgery). During a review of Resident 73's MDS dated [DATE], the MDS indicated Resident 73 was able to understand others and able to make herself understood. The MDS further indicated the resident (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	required substantial / maximal assistance (helper does less than half the effort) with toileting, bathing, lower body dressing, moving from sit to stand, and toilet transfers; and partial / moderate assistance (helper does more than half the effort) with bathing, upper body dressing, oral and personal hygiene, rolling left to right, and moving from sitting to lying. During a review of Resident 73's History and Physical (H&P), dated 6/24/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 73's Nursing Fall Risk Evaluation (NFRE), dated 12/16/2025, the NFRE indicated the resident had a history of one to two falls in the past three months, had balance problems while standing / walking, decreased muscular coordination, required the use of an assistive device, and was a high risk for falls. During a review of Resident 73's care plan (CP) titled The Resident is High risk for falls., initiated 11/12/2024, the CP indicated a goal that the resident's risk for falls will be minimized / eliminated, and the resident would be free from injury. The CP included interventions to review information on past falls and attempt to determine cause of falls, record possible root causes, alter removal of any potential causes, educate the resident / family / caregiver / IDT as to causes. During a review of Resident 73's CP titled Missed wheelchair slid off slowly to floor., initiated 12/16/2025, the CP indicated a goal to prevent future falls. During a review of Resident 73's e-Interact Change of Condition Evaluation form (COC), dated 12/16/2025, the COC indicated on the afternoon of 12/16/2025, Resident 73 had an unwitnessed fall when the resident was found sitting on the floor next to her wheelchair. Resident 73 stated she slid to floor while attempting to sit in the wheelchair. No injuries were identified in Resident 73. During a review of Resident 73's COC, dated 12/19/2025, the COC indicated on the afternoon of 12/19/2025, Resident 73 was in the bathroom with the Certified Nursing Assistant (CNA) and the resident's left and right feet buckled inward resulting in a fall to the floor. The fall resulted in discoloration of the knee and swelling on the right ankle. Resident 73 complained of a numeric pain scale (a standard pain scale with zero being no pain and ten [10] as the worst pain one can imagine) level six (6) out of 10. During a concurrent observation and interview on 1/12/2026 at 10 a.m., observed Resident 73 sitting in a wheelchair at bedside. Resident 73 stated she has had many falls in the facility. Resident 73 stated her most recent fall was in the bathroom with CNA 11. Resident 73 stated the fall caused pain on the right side of her body, she was given ice for the right ankle, and she had an x-ray of the right foot. During an interview on 1/13/2026 at 8:30 a.m. with CNA 11, CNA 11 stated Resident 73 had a fall in the bathroom about two to three weeks prior. CNA 11 stated Resident 73 was standing and both feet gave out resulting in the resident sliding to the floor. CNA 11 stated Resident 73 complained of foot pain after the fall, but the resident had also had a fall a few days prior and was already complaining of pain. During an interview on 1/13/2026 at 1:15 p.m. with Registered Nurse (RN) 1, RN 1 stated the facility process when a resident falls it to first assess the resident, then notify the physician and family and document in the COC form, complete a Fall Risk Evaluation Assessment, and then the department (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	heads will have an IDT post fall meeting. During a concurrent interview and record review on 1/13/2026 at 2:11 p.m. with LVN 1, LVN 1 reviewed Resident 73's COCs dated 12/16/2025 and 12/19/2025, CPs, Progress Notes for 12/2025, and IDT Risk Management Review Notes for 12/2025. LVN 1 stated any time a resident's body reaches the floor, it is considered a fall. LVN 1 stated the facility process when a resident falls is to first assess the resident, then completed a COC and notify the physician to obtain any treatment orders, provide treatments and monitor the resident, CPs will be immediately updated with new interventions to prevent future falls, and the IDT including rehabilitation services and nursing will meet withing three to seven days after the fall. LVN 1 stated the importance of the post fall IDT meeting is to discuss the fall incident and to ensure new interventions are put in place to prevent future falls.ˆLVN 1 stated the post fall IDT meeting is documented on the IDT Risk Management Review form. LVN 1 stated Resident 73 fell on [DATE] and 12/19/2025 and there was no documented evidence the IDT met to discuss the falls, but there should have been. During a concurrent interview and record review on 1/16/2026 at 1:30 p.m. with the Director of Nursing (DON), the DON reviewed the facility policy and procedure (P&P) regarding fall prevention. The DON stated the facility process is when a resident falls the RN assesses the resident, the physician is notified, interventions are put in place to prevent future falls, and the IDT meets within seven days. The DON stated the importance of the IDT meeting is for the whole team including the rehab department, nursing, social services, the Assistant DON, and the DON to meet to discuss the resident's care and to update the CPs with any new interventions to prevent future falls. The DON stated Resident 73 had falls on 12/16/2025 and 12/19/2025, but there were no post fall IDT meetings completed. The DON stated during 12/2025 the post fall IDT meetings were the responsibility of the former Quality Assurance (QA) Nurse, but the QA Nurse did not complete her job duties to ensure that post fall IDT were completed for Resident 73. The DON stated the QA Nurse no longer works at the facility. The DON stated the facility P&P were not followed potentially resulting in further falls with injury to Resident 73. During a review of the facility P&P titled, Fall Management Program last reviewed 4/24/2025, the P&P indicated, POLICY STATEMENT.(facility name) is committed to minimizing the risk of resident falls through a structured Fall Management Program that includes prevention, monitoring, and post-fall evaluation. All falls will be reviewed by the Interdisciplinary Team (IDT) within 3-7 days to ensure timely interventions and continuous quality improvement. PURPOSE.To provide a systematic approach to: Prevent falls. Assess residents after a fall. Implement individualized interventions.Monitor outcomes and reduce fall-related injuries. SCOPE. This policy applies to all residents, licensed nursing staff, rehabilitation staff, dietary staff, social workers, and other members of the IDT involved in resident care and fall prevention. 2. FALL INCIDENT REPORTING. Any resident fall, with or without injury, must be documented immediately by the nurse on duty. 3. IDT POST-FALL REVIEW.The Interdisciplinary Team (IDT) shall review each fall within 3-7 days. Review will focus on: Cause(s) of the fall. Resident's current medical status and risk factors. Effectiveness of existing fall prevention interventions. Recommendations for revised interventions or care plan updates. 4. CARE PLAN AND INTERVENTIONS.Following the IDT review, individualized interventions will be implemented in the resident's care plan. Interventions may include: . Adjustments to mobility or activity levels.Changes in room or equipment setup. Additional staff assistance. Referral to rehabilitation services.Education for resident and family. 5.MONITORING AND DOCUMENTATION.All post-fall assessments, IDT recommendations, and care plan updates must be documented in the Electronic Health Record (EHR). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility P&P titled, Safety and Supervision of Residents Policy last reviewed 4/24/2025, the P&P indicated, Our facility strives to ensure the environment is as free from hazards as possible. Resident safety, supervision, and assistance to prevent accidents are facility-wide priorities. II. Individualized, Resident-Centered Approach to Safety.the interdisciplinary care team evaluates assessment data and observations to identify specific risks or hazards for each resident. The care team implements individualized interventions, which may include: . Adequate supervision. Use of assistive devices. Environmental adjustments. 4A. During a review of Resident 18 admission Record (AR), the AR indicated the facility admitted the resident on 6/29/2020, with diagnoses including chronic pain syndrome (persistent pain that does not go away), and anxiety (feeling of constant worry). During a review of Resident 18's History and Physical (H&P) dated 4/28/2025 the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 18's MDS dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others without cognitive impairments (a person's thinking, memory or judgment ability). The MDS indicated Resident 18 was dependent with activities of daily living (ADLs- activities such as bathing, dressing, and toileting), requiring assistance from staff to perform part of daily tasks. During a concurrent interview and observation on 1/12/2026 at 12:23 p.m. with Resident 18, Resident 18 stated she orders her medications from Amazon or Walmart and has them delivered to the facility. Resident 18 stated she takes the following medications Biofreeze (pain relief product), Artificial Tears (eye drop lubricant), Orajel (oral pain-relieving gel), and [NAME] dry mouth spray (oral lubricant) on her own throughout the day and leave these medications unattended on her table or nightstand. 4B. During a review of Resident 68's AR, the AR indicated the facility admitted Resident 68 on 12/19/2025, with diagnoses including hypertension (HTN-high blood pressure), and cerebral vascular accident (CVA-stroke, loss of blood flow to a part of the brain). During a review of Resident 68's H&P dated 12/22/2025 the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 68's MDS dated [DATE], the MDS indicated the resident had the ability to make self -understood and understand others without cognitive impairments. The MDS indicated Resident 68 was dependent with activities of daily living requiring maximum assistance from staff to perform more than half the effort with showering and upper body dressing. During a concurrent interview and observation on 1/13/2026 at 6:30 a.m., Resident 68 stated the Lidocaine cream 5% (a pain numbing cream applied to the skin) sitting on his nightstand was used to rub on his hand when he (Resident 68) had pain in his hand. Resident 68 states he (Resident 68) uses the cream every day for the hand pain and applies it himself. 4C. During a review of Resident 111 AR, the AR indicated the facility admitted Resident 111 on 12/6/2025, with diagnoses including morbid obesity (extremely overweight) and Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 111's H&P dated 12/8/2025, the H&P indicated Resident 111 had the capacity to understand and make decisions. During a review of Resident 111 MDS dated [DATE], the MDS indicated Resident 111 had the capacity to make self-understood and understood others without cognitive impairments. The MDS indicated Resident 111 was dependent with activities of daily living requiring maximum assistance from staff to perform more than half the effort with showering and upper and lower body dressing. During a concurrent interview and observation on 1/12/2026 at 9:43 a.m., a tube of Pain-relieving cream was observed on Resident 111's overbed table. Resident 111 stated she ordered the cream from Walmart had it delivered to her room and rubs the cream on her body when she has pain. During a concurrent interview and observation on 1/12/2026 at 9:43 a.m., a tube of Pain-relieving cream was observed on Resident 111's overbed table. Resident 111 stated she (Resident 111) ordered the cream from Walmart had it delivered to her room and rubs the cream on her body when she has pain. During an interview on 1/13/2026 at 11:30 a.m., with the Assistant Director of Nursing (ADON), the ADON stated residents should not have medications at their bedside unless they have an assessment completed for self-administration and have a physician's order to do so. The ADON stated Resident 18, Resident 68, and Resident 111 had no assessment for self-administration of medication and no physician's order to have the medications at bedside. The ADON stated medications unattended at the bedside put residents at risk for medication errors, medication duplication and posed a safety risk for residents when medications are left unattended at the bedside. During a review of the facility's policy and procedure (P&P) undated, titled Self-Medication Administration Policy , the P&P indicated, A comprehensive assessment shall be completed by licensed nursing staff, the assessment will evaluate cognitive status, manual dexterity, vision and hearing ability and how to follow instructions, understanding of medication regimen, assessment findings shall be documented in the medical record reassessments will occur at least quarterly or upon change of condition as needed a physicians order must specify authorization for self and medicate self with medication and medication approved for self-administration any changes require a new physicians order medication shall be stored in a locked container or drawer designated for the resident the following must be documented assessment and reassessments physician authorization medications approved for self-administration and monitoring and observations director of nursing insures policy compliance and overseas assessments and monitoring licensed nursing staff conduct assessments. 5. During a review of Resident 3's admission Record, the admission Record indicated the facility originally admitted the resident on 5/31/2017, and readmitted in the facility with diagnoses including dementia (a progressive state of decline in mental abilities), anxiety disorder (a mental health condition where excessive fear and worry interfere with daily life, causing significant distress), and history of falling. During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was able to understand others and make her needs known. The MDS further indicated that Resident 3 required total assistance with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 3 had bed and wheelchair alarm. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's History and Physical (H&P) dated 10/19/2025, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3's Order Summary Report dated 1/16/2026, the Order Summary Report indicated a physician's order dated 10/18/2025 and revised on 1/12/2026 for bed pad alarm to alert staff when resident is transferring unassisted for fall precaution.ˆMonitor presence, placement, and functionality every shift.ˆChange batteries as needed. every shift. During a review of Resident 3's care plan (CP) on high risk for minor injury or major or serious injury related to history of falls initiated on 6/27/2023 and last revised 9/14/2025, the CP indicated bed pad alarm to alert staff when resident is transferring unassisted for fall precaution, monitor presence, placement, and functionality every shift as a few of the interventions in place to minimize resident 3's risk of fall and injury. During a review of Resident 3's fall risk evaluations dated 8/22/2025, 10/18/2025, 10/19/2025, 10/30/2025, and 11/27/2025, the fall risk evaluations indicated that Resident 3 was at a high risk for falls. During a concurrent observation and interview on 1/12/2026 at 12:26 p.m. inside Resident 3's room with Licensed Vocational Nurse (LVN) 10, observed Resident 3 lying in bed with both legs hanging on the left side of the bed. LVN 10 stated Resident 3's legs were hanging on the left side of the bed and Resident 3 was at a high risk for falls due to her poor safety awareness. LVN 10 stated he knows Resident 3 had a physician's order for use of bed pad alarm for the resident's safety. LVN 10 stated he did not see the box for the bed alarm and the sensor pad under the resident. During a follow up interview on 1/12/2026 at 1:26 p.m. with LVN 10, LVN 10 stated that Resident 3 had a physician's order for the bed alarm to alert staff when resident is transferring unassisted for fall precaution and to monitor presence, placement, and functionality every shift. LVN 10 stated the bed pad alarm should have been implemented per physician's order to keep Resident 3's safety. LVN 10 stated if the bed pad alarm was not placed, it placed Resident 3 at risk for falls and incurring injury due to the fall. During a concurrent interview and record review on 1/16/2026 at 9:32 a.m., Resident 3's physician's order, CP, and fall risk evaluations were reviewed with the Minimum Data Set Coordinator (MDSC). The MDSC stated Resident 3 had a physician's order and CP for bed pad alarm for fall precautions and to monitor for presence, placement, and functionality every shift. The MDSC stated Resident 3 was at a high risk for falls as indicated in the fall risk evaluations. The MDSC stated that the nursing staff should have ensured that Resident 3 had the bed pad alarm, and the sensor pad should have been present and in place. The MDSC stated that the nursing staff should have monitored the bed pad alarm was present and in place as indicated in the physician's order as it placed Resident 3 at risk for falls and injury which may lead to hospitalization. During a review of the facility's policy and procedure (P&P) titled, Fall Management Program, last reviewed on 4/24/2025, the P&P indicated the facility is committed to minimizing the risk of resident falls through as structured fall management program that includes prevention, monitoring, and post fall evaluation. The P&P further indicated: - The purpose of the program is to provide a systemic approach to prevent falls and implement individualized interventions. - Fall Prevention Strategies: a. Conduct fall risk assessments on admission, quarterly, and whenever a resident's condition changes. b. Implement individualized interventions based on risk level, which may include environmental (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	modifications (non-slip mats, adequate lighting, bed/chair alarms. - On-going monitoring includes daily observation for residents at high fall risk and evaluation of effectiveness of interventions. During a review of the facility's P&P titled, Bed and Chair Alarm Monitoring System, last reviewed on 4/24/2025, the P&P indicated that the facility utilizes bed and chair alarm monitoring systems as part of a comprehensive fall prevention and resident safety program. Alarms are implemented based on resident assessment and care planning. Alarms are not substitute for supervision and are part of a broader fall prevention strategy. The P&P further indicated: - Licensed nursing staff responsibilities every shift include verifying the placement, activation, volume, and nurse call connection and to document alarm checks. - Certified Nursing Assistants (CNAs) responsibilities include maintaining placement during care, reporting issues immediately, and responding promptly to alarms. - Alarms are installed per manufacturers' instructions and tested prior t

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that its medication error rate was below five (5) percent (%- one per hundred). Three medication errors out of 37 opportunities contributed to an overall error rate of 8.11% affecting two of four residents observed for medication administration (Residents 108 and 122). The medication errors were as follows: 1.a. Resident 108 was not instructed to chew before swallowing after the administration of aspirin (medication inhibiting platelet [blood cells aiding clotting] aggregation). 1.b. LVN 10 administered lidocaine 5% ointment to Resident 108 without a dose indicated in the physician order. 1.c. LVN 10 did not follow the manufacturer's instructions after the administration of lidocaine 5% to Resident 108. These deficient practices had the potential to result in Resident 108's health and well-being to be negatively impacted. 2. For Resident 122, LVN 4 failed to use apical pulse (AP, the heartbeat heard directly over the bottom tip (apex) of the heart) for administration of Digoxin Oral Tablet (a prescription medication used to help a weakened or damaged heart pump blood more efficiently and to stabilize irregular heartbeats) 125 microgram (mcg, a unit of measurement used for extremely small weights) by mouth one time a day for atrial fibrillation (the most common type of irregular heartbeat, where the heart's upper chambers (atria) quiver or beat chaotically instead of contracting normally). The deficient practice could result to severe bradycardia (a resting rate below 40 beats per minute [bpm]) on residents on Digoxin. Findings: a. During a review of Resident 108's admission Record (AR), the AR indicated that the facility admitted the resident on 2/3/2025, with diagnoses including cerebral infarction (commonly known as stroke, caused by a blockage in a blood vessel in the brain, leading to brain damage), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and generalized muscle weakness. During a review of Resident 108's History and Physical (H&P), dated 2/10/2025, the H&P indicated the resident cannot make own decisions but can make needs known. During a review of Resident 108's Minimum Data Set (MDS-a resident assessment tool), dated 12/18/2025, the MDS indicated makes self-understood and had the ability to understand others. The MDS indicated the resident required assistance from staff with mobility including roll left and right on the bed, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and toilet transfer. During a review of Resident 108's Order Summary Report (OSR), the OSR indicated the following: - aspirin 81 mg, give one tablet by mouth one time a day for stroke, chew one tablet before swallowing, dated 2/3/2025. - lidocaine hcl external gel 5%, apply to lower back topically every four hours for pain management, dated 5/3/2025. During an observation onˆ1/14/2026 at 8:11 a.m., in Medication Cart 1 Station 300, LVN 10 was observed preparing medications including aspirin 81 milligrams (mg-a unit of measurement) tablet in one medication cup mixed in with other medications to Resident 108. LVN 10 brought lidocaine 5% ointment tub with no dosage observed on the label. During an observation on 1/14/2026 at 8:23 a.m., at Resident 108's bedside, LVN 10 administered medications including aspiring 81 mg mixed in with other medications in one medication cup and did not instruct resident to chew aspirin before swallowing. LVN 10 scooped lidocaine 5% cream from its (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	container using his two (2) fingers about two (2) inches, index finger and middle finger, and applied it to Resident 108's lower back. During a concurrent interview and record review on 1/14/2026 at 11:23 with LVN 10, reviewed Resident 108's Medication Administration Record for the month 1/2026 with LVN 10. LVN 10 stated he (LVN 10) administered the aspirin in one medicine cup together with all the resident's medications. LVN 10 stated he (LVN 10) has always given it to Resident 108 like this, where he (LVN 10) would take all of them at the same time. LVN 10 stated he (LVN 10) did not give instruction to the resident to chew the aspiring before swallowing. LVN 10 stated he (LVN 10) should have told the resident to chew before swallowing because it is the physician order. LVN 10 stated the purpose of chewing the aspirin is for the medication to dissolve quickly and act fast. LVN 10 stated the resident is taking it to prevent stroke. During a concurrent interview and record review on 1/14/2026 at 11:33 a.m. with LVN 10, reviewed Resident 108's physician order and manufacturer instructions for lidocaine 5%. LVN 10 stated he (LVN 10) applied less than one (1) inch of lidocaine ointment to the resident's lower back. LVN 10 stated the physician order does not indicate how much to apply and he should have clarified the order. LVN 10 stated he (LVN 10) does not check the medication package insert. LVN 10 stated the lidocaine ointment package insert indicated for adults A single application should not exceed five (5) g of lidocaine ointment, 5%, containing 250 mg of lidocaine base (equivalent chemically to approximately 300 mg of lidocaine hydrochloride). This is roughly equivalent to squeezing a six (6) inch (in – a unit of measurement) length of ointment from the tube. In a 70-kilogram (kg – a unit of measurement) adult this dose equals 3.6 mg/kg (1.6 mg/lb) lidocaine base. No more than one-half tube, approximately 17 to 20 g of ointment or 850 to 1000 mg lidocaine base, should be administered in any one day.^Although the incidence of adverse effects with lidocaine ointment, 5% is quite low, caution should be exercised, particularly when employing large amounts, since the incidence of adverse effects is directly proportional to the total dose of local anesthetic agent administered. LVN 10 stated he (LVN 10) does not know how much five (5) grams (g- a unit of measurement) is, he (LVN 10) has no way of knowing. During an interview on 1/16/2026 at 10:11 a.m. with Pharmacist 1 (PH 1), PH 1 stated the est practice as a general guidance for all topical products to measure one fingertip unit (FTU) for a 6-inch area and five (5) grams divided into FTU technically would be 10 FTU. PH 1 stated the use of the FTU is to use a finger with slight amount which is an approximate measurement not an accurate measurement. PH1 stated nurses going over the manufacturer's specifications is the right way of doing measurement and should be followed. PH 1 stated the package insert for Resident 108's lidocaine 5% was the correct one. PH 1 stated the dose still has to be specified as it is guidance for the safety of the resident. PH 1 stated he is trying to find the best resource for the nurses to use and the need to understand basic handling of medication before giving to the residents. During an interview on 1/16/2026 at 2:43 p.m. with the Director of Nursing (DON), the DON stated the aspirin 81 mg the order states chew properly. The DON stated aspirin is used to prevent stroke, an anti-platelet, blood thinner and is a maintenance for dose of the elderly. The DON stated the order should have been clarified with the instructions for chewing before swallowing. The DON stated clarifying the order is for the licensed nurses to know how to administer the medication. The DON stated LVN 10 did not follow physician order for aspirin. During an interview on 1/16/2026 at 2:47 p.m., the DON stated the components of a medication order included the name of drug, dose, route, frequency, and indication. The DON stated the expectation (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	when a licensed nurse encounters a medication order without a dose is to get clarification from the physician and the pharmacy to guide them. The DON stated they can review the manufacturer's guidance in the package insert and clarify it with the physician. The DON stated it should have a dose and should have contacted the pharmacy that this is the manufacturer's guidelines if this is the appropriate amount to give. The DON stated lidocaine order should specify how much and thin the cream should be applied to ensure the resident gets the right amount of dosing. The DON stated the resident could potentially have experience more pain as it is indicated for pain management. During a review of the facility's policy and procedure (P&P) titled, Medication Administration, last reviewed 4/24/2025, the P&P indicated, Policy. Medications will be administered as prescribed by the physician, and only by persons lawfully authorized to do so. ADMINISTRATION PROCESS. Medications are administered in accordance with the written orders of the attending physician. During a review of the facility's P&P titled, Medication Administration, last reviewed 4/24/2025, the P&P indicated that the purpose of this policy is to ensure safe, accurate, and effective administration of medications to patients through standardized procedures that minimize medication errors and promote patient safety. Policy Statement: All medications shall be administered in accordance with: The prescriber's order, The 'Rights of Medication Administration', Manufacturer's instructions. 5. Rights of Medication Administration: Staff must verify the following before every administration:. 3. Right dose 4. Right route. b. During a review of Resident 122's AR, the AR indicated the facility admitted the resident on 2/2/2023, and readmitted the resident on 7/21/2025, with diagnoses including systolic heart failure (a condition where the heart's main pumping chamber (left ventricle) becomes weak, enlarged, or stiff, preventing it from squeezing hard enough to pump sufficient oxygen-rich blood to the body), paroxysmal atrial fibrillation (an intermittent, irregular, and often rapid heart rhythm that starts and stops on its own, typically lasting from a few minutes up to seven days), and atherosclerotic heart disease (a condition where arteries, which carry blood to the heart, become narrowed and hardened due to a buildup of plaque (fat, cholesterol, and other substances)). During a review of Resident 122's H&P, dated 7/22/2025, the H&P indicated the resident had the ability to understand and make decisions. During a review of Resident 122's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's mental abilities—such as memory, thinking, reasoning, and learning—are working normally without significant impairment or decline). During a review of Resident 122's OSR, dated 7/21/2025, the OSR indicated an order for Digoxin Oral tablet 125 mcg (Digoxin). Give one tablet by mouth one time a day for atrial fibrillation. Hold if AP less than (<) 60. During a review of Resident 122's CP Report titled, The resident is on Digoxin/Lanoxin Therapy related to atrial fibrillation, last revised on 8/14/2024, the CP indicated an intervention to administer Digitalis medications as ordered by physician. Monitor for side effects and effectiveness every (q) shift and Digoxin Oral Tablet 125 mcg. Give one tablet by mouth one time a day for atrial fibrillation. Hold if AP < 60. During a concurrent observation and interview on 1/14/2026, at 8:03 a.m., with LVN 4, during (continued on next page)

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MacLay Healthcare Center	12831 MacLay Street Sylmar, CA 91342

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medication Administration Task, observed LVN 4 preparing morning medications in front of Resident 122's room. LVN 4 donned a gown and gloves. LVN 4 obtained a blood pressure (BP) of 115/70 millimeters of mercury (mmHg, a unit of measurement used to measure^pressure). LVN 4 checked the radial pulse (the rhythmic throbbing of an artery that can be felt in the wrist, commonly used to measure heart rate and rhythm) of the resident instead of the apical pulse and registered 71 bpm. LVN 4 administered the Digoxin Oral Tablet 125 mcg (Digoxin) orally to Resident 122. LVN 4 stated he should have taken the apical pulse instead of the radial pulse because there is a difference between the two with regards to accuracy of pulse measured. LVN 4 stated he measured the heart rate (HR) using radial pulse. LVN 4 stated it is a medication error since he did not follow the physician's order. During an interview on 1/14/2026, at 3:39 p.m., with the Minimum Data Set Coordinator (MDSC), the MDSC stated that LVN 4 should have counted the heart rate using a stethoscope (a handheld medical tool used by doctors and nurses to listen to sounds inside the body, primarily the heart, lungs, and intestines) using the apical pulse instead of using radial pulse. The MDSC stated the apical pulse is more accurate than the radial pulse. The MDSC stated there is potential for giving the medication to a HR close to 60 bpm that can further decrease the heart rate. The MDSC stated it is a medication error because LVN 4 did not follow doctor's order to use the apical pulse to determine if Digoxin can be administered to the resident. During an interview on 1/16/2026, at 10:06 a.m., with the DON, the DON stated LVN 4 should have used the apical pulse of Resident 122 for administering Digoxin because it is more accurate than measuring them on the radial pulse. The DON stated measuring heart rate using the radial pulse is less accurate and can miss irregular rhythms of the heart. The DON stated the failure of LVN 4 to measure the HR using the apical pulse can cause potential bradycardia to residents. The DON stated not following the doctor's order to measure AP as parameter to administer Digoxin is a medication error. During a review of the facility's recent P&P titled, Medication Administration, last reviewed on 4/24/2025, the P&P indicated under B. Administration Process: (1) Medications are administered in accordance with the written orders of the attending physicians.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors (means the observed or identified preparation or administration of medications or biologicals which are not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) for two of two sampled residents (Residents 4 and 35) reviewed for insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) use by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (sq, beneath the skin) insulin administration sites. The deficient practice had the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross-reference F658. Findings: 1. During a review of Resident 4's admission Record (AR), the AR indicated the facility admitted the resident on 3/13/2017, and readmitted the resident on 11/17/2025, with diagnoses including type two diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic chronic kidney disease (diabetes has damaged the kidneys' tiny filters over time, making them less able to clean waste and extra fluid from the blood, causing these to build up, and potentially leading to kidney failure if not managed) and mild protein-calorie malnutrition (a condition where a person is not getting enough protein and total calories to meet their body's basic needs, leading to the very early stages of muscle loss or body fat depletion). During a review of Resident 4's History and Physical (H&P), dated 5/8/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 11/12/2025, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severe cognitive impairment (have a very hard time remembering things, making decisions, concentrating, or learning). The MDS indicated the resident was on a high-risk drug class hypoglycemic medication (a group of drugs used to help reduce the amount of sugar present in the blood). During a review of Resident 4's Order Summary Report (OSR), the OSR indicated an order for: 11/17/2025 Insulin Glargine Subcutaneous Solution 100 units per milliliter (unit/ml, theˆconcentrationˆor strength of the insulin) (Insulin Glargine). Inject 15 units subcutaneously at bedtime for type two diabetes mellitus. Rotate Site. 12/11/2025 Novolog Injection Solution 100 unit/ml (Insulin Aspart). Inject as per sliding scale (extra units of insulin to be administered when a person's blood sugar gets high): if 70 - 150 = 0 units. If blood sugar (BS) less than (<)70, give eight (8) ounces (oz, a small unit for measuring weight or volume) of orange juice and call MD; 151 - 200 = two (2) units; 201 - 250 = four (4) units; 251 - 300 = six (6) units; 301 - 350 = eight (8) units; 351 - 400 = 10 units if BS greater than (>) 400, give 12 units and call MD, subcutaneously before meals and at bedtime for type two diabetes mellitus. May rotate injection site. During a review of Resident 4' Location of Administration (LAR) of insulin for 12/2025 until 1/2026, the LAR indicated: - Insulin Glargine Subcutaneous Solution 100 unit/ml was given on: 12/14/2025 at 8:50 p.m. on the Abdomen - Left Lower Quadrant (LLQ) 12/16/2025 at 9:51 p.m. on the Abdomen - LLQ - Novolog Injection Solution 100 unit/ml was given on: 12/2/2025 at 4:35 p.m. on the Abdomen - LLQ 12/3/2025 at 4:26 p.m. on the Abdomen - LLQ 12/4/2025 at 12:25 p.m. on the Arm - left 12/5/2025 at 5:40 a.m. on the Arm - left 12/5/2025 at 5:27 p.m. on the Abdomen - LLQ 12/5/2025 at 9:14 p.m. on the Abdomen - LLQ 12/8/2025 at 8:43 p.m. on the Abdomen - Right Lower Quadrant (RLQ) 12/9/2025 at 12:15 p.m. on the Abdomen - RLQ 12/14/2025 at 8:49 p.m. on the Abdomen - RLQ 12/15/2025 at 12:49 p.m. on the Abdomen - RLQ 12/25/2025 at 4:13 p.m. on the Abdomen - RLQ 12/25/2025 at 8:42 p.m. on the Abdomen - RLQ 12/31/2025 at 5:49 a.m. on the Arm - left 12/31/2025 at 11:53 a.m. on the Arm - left During a review of Resident 4's Care Plan (CP) Report indicating the (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident has diabetes mellitus, last revised on 12/8/2025, the CP indicated an intervention of diabetes medication as ordered by the doctor. Monitor/document for side effects and effectiveness and insulin glargine subcutaneous solution 100 unit/ml (Insulin Glargine). Inject 15 units subcutaneously at bedtime for type two diabetes mellitus, rotate site. During a concurrent interview and record review on 1/14/2026, at 1:43 p.m., with the Minimum Data Set Coordinator (MDSC), reviewed Resident 4's Medical Diagnosis, OSR, LAR, and CP. The MDSC stated there were multiple instances that the licensed nurses did not rotate the insulin administration on Resident 4. The MDSC stated the purpose of rotating insulin administration sites is to prevent discomfort to residents and prevent skin injury to the resident such as lipodystrophy. The MDSC stated if the licensed staff continuously administer the medication on the lipodystrophy sites of the resident, the medication will not be absorbed properly and can cause hyper/hypoglycemia to residents. The MDSC stated not rotating insulin administration site is a medication error. During an interview on 1/16/2026, at 10:06 a.m., with the Director of Nursing (DON), the DON stated the licensed staff should have rotated the sites of insulin administration to Resident 4, unless it is the resident's preference. The DON stated they rotate insulin administration sites to prevent injury to the skin such as lipodystrophy. The DON stated insulin will not be absorbed properly if injected at the sites of lipodystrophy that can cause hypo or hyperglycemia to residents. The DON stated that as professional nurses we are to rotate insulin administration sites, follow physician's orders, and follow manufacturer's specifications to safely administer insulin. The DON stated that not rotating insulin administration site is a medication error. During a review of the facility's recent policy and procedure (P&P) titled, Medication Error Reporting and Management, last reviewed on 4/24/2025, the P&P indicated the facility is committed to safe medication administration. Any medication errors, including omissions, incorrect doses, or wrong routes, must be reported, evaluated, and documented to protect resident safety and prevent recurrence. Purpose To: - Ensure resident safety and well-being - Promote a culture of accountability and continuous improvement - Comply with CMS, state regulations, and facility standards Procedure 1. Definition of Medication Error A medication error includes: - Wrong resident - Wrong drug dose, route, or time - Missed or omitted medication - Improper storage or preparation - Administration without a valid order During a review of the facility's recent P&P titled, Insulin Administration, last reviewed on4/24/2025, the P&P indicated the facility ensures that insulin is administered safely, accurately, and timely in accordance with physician orders, facility protocols, and accepted standards of nursing practice. Insulin is classified as a high-alert medication and requires strict adherence to medication administration procedures to prevent adverse events. POLICY GUIDELINES 1. Physician Orders All insulin administration requires a current physician or authorized practitioner order. 4.Insulin Administration Injection sites must be rotated to prevent tissue damage. During a review of the facility-provided Highlights of Prescribing Information (HPI) on the use of Lantus (insulin glargine injection) for subcutaneous injection, with initial U.S. approval in 2000, the HPI indicated to rotate injection sites to reduce the risk of lipodystrophy. 2. During a review of Resident 35's AR, the AR indicated the facility admitted the resident on 7/13/2010, and readmitted the resident on 12/23/2023, with diagnoses including type 2 diabetes mellitus with chronic kidney disease (a long-term condition where the kidneys do not work as well as they should), retinopathy (an eye disease often caused by diabetes), and neuropathy (when nerve damage leads to pain, weakness, numbness or tingling in one or more parts of your body). During a review of Resident 35's H&P, dated 11/1/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 35's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). The MDS indicated the resident was on a high-risk drug class hypoglycemic medication. The MDSC stated not rotating insulin administration site is a medication error. During a review of Resident 35's OSR, the OSR indicated an order for: - 12/11/2025 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Humulin R Injection Solution 100 unit/ml (Insulin Regular (Human)). Inject as per sliding scale: if 0 - 80 If conscious, give 4 oz of juice. If unconscious, give glucagon (a hormone that your pancreas makes to help regulate your blood glucose (sugar) levels) one milligram (mg, a unit of weight) intramuscular (IM, a shot of medicine given into a muscle) x 1. Notify MD; 81 - 199 = 0 No coverage; 200 - 250 = two (2) units; 251 - 300 = four (4) units; 301 - 350 = six (6) units; 351 - 400 = eight (8) units; 401+ = 10 units Notify MD, subcutaneously before meals and at bedtime for DM. May Rotate Injection Site. - 12/12/2025 Insulin NPH Isophane & Regular Suspension (70-30) 100 unit/ml. Inject 12 unit subcutaneously two times a day for DM. May rotate injection site. During a review of Resident 35's LAR of insulin for 12/2025 until 1/2026, the LAR indicated: - Insulin NPH Isophane & Regular Suspension (70-30) 100 unit/ml was given on: 12/8/2025 at 8:16 a.m. on the Abdomen - RLQ 12/9/2025 at 9:18 a.m. on the Abdomen - RLQ 12/14/2025 at 8:22 a.m. on the Deltoid - right 12/15/2025 at 8:19 a.m. on the Deltoid - right - Humulin R Injection Solution 100 unit/ml was given on: 12/5/2025 at 11:50 a.m. on the Abdomen - Left Upper Quadrant (LUQ)^ 12/6/2025 at 12:25 p.m. on the Abdomen - LUQ 12/9/2025 at 12:04 p.m. on the Abdomen - LLQ 12/15/2025 at 11:33 a.m. on the Abdomen - LLQ 12/24/2025 at 12:01 p.m. on the Abdomen - LLQ 12/25/2025 at 11:39 a.m. on the Abdomen - LLQ During a review of Resident 35's CP Report titled, The resident has diabetes mellitus, last revised on 12/8/2025, the CP indicated an intervention to administer medication as ordered by the physician. Monitor for side effects and effectiveness and inject as per sliding scale: if 0 - 80 If conscious, give 4 oz of juice. If unconscious, give glucagon 1mg IM x 1. Notify MD; 81 - 199 = 0 No coverage; 200 - 250 = two (2) units; 251 - 300 = four (4) units; 301 - 350 = six (6) units; 351 - 400 = eight (8) units; 401+ = 10 units Notify MD, subcutaneously before meals and at bedtime for DM. Rotate Site. During a concurrent interview and record review on 1/14/2026, at 1:43 p.m., with the MDSC, reviewed Resident 35's Medical Diagnosis, OSR, LAR, and CP. The MDSC stated there were multiple instances that the licensed nurses did not rotate the insulin administration on Resident 35. The MDSC stated the purpose of rotating insulin administration sites is to prevent discomfort to residents and prevent skin injury to the resident such as lipodystrophy. The MDSC stated if the licensed staff continuously administer the medication on the lipodystrophy sites of the resident, the medication will not be absorbed properly and can cause hyper/hypoglycemia to residents. During an interview on 1/16/2026, at 10:06 a.m., with the DON, the DON stated the licensed staff should have rotated the sites of insulin administration to Resident 35, unless it is the resident's preference. The DON stated they rotate insulin administration sites to prevent injury to the skin such as lipodystrophy. The DON stated insulin will not be absorbed properly if injected at the sites of lipodystrophy that can cause hypo or hyperglycemia to residents. The DON stated that as professional nurses we are to rotate insulin administration sites, follow physician's orders, and follow manufacturer's specifications to safely administer insulin. The DON stated that not rotating insulin administration site is a medication error. During a review of the facility's recent P&P titled, Medication Error Reporting and Management, last reviewed on 4/24/2025, the P&P indicated the facility is committed to safe medication administration. Any medication errors, including omissions, incorrect doses, or wrong routes, must be reported, evaluated, and documented to protect resident safety and prevent recurrence. Purpose To: - Ensure resident safety and well-being - Promote a culture of accountability and continuous improvement - Comply with CMS, state regulations, and facility standards Procedure 1. Definition of Medication Error A medication error includes: - Wrong resident - Wrong drug dose, route, or time - Missed or omitted medication - Improper storage or preparation - Administration without a valid order During a review of the facility's recent P&P titled, Insulin Administration, last reviewed on4/24/2025, the P&P indicated the facility ensures that insulin is administered safely, accurately, and timely in accordance with physician orders, facility protocols, and accepted standards of nursing practice. Insulin is classified as a high-alert medication and requires strict adherence to medication administration procedures to prevent adverse events. POLICY GUIDELINES 1. Physician Orders All insulin administration requires a current physician or authorized practitioner order. 4.Insulin (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administration Injection sites must be rotated to prevent tissue damage. During a review of the facility-provided HPI on the use of Humulin R (insulin human) injection, for subcutaneous or intravenous use, with initial U.S. approval in 1982, the HPI indicated subcutaneous injection: inject subcutaneously 30 minutes before a meal into the thigh, upper arm, abdomen, or buttocks. Rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis. During a review of the facility-provided Patient Information (PI) for Novolin N, the PI indicated skin thickens or pits at the injection site (lipodystrophy). Change (rotate) where you inject your insulin to help prevent these skin changes from happening. DO not inject insulin onto this type of skin.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, interview, and record review, the facility failed to operate and execute overall safe and sanitary food and nutrition services operations when:1. The puree (pudding like consistency) pancake did not fall off the spoon during the spoon tilt test (a method used to determine the stickiness of the food and ability of the food to hold together) conducted by [NAME] 1 during breakfast service and there was no supervision available during the food preparation.2. Puree cranberry yogurt mousse did not fall off the spoon tilt test and was too thick during lunch service.These deficient practices had potential to cause the residents to not be able to eat their food and/or choke (when food gets stuck in your airway, blocking the flow of the air to your lungs) on the food to 11 of 11 residents on puree diet. 3. One (1) dented can was stored with non-dented cans 4. Storage racks have no physical barrier from the floor to prevent spills during mopping.5. The pitchers had sticker residues. 6. Pans were stored stacked wet.7. [NAME] dirt debris were on the clean pans. These deficient practices had potential to result in harmful bacterial growth and cross-contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 130 of 132 medically compromised residents who received food and ice from the kitchen.8. Dietary staff threw diet tickets (specialized labels that outline the specific diet order, food preferences, and nutritional requirements for a resident, typically lists the resident's name, room number, diet order, and allergies) on the trash can during dishwashing.This deficient practice had potential to violate 130 of 132 residents' rights for privacy and confidentiality of personal and medical records.9. [NAME] was hard and overcooked and French fries pieces were burnt.10. Hot foods were not served hot for lunch service.These deficient practices had potential to result in decrease in food intake to 130 to 132 residents on regular and therapeutic diets, resulting in unplanned weight loss.Findings: 1. During a review of the facility's menu spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled Winter 2026, dated 2/27/2026, the spreadsheet indicated residents on International Dysphagia Diet Initiative (IDDSI - a framework made up of levels and describe food textures and drink thickness)/ level four (4) puree diet would include the following food in the tray for breakfast: Cranberry juice 4 ounces (oz - a unit of measurement) Puree oatmeal 4 oz Puree ham slice 1/3 cup (c - a household measurement) Puree pancake 1/2 c Milk 8 oz Coffee 8 oz Syrup 1 oz Margarine 1 eachDuring an observation on 2/27/2026 at 7:01 a.m. of [NAME] 1's food preparation, observed [NAME] 1 added liquid to puree ham and got a fork and tilted the fork. Observed [NAME] 1 get a plastic spoon, flick the spoon using force and the puree ham fell off the spoon.During an observation on 2/27/2026 at 7:13 a.m. of [NAME] 1 preparing the puree pancake, observed [NAME] 1 mixing the puree pancake using a whisk (a kitchen utensils for mixing foods) and perform a spoon tilt test using a fork and the puree pancake did not fall off the spoon. Observed [NAME] 1 perform a spoon tilt test using a plastic spoon and there was a thick film of food left on the spoon. Observed [NAME] 1 add water to the puree pancakes and use a fork to test if there was some food falling off. Observed [NAME] 1 did not perform spoon tilt test after adding water to the puree pancake. During a concurrent observation and interview on 2/27/2026 at 7:18 a.m. of the puree pancake with [NAME] 1, [NAME] 1 stated she added hot water to the puree pancake because it was too thick. [NAME] 1 stated she used a fork to check the consistency of the food then used the spoon. [NAME] 1 performed a spoon tilt test and there was a thick film of food left on the spoon. [NAME] 1 stated puree pancake was sticky.During an observation on 2/27/2026 at 7:32 a.m. in the kitchen, observed the Dietary Supervisor (DS) walk in the kitchen.During an observation on 2/27/2026 at 7:36 a.m. in the kitchen, observed the Assistant Dietary Supervisor (ADS) walk in the kitchen and started checking trays. During an observation on 2/27/2026 at 7:38 a.m. of [NAME] 1 in trayline (an area where foods were assembled from the steamtable to resident's plate), observed [NAME] 1 add hot (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	water to the puree ham.During a concurrent test tray (a process of tasting, temping, and evaluating food quality) observation and interview of puree breakfast tray on 2/27/2026 at 7:40 a.m., observed the DS perform a spoon tilt test for puree pancake using the force of his (DS) hand. Observed puree pancake fall off the spoon but left a thick film on the spoon. The DS stated the texture was okay because it was smooth, however, a thick film of food was left on the spoon after the spoon tilt test. The DS stated the puree pancake, puree ham, and puree oatmeal left more film of food on the spoon, so the food products were still sticky. The DS stated the puree food might get stuck in the residents' mouth because the food was sticky and would take residents time to swallow as a potential outcome. The DS stated the residents on IDDSI diet would not be met as IDDSI diet are for residents with dysphagia (difficulty swallowing). The DS stated they performed spoon tilt test and fork drip test to meet the right texture and consistency of the puree foods. The DS stated sticky food might cause pain and irritation, and food getting stuck on the residents' throat with a potential for choking as a potential outcome. During an interview on 2/27/2026 at 8:02 a.m. with the DS, the DS stated adding hot water to puree food was okay until the correct consistency of food was met. The DS stated the recipe indicated that adding water or thickener could change nutrition content but its per facility discretion. The DS stated staff are supposed to check the puree food consistency every 15 minutes.During an interview on 2/27/2026 at 8:11 a.m. with the DS, the DS stated the updated diet roster for IDDSI residents was from yesterday (2/26/2026) because he just came in and forgot to get the list in the office.During an interview on 2/27/2026 at 8:19 a.m. with the DS, the DS stated the puree diet list was not anywhere in the kitchen (not in preparation area, trayline or by the kitchen entrance) and it was not in the folder.During an interview on 2/27/2026 at 8:40 a.m. with the ADS, ADS stated he did not check the breakfast puree food for spoon tilt test.During an interview on 2/27/2026 at 9:48 a.m. with [NAME] 1, [NAME] 1 stated she prepared the puree foods and followed the recipe for puree pancakes. [NAME] 1 stated she did not know the exact measurement of food, but she used five (5) portions of pancake to 4 quarts of water and placed it in the blender. [NAME] 1 stated she used the spoon tilt test and food should fall little by little. [NAME] 1 stated she did not know why the puree pancake was sticky, but she thinks it was because of the amount of ingredients in the recipe. [NAME] 1 stated the puree pancake passed the spoon tilt test, but it was a little sticky. [NAME] 1 stated she added water throughout trayline but did not check the consistency of the puree food before the start of trayline. [NAME] 1 stated puree diet is for residents that could not eat whole foods because they have dentures, something is wrong with their throat and could not swallow. The DS stated residents could choke if the food is not in the right texture, consistency and if it was sticky.During a review of the facility's policies and procedures (P&P) titled Standardized Recipes, dated 4/24/2025, the P&P indicated, Policy: A standardized recipe adjusted to appropriate yield is available for each menu item and is used in the preparation of each.During a review of the facility's P&P titled Resident Menu Policy, dated 4/24/2025, the P&P indicated, Purpose: To ensure all residents receive adequate nutrition and hydration through safe, accurate, and therapeutic meal services in accordance with physician orders, care plans, and applicable regulations. Scope: This policy applies to all residents.including those requiring modified diets or therapeutic nutrition interventions. (4) Comply with IDDSI standards for modify texture.During a review of the facility's P&P titled IDDSI Level 4 Diet (Pureed) Policy and Diet Manual, dated 4/24/2025, the P&P indicated, Provides diet that meet residents' swallowing and texture modification needs. All residents prescribed IDDSI Level 4- Pureed diet shall receive foods that are smooth and cohesive to ensure safe swallowing nutrition, and compliance with IDDSI standards. All pureed food must be smooth, uniform, and free of lumps. Hold shape on spoon (passes spoon tilt test).During a review of the facility's standardized recipe titled, Breakfast Ham slice, dated 2026, the recipe indicated, Puree: place portions needed into a food processor, process to a fine texture for every 5 portions, prepare a slurry with 2 1/2 tbsp thickener and 1/2 c hot liquid (water or apple juice). Mix well with a wire whip, Add 1/2 of the slurry to the meat. Process for 1 minute. If it is too dry, add more slurry until meat is (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pudding consistency. With a rubber spatula, scrape down sides of the bowl. Process 30 seconds, reheat to 165 F. All IDDSI texture modifications need to pass their established testing methods at the start and every 15 minutes for the duration of service.During a review of the facility's standardized recipe titled, Puree Pancake (Mix), dated 2026, the recipe indicated, Finished product should pass both the 1) Spoon Tilt test and the 2) Fork Drip test.All IDDSI texture modifications need to pass their established testing methods at the start of every 15 minutes for duration of the service.2. During a review of the facility's menu spreadsheet titled, Winter 2026, dated 2/27/2026, the spreadsheet indicated residents on International Dysphagia Diet Initiative level 4 puree diet would include the following food in the tray for lunch: Puree fish with sauce 1/2 c Mashed potatoes 1/2 c Puree cooked broccoli 1/3 c Puree bread with margarine 1 each Cranberry yogurt mousse 1/2 c Beverage 8 oz During a concurrent test tray observation and interview on 2/27/2026 at 1:00 p.m. of the puree diet with the DS, the DS performed spoon tilt test on the cranberry yogurt mousse, and it did not fall off the spoon even with agitation and strong force. The DS stated the mousse was too thick and residents might choke due to the food getting stuck in their throat. The DS [NAME] 1 prepared the dessert (mousse), checked the consistency and texture of it and the staff plated it.During an interview on 2/27/2026 at 3:12 p.m. with the Registered Dietitian (RD), the RD stated he did not observe and test the cold food texture and consistency for puree cold food including cranberry yogurt mousse, and the DS was supposed to check it. The RD stated the ADS was supposed to check the consistency and texture of the food if the DS was not around. The RD stated if the food did not fall off the spoon during the spoon tilt test, it would be sticky. The RD stated if the food was sticky, it could be stuck in the residents' throat causing them to choke as a potential outcome. During a review of the facility's standardized recipe titled, Cranberry Yogurt Mousse, dated 2026, the recipe indicated, This recipe is suitable for all diet textures. All IDDSI texture modifications need to pass their established testing methods at the start and every 15 minutes for the duration of service.During a review of the IDDSI guideline website titled IDDSI, dated 7/2019, the IDDSI guideline indicated, Level 4 Pureed is usually eaten with spoon, falls off spoon in a single spoonful when tilted and continues to hold it shape on the plate, no lumps, not sticky, and liquid must not separate from solid. Food testing method: Spoon tilt test and Fork drip test.3. During a concurrent observation and interview on 2/27/2026 at 11:00 a.m., of the dry storage room with the DS, observed 1 dented can stored with non-dented cans. The DS stated dented cans should be separated from non-dented cans to prevent residents from consuming them as it could cause foodborne illnesses. During a review of the facility's P&P titled, Proper Disposal of Dented Cans Policy, dated 4/24/2025, the P&P indicated, to prevent the use of the canned goods that may place residents at risk for foodborne illness.The facility will not sure any canned food that is dented, leaking, bulging, rusted or otherwise compromised. Dietary staff will inspect canned food upon delivery and during storage checks. Any can that appears damaged or unsafe will be removed from food service areas and discarded.During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-101.11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under 3-601.12, honestly presented. 3-201.11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of S3-101.11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fail victim to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard.4. During a concurrent observation and interview on 2/27/2026 at 11:05 a.m., of the drying rack, with the DS, observed the drying rack with no physical barrier from the floor. The DS stated there would be (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cross-contamination from the water spill from the mop going to the clean pots. The DS stated foodborne illness would be a potential outcome of cross-contamination of equipment to food.During a review of the facility's P&P titled, Cross Contamination Prevention Policy, dated 4/24/2025, the P&P indicated To prevent cross-contamination during food storage, preparation, cooking, and service to protect residents and staff from foodborne illness. The dietary manager or designee will conduct routine kitchen checks and address concerns immediately. Any unsafe practice will be corrected, and staff will be re-educated as needed.During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-307.11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under subparts 3-391 - 3-306.5. During a concurrent observation and interview on 2/27/2026 at 11:08 a.m., of the pitchers, with the DS, observed sticker residues on the pitchers. The DS stated the pitchers should be free from sticker residue to prevent cross-contamination.During a review of the facility's P&P titled Cross-Contamination Prevention Policy, dated 4/24/2026, the P&P indicated, (3) Utensils and Equipment. Knives, cutting boards and utensils must not be shared between raw and ready-to-eat foods unless washed, rinsed, and sanitized first. Equipment and slices, prep tables and blenders must be cleaned and sanitized in between uses and anytime food types are changed.During a review of the facility's P&P titled Ware Washing, dated 4/24/2025, the P&P indicated, Utensils, dishes, beverage containers, pots and pans, flatware used for the preparation, service, or storage of food will be cleaned and sanitized after each use. (2) Dishes will be stacked and rinse free of large loose food particles. Dirt shall be loosened by scrubbing the surface of the dishware with a brush or abrasive pad and rinsing.6. During a concurrent observation and interview on 2/27/2026 at 11:09 a.m., of the pans in the storage area, with the DS, observed pans stacked wet.During a concurrent observation and interview on 2/27/2026 at 11:15 a.m., of the pots and pans areas with the DS, the DS stated the pans were not air dried. The DS stated the pans should be air dried and not stacked wet to prevent bacterial growth and cross-contamination of food.During review of the facility's P&P titled, Ware Washing, dated 4/24/2025, the P&P indicated, (7) allow clean dishes to air dry completely before storing.During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-901.11 Equipment and Utensils, air-drying required. After cleaning and sanitizing equipment and utensils: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food and; (B) May not be cloth dried except that utensils that have been air-dried may be polished with cloths that are maintained clean and dry.7. During a concurrent observation and interview on 2/27/2026 at 11:10 a.m., of the pans, with the DS, observed white dirt debris in the pans. The DS stated pans should be dirt and debris free to prevent cross-contamination equipment and food.During an interview on 2/27/2026 at 3:17 p.m. with the RD, the RD stated he found something with regards to sanitation in the kitchen, but he needed to go back to his (RD) report for issues. The RD stated the kitchen should be clean and there were sanitation issues, it could spread infection, attract unwanted pests, microbes and bacteria to the residents. During a review of the facility's P&P titled, Equipment and Kitchen Utensil Cleanliness Policy, dated 4/24/2025, the P&P indicated , To ensure all kitchen equipment and utensils are clean, sanitary, and safe food preparation and service.The facility will clean and sanitize all kitchen equipment and utensils routinely after use, and between food preparation tasks to prevent contamination and maintain safety operations. During a review of Food Code 2022, the Food Code 2022 indicated, 4-602.12 Cooking and Baking Equipment. (A) The food contact surfaces of cooking and baking equipment shall be cleaned at least every 24 hours. This section does not apply to hot oil cooking and filtering equipment if it is cleaned as specified subparagraph 4-602.11 (D)(6).8. During a concurrent observation and interview on 2/27/2026 at 11:11 a.m., of the trash by the dishwashing area, with the DS, observed diet tickets in the trash. The DS stated diet tickets should not be in the trash due to Health Insurance Portability and Accountability Act (HIPPA - a law that sets national (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	standard to protect sensitive information, making it private and secure) violation.During an interview on 2/27/2026 at 3:16 p.m., with the RD, the RD stated the shredder is used for confidential documents including the meal tickets to protect the residents' identity. The RD stated if the meal tickets were not shredded before throwing, anyone could use residents' information as a potential outcome. During a review of the facility's P&P titled, Resident Privacy and Confidentiality Policy, dated 4/24/2025, the P&P indicated Our facility will safeguard the confidentiality of all resident personal and medical records. Access to these records is limited to authorized staff members and approved business associates.9. During a concurrent observation and interview on 2/27/2026 at 12:35 p.m., of the rice, with the Registered Dietitian (RD) and Dietary Aide 3, the rice observed was overcooked and with burnt brown discoloration on the side. The RD stated the rice should not be overcooked and asked the staff to remove the top portion of the rice. DA 3 stated the rice stayed in the oven too long so he removed the top part and the side of the rice which was burnt before serving. During an observation on 2/27/2026 at 12:49 p.m., of the French fries on the steamtable, observed French fries pieces were burnt. During a concurrent observation and interview on 2/27/2026 at 12:51 p.m. of the French fries with the DS, the DS stated some fries are burnt and it should not be burnt as it would be hard to eat for the residents who had problems with chewing. The DS stated residents would not eat the fries, would lose their appetite and would cause weight loss as a potential outcome of burnt and overcooked food.During an interview on 2/27/2026 at 3:21 p.m. with the RD, the RD stated burnt rice, and French fries affect palatability and would not nourish the residents as they would not eat it. The RD stated if residents would not eat the food, it will not meet their calorie needs, contributing to weight loss as a potential outcome. The RD stated burnt food would cause dissatisfaction to the residents. During a review of the facility's P&P titled, Standardized Recipe Development and Compliance Policy, dated 4/24/2026, the P&P indicated, To ensure consistent quality, nutrition, and portion accuracy for all meals served to residents. The facility will maintain standardized recipes for menu items to ensure meals are prepared consistently and in accordance with dietary requirements. Standardized recipes must include ingredients, measurements, preparation steps, cooking instructions, portion size, and yield. Dietary staff must follow recipes as written and may not substitute ingredients or adjust portions without approval of the Dietary Manager or Registered Dietitian as applicable. 10. During a review of the facility's menu spreadsheet titled, Winter 2026, dated 2/27/2026, the spreadsheet indicated residents on regular diet (diet with no restriction) would include the following food in the tray: Crunchy fish 1 each Oven curly fries 3 oz Broccoli salad 1/2 c Roll/Margarine 1 each Cranberry yogurt mousse 1/2 c Beverage 8 ozDuring a concurrent test tray observation and interview on 2/27/2026 at 1:29 p.m. with the DS, observed the DS took the temperatures using the facility thermometer and the foods had the following temperatures: Crunchy fist 120 F Oven curly fries 100 FThe DS stated the food was not palatable because the temperatures for the hot foods were not in a palatable temperature and it was not hot enough. The DS stated the residents might not eat the food because it was not what they expected. The DS stated a low food intake would lead to weight loss as a potential outcome. During an interview on 2/27/2026 at 3:21 p.m. with the RD, the RD stated the last cart dropped food temperatures and could cause dissatisfaction for the residents.During a review of the facility's P&P titled, Menu and Palatability, dated 4/24/2025, the P&P indicated, The facility provides meals that are palatable, flavorful, attractive, and served at appropriate temperatures to support adequate intake and resident satisfaction. Menus are planned to include variety in flavor, color and texture. Procedure:1. Foods are seasoned appropriately within diet restrictions. 2. Meals are presented neatly and in a manner that supports appetite and dignity. 3. Hot foods are served hot and cold foods are served cold. 4. Meal quality is monitored through meal rounds, taste testing, and resident feedback.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow the menu and did not meet nutritional needs when: 1. [NAME] 1 did not follow the recipe for green beans. 2. Residents on regular diet and therapeutic diet, including large portion diet (adding additional food to increase protein and calories) were not served three (3) ounces (oz - a unit of measurement) of pork. The menu did not clearly indicate portion size for pork and mushroom sauce. 3. Resident meal trays were not accurate:3.1 Resident 39 did not get puree oatmeal on resident's tray on 1/13/2026 3.2 Resident 46 did not have a bowl of puree oatmeal on the resident's tray on 1/13/2026. 3.3 Resident 66 did not have a cup of coffee on the resident's breakfast tray on 1/13/2026. 3.4 Resident 96 did not have margarine and jelly on the resident's breakfast tray on 1/16/20206. These failures had the potential to result in decreased food flavor, decreased food and nutrient intake for 125 of 127 residents on regular and therapeutic diets, resulting in unplanned weight loss. Findings: 1. During a review of Resident 135's admission Record (AR), the AR indicated the facility admitted Resident 135 on 1/9/2026 with diagnosis of type 2 diabetes (DM 2ˆ-ˆa disorder characterized by difficulty in blood sugar control and poor wound healing), acute kidney failure (condition in which the kidneys suddenly cannot filter waste from the blood), and pressure ulcer of sacral stage 4 (injuries to skin and underlying tissue resulting from prolonged pressure on the skin). During a review of Resident 135's Minimum Data Sheet (MDS - a resident assessment tool), dated 1/15/2026, the MDS indicated Resident 135 understood others and made self-understood. During a review of Resident 135's Order Listing Report, dated 1/13/2026, the order listing indicated Resident 135 was ordered consistent carbohydrate (CCHO - diet with the same amount of carbohydrate per meal for blood sugar management), regular, think liquid consistency (no restrictions), large portions (adding extra food to increase protein and calories per day) diet. During a review of Resident Council minutes, dated 1/6/2026, the resident council minutes indicated Resident 135 has issues with small food portion sizes and bland (lacks flavor) food. During a review of the facility's menu spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled, Fall 2025, dated 1/12/2025, the spreadsheet indicated residents on regular and therapeutic diets would include the following foods on the tray: - Pork/mushroom sauce 4 oz - Herbed rice 1/2 cup (c - a household measurement) - Mixed vegetables 1/2 c (substituted with green beans) - Roll and margarine 1 each - Peach pie 1 slice - Beverage 8 oz During an interview on 1/12/2026 at 11:33 a.m. with [NAME] 2, [NAME] 2 stated there was a substitute for mixed vegetables to green beans. [NAME] 2 stated there was no recipe for green beans, but she used the mixed vegetable recipes in preparation of green beans. During a concurrent test tray (a process of tasting, temping, and evaluating the quality of food) and interview on 1/12/2026 at 1:31 p.m. of the regular diet tray with the Dietary Supervisor (DS) and [NAME] 2, DS stated the green beans were bland in taste. [NAME] 2 stated she did not have the recipe for green beans but followed the recipe for mixed vegetables and just added butter and pepper to the green beans. The DS stated the recipe for green beans indicated green beans, salt, pepper and margarine. The DS stated it was important to follow the recipe as the taste of the food could be affected if the recipe is not followed. The DS stated the residents would most likely not eat the food. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policies and procedures (P&P) titled, Standardized Recipe Development and Compliance Policy, dated 4/24/2026, the P&P indicated, To ensure consistent quality, nutrition, and portion accuracy for all meals served to residents. The facility will maintain standardized recipes for menu items to ensure meals are prepared consistently and in accordance with dietary requirements. Standardized recipes must include ingredients, measurements, preparation steps, cooking instructions, portion size, and yield. Dietary staff must follow recipes as written and may not substitute ingredients or adjust portions without approval of the Dietary Manager or Registered Dietitian as applicable. During a review of the facility's standardized recipe titled, Green Beans, dated 4/24/2025, the recipe indicated ingredients: green beans, salt, black pepper, margarine. Method: place vegetables in steam table pans with small amounts of water. Steam 10-15 minutes PSI or 5-7 minutes. Pressure less drain. Add salt and margarine to the cooked vegetables. 2. During a review of Resident 113's AR, the AR indicated the facility admitted Resident 113 on 9/8/2020 with diagnoses including essential hypertension (high blood pressure), chronic diastolic congestive heart failure (a progressive heart disease that affects pumping action of the heart muscles), and anemia (a condition in which the body does not get enough oxygen -rich blood). During a review of Resident 113's Minimum Data Sheet, dated 12/11/2025, the MDS indicated Resident 113 understood others and was self-understood. The MDS indicated Resident 113 needed setup and cleanup assistance (helper sets up and clean up; resident completes activity. Helper assists only prior to or following activity) when eating. During a review of Resident 113's Order Listing Report, dated 11/19/2025, the order listing indicated Resident 113 was ordered no added salt diet (NAS - no added salt packet on the tray), regular, thin liquid diet. During an interview on 1/12/2026 at 10:54 a.m. with Resident 113, Resident 113 stated the portion sizes for food were not enough. During an observation on 1/12/2026 at 12:21 p.m. of the trayline lunch service, observed there was only one pan of pork and the portion sizes varied. During a concurrent observation and interview with [NAME] 2 on 1/12/2026 at 12:36 p.m. of the pork slices portion sizes with [NAME] 2, [NAME] 2 stated the portion size of the pork slices were 4 oz and she weighed them. [NAME] 2 weighed three (3) random pork slices using the facility food weighing scale and observed the following readings: - 1st pork slice: 2.69 oz - 2nd pork slice: 3.26 oz - 3rd pork slice: 3.22 oz During an interview on 1/12/2026 at 12:38 p.m. with the DS, the DS stated the difference between the regular diet and large portion diet was the large portion would receive 1 oz more of pork for a total of 5 oz. The DS stated the large portion diets are for residents who need extra calories and protein to promote weight gain. During an interview on 1/12/2026 at 12:44 p.m. with the DS, the DS stated the portion size for pork is 3 oz and 1 oz of mushroom sauce for regular diet. The DS stated if residents got 2.69 oz of pork, the residents would get less calories and protein and would not meet their needs. The DS stated the residents would still be hungry and could lose weight as a potential outcome. The DS stated residents (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	who received more than 3 oz could potentially gain weight. During an interview on 1/12/2026 at 12:53 p.m. with the Registered Dietitian (RD), the RD stated there was confusion on the spreadsheet and it did not indicate that mushroom sauce is 1 oz and 3 oz for the pork however, the recipe indicated the correct portion sizes. The RD stated it was important to follow the menu and portion sizes to ensure residents meet their needs. During a review of the facility's diet manual titled, Large Portion Diet, dated 4/24/2025, the diet manual indicated A large portion diet may be offered to residents requiring calorie intake exceeding the level offered by the regular diet. The diet increases the daily servings of the following: Meat, fish, poultry, cheese and egg- 5-6 oz for regular portions and 8-9 oz for large portion of daily servings. During a review of the facility's P&P titled, Menu Spreadsheet Control Policy, dated 4/24/2025, the P&P indicated To maintain consistent meal service by controlling menu planning and menu spreadsheet updates. The facility will maintain an approved menu schedule, and changes to the menu spreadsheet will be controlled and documented to ensure meals served match planned meals. During a review of the facility's P&P titled, Portion Size and Portion Control Policy, dated 4/24/2025, the P&P indicated To ensure residents receive consistent meal portions that meet nutritional needs and physician diet orders. The facility will serve meals using standardized portion sizes to ensure accuracy, consistency, and compliance with nutrition requirements. Staff must follow tray cars for any resident specific adjustments, including large portion meals, supplements, or restrictions. If portion concerns are identified, they will be corrected immediately, and staff will be re-educated as needed. The dietary manager or designee will complete routine meal tray observations and portion accuracy checks. 3.1 During a review of Residentˆ39's AR, the AR indicated the facility originally admitted Residentˆ39 onˆ7/21/2015 and readmitted in the facility on 6/2/2018ˆwith diagnoses includingˆdementia (a progressive state of decline in mental abilities),ˆdiabetesˆmellitus,ˆandˆmuscle wastingˆand atrophyˆ(weakening, shrinking, and loss of muscle).ˆ During a review of Residentˆ39's History and Physical (H&P) datedˆ5/4/2025, the H&PˆindicatedˆResidentˆ39 hadˆthe capacity to understand and make decisions.ˆ During a review of Residentˆ39's MDS, dated [DATE], the MDS indicated Residentˆ39 was able to understand others and make her needs knownˆbutˆhadˆseverelyˆimpaired cognitionˆ(having the ability to think, learn, and remember clearly). The MDS furtherˆindicatedˆResidentˆ39ˆrequiredˆsubstantial/maximalˆassistanceˆwith eating.ˆ During a review of Residentˆ39's Order Summary Report (OSR),ˆdatedˆ1/16/2026, the OSR indicated a physician's order datedˆ7/29/2025ˆforˆconsistent carbohydrate/no added saltˆ(CCHO/NAS diet) pureedˆlevel 4ˆtexture (food that hasˆbeenˆblended or mashed into a thick, smooth, moist paste withˆnoˆlumps)ˆthin level zero (0) consistencyˆ(liquids that flow like water).ˆ During a review of Residentˆ39 care plan (CP)ˆon nutritional problem or potential nutritional problem,ˆinitiatedˆonˆ9/26/2019 and last revised on 1/14/2026, the CPˆindicatedˆthe resident is at risk for weight changes and aspiration with interventionsˆto provide and serve diet as orderedˆandˆmonitorˆand record every meal.ˆˆ (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's menu spreadsheet titled Fall 2025, dated 1/13/2026, the spreadsheet indicated residents on puree diet in accordance with IDDSI Level 4 would include the following in the meal tray: - Apple juice 4 oz - Puree oatmeal 4 oz - Puree sausage patty 1/3 c - Puree pancakes 1/2 c - Milk 2% 8 oz - Coffee 8 oz - Margarine 1 each - Syrup 1 oz. During aˆconcurrent observation and interview onˆ1/13/2026 at 8:15 a.m. inside Resident 39's roomˆwith Certified Nursing Assistant (CNA)ˆ7,ˆResident 39's breakfast tray ticketˆand content of the breakfast trayˆwas reviewed with CNA 7. CNA 7 stated Resident 39's breakfast tray ticketˆindicatedˆ4 oz of pureed oatmeal, number 12 scoop for pureed sausage patty, eight (8) oz of water, 1 margarine, and 1 diet syrup. CNA 7 statedˆResident 39 only received light brown colored pureedˆfood andˆstatedˆit is the pureed sausage patty, iced water, 1 margarine, and 1 diet syrup. CNA 7 stated Resident 39 did notˆreceiveˆthe pureed oatmeal. CNA 7ˆstatedˆif a resident's meal tray is not complete, she will go to the kitchen andˆtell them what is missing from the tray. CNA 7 stated Resident 39's breakfast tray should have been completeˆwhen served to the resident.ˆ Duringˆa concurrentˆinterviewˆand record review on 1/16/2026ˆatˆ4:20ˆp.m., Resident 39's physician's order,ˆphotographsˆof breakfast meal ticket for 1/13/2026ˆand food items served in the breakfast meal trayˆwere reviewedˆwith theˆDirector of Nursing (DON). TheˆDONˆstatedˆResident 39 had a physician's order for CCHO/NAS diet pureed level 4 thin level 0ˆand that the photographsˆindicatedˆResident 39 shouldˆreceive 4ˆoz of pureed oatmeal, number 12 scoop for pureed sausage patty, 8 oz of water, 1 margarine, and 1 diet syrupˆbut theˆbreakfastˆtray was missing the pureedˆoatmeal.ˆThe DONˆstatedˆthat final check of theˆmealˆtrays beforeˆsending themˆto each stationˆis done by two (2) Licensed Nurses (LNs)ˆto ensure the trays areˆaccurateˆand include all the itemsˆindicatedˆin each meal ticket. The DONˆstatedˆtheˆkitchenˆstaff and LNsˆshould have ensuredˆthe trayˆcontentsˆwereˆaccurateˆprior to serving the breakfast tray to Resident 39. The DONˆstatedˆif the tray had missing items, it placed Resident 39 at riskˆdecreased food and nutrient intake which mayˆleadˆto unintended weight loss. 3.2. During a review of Resident 46's AR, the AR indicated that the facility originally admitted the resident on 8/1/2022 and readmitted on [DATE] with diagnoses including dysphagia (difficulty swallowing), oropharyngeal phase (in the mouth to throat), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), and dementia. During a review of Resident 46's H&P, dated 2/2/2025, the H&P indicated that the resident does not have assay to understand and make a decision. During a review of Resident 46's MDS dated [DATE], the MDS indicated the resident has severely impaired cognitive skills (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life) for daily decision making. The MDS further indicated that the resident required partial/moderate assistance with eating (helper does less than half the effort) and was on a mechanically altered diet (a specialized, medically prescribed eating plan designed for individuals who have difficulty chewing or swallowing safely (dysphagia), or who have severe dental issues) while a resident in the facility. During a review of Resident 46's OSR, dated 11/15/2025, the OSR indicated an order for fortified diet (nutrient-enriched food), pureed level four (4) texture, mildly thick level two (2) consistency (a fluid consistency designed for safe swallowing, characterized as being slightly thicker than water, flowable, and sippable), large portion, protein every meal, pudding every lunch and dinner for diet. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved appearance, flavor and temperature when: 1. Herbed rice was hard on the outside and soft on the inside. 2. [NAME] beans were bland, no salt flavor and olive green in color. 3. Foods were not at a palatable temperatures: On 1/12/2026 during test tray (a process of tasting, temping, and evaluating the quality of food), peach pie at 66 degrees Fahrenheit (F, degree of temperature), puree peach pie at 69 F. Pancake at 120 F, sausage patty 120 F, oatmeal 120 F, milk 48.8 F for breakfast on 1/13/2026. These failures had potential to result in 125 of 127 facility residents at risk of unplanned weight loss, a consequence of poor food intake, getting food from the kitchen. Findings: 1. During a review of Resident 6's admission Record, the admission record indicated the facility initially admitted Resident 6 on 3/27/2025 and readmitted on [DATE] with diagnoses including acute and chronic respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood), acute on chronic diastolic congestive heart failure (the left side of the heart becomes stiffer than normal causing the heart to not pump enough blood to the body) and hyperlipidemia (high fat in the blood). During a review of Resident 6's Minimum Data Sheet (MDS - a resident assessment tool), dated 10/3/2025, the MDS indicated Resident 6 understood others and make self-understood. The MDS indicated Resident 6 needed set up and clean up assistance (helper sets up or cleans up; resident completes activity, helper assists only prior to or following the activity) when eating. During a review of Resident 6's Order Listing Report, dated 1/7/2026, the order listing indicated Resident 6 was ordered consistent carbohydrate (CCHO - diet containing the same amount of carbohydrate each meal to manage blood sugar), regular, Level 0, thin liquid consistency, large portion diet (adding additional food to the tray to increase protein and calories). During an interview on 1/12/2026 at 1:07 a.m. with Resident 6, Resident 6 stated the rice on her plate was too dry and she would not eat it. During a review of the facility's menu spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled, Fall 2025, dated 1/12/2025, the spreadsheet indicated residents on regular and therapeutic diets would include the following foods on the tray: - Pork/mushroom sauce 4 ounces (oz - a unit of measurement) - Herbed rice 1/2 cup (c - a household measurement) - Mixed vegetables 1/2 c (substituted with green beans) - Roll and margarine 1 each - Peach pie 1 slice - Beverage 8 oz During a concurrent test tray (a process of tasting, temping, and evaluating the quality of food) observation and interview on 1/12/2026 at 1:31 p.m. with the Dietary Supervisor (DS) and the Registered Dietitian (RD), the RD stated the herbed rice had mixed texture and it was hard on the top and soft in the middle. The RD stated rice should be soft when it comes to acceptability of food. The DS stated residents would not accept the rice because of its hard texture. The DS stated residents would not eat the food because of its hard texture and could potentially lose weight. During a review of the facility's policies and procedures (P&P) titled, Standardized Recipe Development and Compliance Policy, dated 4/24/2026, the P&P indicated, To ensure consistent quality, nutrition, and portion accuracy for all meals served to residents. The facility will maintain standardized recipes for menu items to ensure meals are prepared consistently and in accordance with dietary requirements. Standardized recipes must include ingredients, measurements, preparation steps, cooking instructions, portion size, and yield. Dietary staff must follow recipes as written and may not substitute ingredients or adjust portions without approval of the Dietary Manager or Registered Dietitian as applicable. During a review of facility's standardized recipe titled, Herbed Rice, dated 4/24/2026, the recipe indicated, Prepare broth using base and water. Bring to boil. Add rice. 2. During a review of Resident 63's admission Record, the admission record indicated the facility initially admitted Resident 63 on 2/26/2024 and readmitted on [DATE] with diagnoses including type 2 diabetes (DM -a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic kidney disease (kidneys are damaged and cannot filter well over time) and essential (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DS stated desserts have been on the trays since 11:30 a.m. During an interview on 1/12/2026 at 1:28 p.m., with the DS, the DS stated the staff placed the dessert and beverages in advance on the cart. The DS stated residents would complain about the temperatures and would not like the food because it was not palatable, resulting in dissatisfaction. The DS stated residents would not eat the food and eventually lose weight. During an observation on 1/13/2026 at 7:02 a.m. of the food temperatures in trayline, observed [NAME] 2 check the temperature of the sausage patties and the temperature was 115 F. [NAME] 2 checked the temperature for the pureed pancakes and the temperature was at 110 F. The DS instructed [NAME] 1 to place the sausage patties and pureed pancakes in the oven. During a concurrent observation and interview on 1/13/2026 at 7:16 a.m. of the trayline with the DS, observed [NAME] 1 check the temperature of the pureed pancakes. The DS stated the pureed pancakes temperature was 100 F and needed to placed back in the oven. The DS stated there was no substitution on the menu today. During an interview on 1/13/2026 at 7:30 a.m. with the DS, the DS stated they took the temperature for pureed pancakes, and it was 145 F. During an observation on 1/13/2026 at 8:15 a.m., observed trayline just finished and the last cart went out of the kitchen. During a concurrent test tray observation and interview on 1/13/2026 at 8:16 a.m. of regular diet test tray with the DS, observed the DS check the temperature for the pancake, sausage patty, oatmeal, and milk. The DS stated the pancake was at 120 F, the sausage patty was at 120 F, the oatmeal was at 120 F, and the milk was at 48.8 F. The DS stated the temperature for milk could be a little lower and the hot food could be a bit hotter. The DS stated the test tray was not a hot meal as trayline was late today. The DS stated residents might not like the food, complain about it, and would not eat if the food is cold. The DS stated residents would lose weight as a potential outcome. During a review of the facility's P&P titled, Menu and Palatability, dated 4/24/2025, the P&P indicated, The facility provides meals that are palatable, flavorful, attractive, and served at appropriate temperatures to support adequate intake and resident satisfaction. Menus are planned to include variety in flavor, color and texture. Procedure: 1. Foods are seasoned appropriately within diet restrictions. 2. Meals are presented neatly and in a manner that supports appetite and dignity. 3. Hot foods are served hot and cold foods are served cold. 4. Meal quality is monitored through meal rounds, taste testing, and resident feedback.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MacLay Healthcare Center	12831 MacLay Street Sylmar, CA 91342

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, interview, and record review, the facility failed to ensure therapeutic diets were prescribed by the attending physician to one of three sampled residents (Resident 66) by failing to ensure that the resident's four (4) ounces (oz., the smallest measurement of weight and volume) of Magic Cup (a high-calorie, protein-packed, single-serving, pudding-style dessert designed for people who need extra nutrition, particularly in healthcare settings) or high protein nutrition (HPN, is a concentrated, convenient source of protein-usually in the form of powder, shakes, or bars-designed to help people easily increase their daily protein intake) had a physician's order. The deficient practice had a potential for residents to receive and consume foods in the form inappropriate for the resident to consume. Findings: During a review of Resident 66's admission Record (AR), the AR indicated the facility admitted the resident on 5/8/2021, and readmitted the resident on 9/6/2025, with diagnoses including type two (2) diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), iron deficiency anemia (a common blood condition where the body lacks enough iron to produce hemoglobin, the protein in red blood cells that carries oxygen, resulting in extreme fatigue, weakness, pale skin, and shortness of breath), and dementia (a progressive state of decline in mental abilities). During a review of Resident 66's History and Physical (H&P), dated 5/30/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 66's Minimum Data Set (MDS, a resident assessment tool), dated 11/6/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had severe cognitive impairment (inability to plan and carry out regular tasks (Activities of daily living/instrumental activities of daily living) and apply judgment). The MDS indicated the resident required substantial to set up assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident was on a therapeutic mechanically altered diet (a specialized, medically prescribed eating plan designed for individuals who have difficulty chewing or swallowing). During a review of Resident 66's Order Summary Report (OSR), dated 10/2/2025, the OSR indicated an order for consistent carbohydrate diet (CCHO, a meal plan designed to keep blood sugar levels stable, primarily for people with diabetes)/ no added salt diet (NAS, is a eating plan that restricts sodium by eliminating the use of salt shakers and salt-based seasonings during cooking and at the table) diet pureed- level four (4) texture (it isˆfood that has been blended into a completely smooth, thick,, and moist paste that requires absolutely no chewing), thin level zero (0) consistency (liquids that have the same consistency as water, flowing quickly and easily without any restrictions). The OSR did not indicate any order for four (4) oz. Magic Cup or HPN. During a review of Resident 66's Tray Meal Ticket (TMT), dated 1/13/2026, Breakfast, the TMT indicated the resident had a beverage preference of 4 oz. Magic Cup or protein drinks. During a review of Resident 66's Care Plan (CP) Report titled, The resident has nutritional problem or potential nutritional problem on therapeutic and mechanical altered diet related to multiple medical conditions, last revised on 1/13/2026, the CP indicated an intervention to provide, serve diet as ordered. Monitor intake and record every (q) meal. During a concurrent observation, interview, and record review on 1/13/2026 at 8:34 a.m., with Certified Nursing Assistant (CNA) 5, inside Resident 66's room, observed Resident 66's breakfast meal tray without a cup of coffee. Reviewed with CNA 5 the resident's meal tray ticket, CNA 5 stated the meal tray ticket indicated the resident should have a cup of coffee, but the meal tray did not have it. CNA 5 stated she should have checked for the completeness of the meal tray before serving them to the resident to ensure the resident's preferences and nutritional needs with food are met. The CNA verified the meal tray ticket indicating Resident 66's preferred beverage of 4 oz. Magic Cup or HPN. During a concurrent observation and interview on 1/15/2026, at 1:10 p.m., with CNA 13, in the dining room, observed Resident 66 lunch meal tray with one carton Mighty Shake vanilla flavor being served to the resident by CNA 13. CNA 13 (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated she did not check the lunch meal tray ticket if the Mighty Shake is indicated in there. During a review of Resident 66's TMT, dated 1/15/2026, Lunch, the TMT did not indicate 4 oz. of Magic Cup or HPN to be placed in the tray. During an interview on 1/15/2026, at 1:21 p.m., with Registered Dietician (RD) 1, RD 1 stated it is important to have an accurate meal tray served to Resident 66 because the Magic Cup and the HPN contains added calories (a unit of measurement for energy, specifically representing the amount of energy provided by food and drinks) and the resident is on CCHO diet and had diabetes. RD 1 stated consuming Magic Cup and HPN on the diet of the resident can increase the resident's blood sugar level affecting her diabetes. During an interview on 1/15/2026, at 2:20 p.m., with RD 1, RD 1 stated he was the one who recommended the HPN and it was discontinued on 12/23/2025. RD 1 stated the Magic Cup was a preference of the resident as RD 1 saw on the previous RD's note. RD 1 stated there should be an order for Magic Cup or HPN when it is still being served to the resident to ensure appropriate nutrition is provided to Resident 66. RD 1 stated he does not know why it is being served to the resident as it was discontinued on 12/23/2025. During an interview on 1/16/2026, at 10:06 a.m., with the Director of Nursing (DON), the DON stated the staff should have checked the breakfast meal tray of Resident 66 for accuracy and completeness to serve meals better and to meet the nutritional needs of the resident. The DON stated they need physician's order to ensure the resident received the supplements recommended by the RD in consultation with the Physician. The DON stated the failure of the licensed staff to obtain an order from the Physician on the use of Magic Cup and HPN can worsen the resident's health condition since the resident had diabetes. During a review of the facility's recent policy and procedure (P&P) titled, Diet Order Policy, last reviewed on 4/24/2025, the P&P indicated all resident diet orders must be accurate, complete, and timely to ensure proper nutritional care, compliance with physician instructions, and resident safety. The facility requires that all diet orders be clearly documented, communicated, and implemented by the interdisciplinary care team. Purpose To establish standardized procedures for obtaining, reviewing, documenting, and implementing diet orders for residents to ensure nutritional needs and safety requirements are met. POLICY GUIDELINES 1.ORDERING DIETS - All diet orders must be prescribed by the resident's physician or authorized practitioner. - Diet orders must specify: Type of diet (e.g. regular, Pureed Level 4, Large Portion, Diabetic, Cardiac, etc.) Texture modifications or liquid consistencies if applicable (refer to IDDSI standards if used) Any calorie or protein modifications (e.g., Large Portion Diet) Any allergies or dietary restrictions During a review of the facility's recent P&P titled, Meal Ticket Policy, last reviewed on 4/24/2025, the P&P indicated the facility utilizes meal ticket as a vital communication tool to ensure residents receive meals that accurately reflect their diet orders, texture modifications, allergies, and preferences. Proper handling, accuracy, and documentation of meal tickets are essential for resident safety and satisfaction. During a review of the facility's recent P&P titled, Tray Accuracy Verification Policy, last reviewed on 4/24/2025, the P&P indicated the facility is committed to ensuring that all resident meal trays are accurately prepared and delivered according to prescribed diet orders, including texture modifications, portion sizes, and resident preferences, to promote safety, satisfaction, and regulatory compliance. POLICY GUIDELINES Tray Assembly - Tray tickets must reflect the resident's diet type, texture modifications, allergies, and preferences. 2. TRAY VERIFICATION PROCESS - Prior to meal delivery, a designated dietary member must perform the following: - Verify all food items and beverages match the tray ticket and diet order, including: Diet type (e.g., Regular, Pureed, mechanical Soft, Large Portion) Texture and consistency Portion sizes and substitutions as ordered Allergen considerations

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide residents' meals at regular times scheduled in accordance with resident needs, preferences, and requests when lunch was served late on 1/12/2026 and breakfast was served late on 1/13/2026. This deficient practice had the potential to result in hunger and frustrations to 125 to 127 residents getting food from the kitchen. Findings: During a review of Resident 35's admission Record, the admission record indicated the facility initially admitted Resident 35 on 7/13/2010 and readmitted on [DATE] with diagnoses including end stage renal disease (the kidneys cease functioning on a permanent basis), type 2 diabetes (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), and hyperlipidemia (high fats in the blood). During a review of Resident 35's Minimum Data Sheet (MDS - a resident assessment tool), dated 12/3/2025, the MDS indicated Resident 35 understood others and make self-understood. The MDS indicated Resident 35 needed set up and clean up assistance when eating. During a review of Resident 35's Order Listing Report, dated 7/29/2025, the order listing indicated Resident 35 was ordered Consistent Carbohydrate diet (CHO - diet with the same amount of carbohydrates per meal for blood sugar management), renal (diet limiting protein, high salt, high potassium and high phosphorus rich food), regular texture, thin consistency, large portion diet (providing extra food to the tray to increase protein and calorie in the meal). During an interview on 1/12/2026 at 9:28 a.m. with Resident 35, Resident 35 stated the food from the kitchen comes out late. During a review of the facility's resident council meeting minutes, dated 11/6/2025, the minutes indicated food trays may get late for some of the residents. During an observation on 1/12/2026 at 11:33 a.m. of the meal schedule posted in the hallway, observed a paper posted in the hallway indicated meals are scheduled as follows: Breakfast 7:15- 8:15 a.m. Lunch 12:15-1:15 p.m. Dinner 5:15-6:15 p.m. During an observation on 1/12/2026 at 12:21 p.m. of the trayline (an area where foods were assembled form the steamtable [kitchen appliance that keeps food warm at a safe temperature for serving] to resident's plates) service, observed the staff started trayline lunch service. During an observation on 1/12/2026 at 1:31 p.m., of the trayline service, observed staff finished trayline lunch service. During an observation on 1/13/2026 at 7:22 a.m. of the trayline service, observed staff started trayline breakfast service. During an observation on 1/13/2026 at 8:15 a.m. of the trayline service, observed staff finished trayline breakfast service. During an interview on 1/13/2026 at 8:23 a.m. with the Dietary Supervisor (DS), the DS stated the breakfast first cart should be coming out at 7:15 a.m. but the trayline was late today. The DS stated the passing of trays to the residents was late too because the kitchen staff and the nurses were trying to make sure the trays were accurate. During an interview on 1/13/2026 at 11:55 a.m. with the DS, the DS stated breakfast was scheduled to be served from 7:15 a.m. to 8:15 a.m. but yesterday, the trayline ended at 8:30 a.m. and it was late. The DS stated today they are trying hard to serve on time and check the tray accuracy at the same time. The DS stated she did not communicate to the residents that their meals would be late and did not communicate it with other team members. The DS stated residents would be upset and would be hungry because of receiving late meals. During an interview on 1/13/2026 at 12:59 p.m. with the Registered Dietitian (RD), the RD stated residents have scheduled mealtimes especially for those with diabetes to control their sugar levels that affect their metabolism (the body's engine, converting food and drink into the energy required for breathing, thinking, repairing cells, and moving) and so that residents would not be hungry. During a review of the facility's policies and procedures (P&P) titled, Meal Service Policy, dated 4/24/2025, the P&P indicated Resident meals will be served daily in a consistent and timely manner to promote adequate nutrition, hydration, and resident satisfaction. Meals provided at regular scheduled hours, with no more than fourteen (14) hours between the (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	evening and breakfast the following day. Meal service will follow the established schedule below: Breakfast 7:15-8:15 a.m. Lunch 12:15-1:15 p.m. Dinner 5:15-6:15 p.m.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1.Food items were not properly labeled with the food item name. 2.Kitchen equipment and utensils were not free from dirt, dust, and food debris. a. Sticker residue on two (2) trays inside the walk-in refrigerator, walk-in freezer shelves, and dry storage room shelves. b. There was dirt, food, and food debris on the walk-in freezer floors. c. There were dried-up sauce spills on the dry storage walls. d. A cart with straw decoration (not cleanable surface) was used during trayline (an area where foods were assembled from the steamtable to resident's plate). e. Clean pans on the storage racks had rice grains and were not free from debris. f. Kitchen floors by pots and pans storage racks had dirt and food debris. 3. Five (5) dented cans were stored with non-dented cans. 4. Pans were stacked wet in the storage area. 5. Pot and pans racks did not have a physical barrier to avoid spills when mopping. These failures had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 125 of 127 medically compromised residents who received food and ice from the kitchen. Findings: 1. During an observation on 1/12/2026 at 8:40 a.m. of the food inside the walk-in refrigerator, observed cooked poultry not labeled with the name. During an interview on 1/12/2026 at 9:04 a.m. with the Dietary Supervisor (DS) inside the walk-in refrigerator, the DS stated they label prepared food with the food item name, date it was prepared, and use by date. The DS stated it was important to label the food with the name of the product so that they know which ingredients were in it for residents with food allergies. The DS stated the chicken, prepared chicken with butter, and the hamburger patty were not labeled and should have been labeled. The DS stated allergic reaction, dissatisfaction and complaints could be the potential outcome for not labeling food. During a review of the facility's policies and procedures (P&P) titled, Food Labeling and Dating Policy, dated 4/24/2025, the P&P indicated To ensure all food items stored, prepared, opened, thawed, or served at the facility are properly labeled and dated to promote food safety, prevent foodborne illness, maintain quality, and ensure regulatory compliance . Any food item that is labeled, undated, or expired will be removed from service. Labeling: Writing the required information of food containers to identify contents, storage date, discard date and staff initials. During a review of Food Code 2022, the Food Code 2022 indicated, 3-501.17 Commercially processed food, open and hold cold, (B) except specified in (E) - (G) of this section, refrigerated, ready-to-eat time/temperature control for food safety food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacture's use-by- date if the manufacturer determined the use-by date based on food safety. 2A. During an observation on 1/12/2026 at 8:40 a.m. of the food trays, observed two (2) food trays with ripped off stickers and residue. During an interview on 1/12/2026 at 9:13 a.m. with the DS in the walk-in refrigerator, the DS stated the tray had tape and sticker residue and it was not okay because the stickers may fall into the food, the stickers could attract dirt and it's unsanitary. The DS stated residents could get sick, throw up, have diarrhea and food poisoning as a potential outcome. During an interview on 1/12/2026 at 9:17 a.m. with the DS in the walk-in freezer, the DS stated there was sticker residue in the walk-in freezer shelves and it needed to be cleaned for food safety. During an interview on 1/12/2026 at 9:27 a.m. with the DS, the DS stated there were sticker residue on the shelves in the dry storage room and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they were old stickers. The DS stated they need to clean the sticker residue to prevent cross-contamination of food. 2B. During an observation on 1/12/2026 at 8:53 a.m. of the walk-in freezer, observed dirt and food debris on the floor. During an interview on 1/12/2026 at 9:17 a.m. with the DS in the walk-in freezer, the DS stated there was food on the floor and it needed to be cleaned to prevent pests that could harbor bacteria. The DS stated residents could get sick as a potential outcome. 2C. During an observation on 1/12/2026 at 8:59 a.m. of the dry storage area, brown spills observed on the dry storage room wall. During an interview on 1/12/2026 at 9:25 a.m. with the DS in the dry storage room, the DS stated the wall has spills, but she was not sure where it came from. The DS stated the staff detail clean every Wednesday, but they would clean the spill right away to prevent cross-contamination. 2D. During an observation on 1/12/2026 at 11:43 a.m. of the trayline service, observed a cart with straw decorations was used for the soup bowls. During an interview on 1/14/2026 at 3:33 p.m. with the DS, the DS stated the cart with straw decorations was for the activities department's use and it should not be used in trayline because the decor is not a cleanable surface. The DS stated cross-contamination of food would be the potential outcome for using the cart with decor. 2E. During a review of Resident 55's admission Record, the admission Record indicated the facility initially admitted Resident 55 on 9/12/2018 and readmitted on [DATE] with diagnoses including of type 2 diabetes (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic kidney disease (kidneys are damaged and cannot filter well overtime), and gastroesophageal reflux disease (GERD - a chronic condition where stomach acid frequently flows back up into the food pipe causing irritation and symptoms like heartburn, chest pain, difficulty in swallowing). During a review of Resident 55's Minimum Data Sheet (MDS - a resident assessment tool), dated 12/25/2025, the MDS indicated Resident 55 understood others and make self-understood. The MDS indicated Resident 55 needed setup and clean up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) when eating. During a review of Resident 55's Order Listing Report, dated 11/14/2025, the order listing indicated Resident 55 had no added salt (NAS - no salt packets on the tray), regular texture, thin consistency (no restriction) diet order. During an interview on 1/12/2026 at 10:13 a.m. with Resident 55, Resident 55 stated dishes were not clean enough. During an observation on 1/12/2026 at 12:31 p.m. of the pots and pans storage area, observed stored pans with rice particles. During a concurrent observation and interview on 1/14/2026 at 3:53 p.m. of the clean pans with the DS in the pots and pans storage area, observed rice particles on the pans. The DS stated the staff needed to rewash the pans as there is still rice debris. The DS stated it was not okay to have rice debris on the pans because of cross contamination of food. 2F. During an observation on 1/14/2026 at 12:36 a.m. of the pots and pans, observed the floors with dirt and brown food debris. During an interview on 1/14/2026 at 12:40 p.m. with the DS in the pot and pan storage area, the DS stated there was dust and dirt debris under the rack of the pot and pan storage rack and needed to be deep cleaned to prevent cross-contamination. The DS stated the rack was not movable so staff would not be able to reach it. The DS stated the floors must be mopped and cleaned every night. During a review of the facility's P&P titled, Dry Storage and Walk-in Freezer Sanitation Policy, dated 4/24/2026, the P&P indicated, To maintain a clean and organized dry storage room and walk-in freezer to prevent food contamination and ensure safe storage. The facility will maintain dry storage and walk-in freezer areas in clean, organized, pest-free condition with proper food storage practices. Any spills damaged packaging, or expired items must be removed immediately. A routine cleaning schedule will be followed for both areas. During a review of the facility's P&P titled, Cross-Contamination, dated 4/24/2026, the P&P indicated To prevent cross-contamination during food storage, preparation, cooking, and service to protect residents and staff from foodborne illness. The facility will prevent cross-contamination by separating raw foods from cooked/ready-to-eat foods, using proper hand hygiene, and cleaning and sanitizing all food contact surfaces and equipment. During review of the facility's P&P titled Equipment and Kitchen Utensil Cleanliness Policy, dated 4/24/2025, the P&P indicated To ensure all kitchen equipment are (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	clean, sanitary, and safe for food preparation and service. The facility will clean and sanitize all kitchen equipment and utensils routinely, after use, and between food preparation tasks to prevent contamination and maintain safe operations. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-601.11 (A) Equipment Food Contact Surfaces and utensils shall be cleaned: (1) Except as specified in (B) of this section, before use with a different type of raw animal food such as beef, fish, lamb, pork or poultry; (2) Each time there is a change from working with raw foods to working with ready-to-eat food; (3) Between uses with raw fruits and vegetables and with time/temperature control for safety food. (4) Before using or storing a food temperature measuring device, and (5) At the time during the operation when contamination may have occurred. During a review of Food Code 2022, the Food Code 2022 indicated, 4-601.11 (E) Except when dry cleaning methods are used as specified under S 4-603.11, surfaces of utensils and equipment contacting food that is not time/temperature control for safety food shall be cleaned: (1) At anytime when contamination may have occurred; (2) At least every 24 hours for iced tea dispensers and consumer self-service utensils such as tongs, scoops, or ladles; (3) Before restocking consumer self-service equipment and utensils such as condiment dispensers and display containers; and (4) In equipment such as ice bins and beverage dispensing nozzles and enclosed components of equipment such as ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specification, at a frequency necessary to preclude accumulation of soil or mold. During a review of Food Code 2022, the Food Code 2022 indicated,4-602.13 Nonfood-Contact Surfaces. Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. 3. During a concurrent observation and interview on 1/12/2026 at 9:27 a.m. of the canned goods in the dry storage room with the DS, the DS stated there were 5 dented cans that were stored with the non-dented cans, and they were supposed to be separated by the paper room for return and so they would not use it. The DS stated residents could get sick from foodborne illness. During a review of the facility's P&P titled, Proper Disposal of Dented Cans Policy, dated 4/24/2026, the P&P indicated, To prevent the use of unsafe canned good that may place residents at risk for foodborne illness. Dietary staff will inspect canned food upon delivery and during storage checks. Any can that appears damaged or unsafe will be removed from food service areas and discarded. Routine dry storage inspections will include checks for damaged canned goods. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-101.11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under 3-601.12, honestly presented. 3-201.11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of S3-101.11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fail victim to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard. 4. During an observation on 1/14/2026 at 12:31 p.m. of the pots and pans storage area, observed stacked pans had water droplets. During an interview on 1/14/2026 at 12:38 p.m. with the DS in the pots and pans storage area, the DS stated the pans were not air dried and the staff should not be stacking the pans wet before storing it. The DS stated it was important to air dry so that the moisture would not stick to the pan before storing it. The DS stated the bacteria might grow causing residents to become potentially sick. During a review of the facility's P&P titled, Ware Washing, dated 4/24/2026, the P&P indicated, Utensils, dishes, beverage containers, pots and pans, flatware used for the preparation, service, or storage of food will be cleaned and sanitized after use. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an observation on 1/14/2026 at 12:36 p.m. of the pots and pans racks, observed there was no physical barrier between the floor and rack. During an interview on 1/14/2026 at 12:40 p.m. with the DS in the pot and pans storage area, the DS stated there was no physical barrier between the storage rack and the floor. The DS stated water from the mop could splatter during cleaning to the clean pots and pans and could cause cross-contamination. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-307.11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under subparts 3-391 - 3-306.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards for one of one sampled resident (Resident 11) by failing to document accurately the dialysis access site on the Dialysis Communication Records on 12/18/2025, 12/30/2025, 1/4/2026, and 1/6/2026. This deficient practice had the potential to result in Resident 11's dialysis access to go unmonitored and unchecked post-dialysis. Findings: During a review of Resident 11's admission Record (AR), the AR indicated that the facility originally admitted the resident on 10/15/2025, and readmitted on [DATE], with diagnoses including end-stage renal disease (ESRD- irreversible kidney failure), dependence on renal dialysis, and acute posthemorrhagic anemia (a type of anemia that develops suddenly after a person loses a large amount of blood quickly). During a review of Resident 11's History and Physical (H&P), dated 12/10/2025, the H&P indicated that the resident could not make own decisions but could make needs known. During a review of Resident 11's Minimum Data Set (MDS-a resident assessment tool) dated 10/22/2025, the MDS indicated the resident usually has the ability to make self-understood and understand others. The MDS further indicated that the resident required assistance from staff with upper and lower body dressing and personal hygiene and while a resident of the facility dialysis treatment was performed. During a review of Resident 11's Order Summary Report, dated 12/23/2025, the OSR indicated Enhanced Barrier Precautions-Staff to utilize gowns and gloves for high-contact resident care activities related to permacath (a flexible tube used for dialysis treatment) on right upper chest. During a review of Resident 11's Care Plan (CP) focused on needs dialysis related to ESRD, dated 11/10/2025, the CP indicated the resident with goals of minimizing signs and symptoms of complications from dialysis included interventions to: Check and change dressing daily at access site. Document. Monitor vital signs twice a shift after dialysis, on dialysis days. Monitor/document/report PRN (as needed) any signs and symptoms of infection to access site: Redness, swelling, warmth, or drainage. Monitor/document/report PRN for signs and symptoms of the following: Bleeding. During a concurrent interview and record review on 1/15/2026 at 3:20 p.m. with Licensed Vocational Nurse (LVN) 8, reviewed Resident 11's Dialysis Communication Records (DCR). LVN 8 stated that for residents on dialysis treatment, nursing staff check their vital signs including blood pressure before and after each dialysis treatment and if the blood pressure was too low or too high, staff report them to the physician. LVN 8 stated that when residents return from dialysis treatment, they fill out the paper in the dialysis binder including the resident's latest vitals. LVN 8 stated that documentation is important to monitor the resident's condition post-dialysis to ensure that the resident is okay and tolerated the dialysis treatment. LVN 8 stated she was the nurse that signed on the Dialysis Communication Record on 12/18/2025, 12/30/2025, 1/4/2026, and 1/6/2026. LVN 8 stated she (LVN 8) documented under the arteriovenous (AV) shunt (a direct, artificial connection made between an artery and a vein) site that bruit (an audible vascular sound associated with turbulent blood flow), and thrill (palpable vibratory sensations over the fistula [dialysis access point]) were present and there was no pain at the access site. LVN 8 stated she made a mistake in documenting the incorrect site. LVN 8 stated she should have documented the right upper chest permacath. LVN 8 stated the reader reading her documentation would think that the resident has an AV shunt site and that would not be accurate and may show that she (LVN 8) did not check the resident's permacath. During an interview on 1/16/2026 at 2:35 p.m. with the Director of Nursing (DON), the DON stated that after the resident arrives from dialysis, the licensed nurses assess the resident`s vital signs and any change in condition after the dialysis treatment. The DON stated that the licensed nurse's documentation should be placed in the dialysis communication record or they should write a narrative in the nursing progress notes. The DON stated licensed nurses check for any new orders from the dialysis centers, (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the dialysis access site for any bleeding, swelling, they check to see if a dressing is in place and if the dressing is intact. The DON stated the purpose of checking the resident's vital signs and signs and symptoms of complications is to check the well-being of the resident after undergoing dialysis which can be exhausting, and the transport back may have changed the resident's vital signs which is why it is critical that licensed nurse check on the resident upon their return from dialysis. The DON stated their facility policy was not followed when Resident 11's dialysis access site was documented as AV shunt and should have documented permacath right upper chest. The DON stated unchecked or unmonitored vital signs and access site can cause potential harm to the resident such as hypotension, bleeding, and need to be relayed to the doctor immediately. During a review of the facility-provided policy and procedure (P&P) titled, Hemodialysis Residents Policy last reviewed and approved on 4/24/2025, the P&P indicated that the facility provides residents receiving hemodialysis with safe, accurate, and appropriate care, assessments, and interventions in coordination with the dialysis center to support optimal resident outcomes. I. admission and General Care - Care Planning: - Implement a care plan that includes: - Monitoring of risk factors - Access site assessment. II. Post-Hemodialysis and Ongoing Care - Vital Signs & Safety - Check vital signs post-dialysis or as ordered. III. Documentation Requirements - Dialysis Communication Record - Ensure completion and filling of the Dialysis Communication Record - Medical Record Documentation - Documentation should include: - Vital signs - Weight - Pertinent observations regarding resident status. During a review of the facility-provided P&P titled, Charting and Documentation Policy last reviewed and approved on 4/24/2025, the P&P indicated that the purpose of this policy is to ensure accurate, complete, and timely documentation of all resident care, treatments, and observations. The P&P indicated that All resident care, assessments, medications, treatments, and changes in condition must be documented in the medical record promptly, accurately and according to facility and regulatory requirements. The P&P indicated guidelines included the use of clear, legible, and factual entries.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on interview and record review, the facility failed to ensure necessary care was provided consistently for one (1) of two (2) sampled residents (Resident 3) reviewed for hospice services (a program designed to provide a caring environment for meeting the physical and emotional needs of the terminally ill) by: 1. Failing to ensure hospice staff including Licensed Vocational Nurse (LVN), and Hospice Aide (HA), provided nursing and visitation notes to the facility. 2. Failing to ensure LVN and HA visited Resident 3 as indicated in the calendar of visits provided by Hospice Provider (HP) 2 to the facility. These deficient practices had the potential to negatively affect Resident 3's physical comfort and psychosocial well-being resulting in the delay or lack of necessary hospice care and services. Findings: During a review of Resident 3's admission Record, the admission Record indicated the facility originally admitted the resident on 5/31/2017, with diagnoses including dementia (a progressive state of decline in mental abilities), anxiety disorder (a mental health condition where excessive fear and worry interfere with daily life, causing significant distress), and history of falling. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool) dated 12/26/2025, the MDS indicated Resident 3 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was able to understand others and make her needs known. The MDS further indicated that Resident 3 required total assistance with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 3 received hospice services. During a review of Resident 3's History and Physical (H&P) dated 10/19/2025, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3's Order Summary Report dated 1/16/2026, the Order Summary Report indicated a physician's order dated 12/17/2025 to admit Resident 3 in the facility under the care of HP 2 for routine level of care with a primary diagnosis of Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities). During an interview on 1/12/2026 at 12:26 p.m. inside Resident 3's room with Licensed Vocational Nurse (LVN) 10, LVN 10 stated resident declined with her functional status for at least more than one month and was placed on hospice care. LVN 10 stated HP 2 staff visits and signs-in their attendance in the binder. During a review of Resident 3's hospice binder for the Plan of Care (POC) Summary dated 12/17/2025, the POC Summary indicated the following: - 12/17/2025: HA - to visit patient two times (2x) a week to assist with personal grooming as directed by the POC created by Registered Nurse (RN) case manager. - 12/17/2025: Skilled Nurse (SN) to visit patient one to two times per week and as needed for SN care routine and reports to RN. During a concurrent interview and record review on 1/14/2025 at 11:55 a.m., Resident 3's hospice binder was reviewed with the MDS Coordinator (MDSC) including the calendar of visits from 12/17/2025 to 3/14/2026, hospice team sign-in sheet from 12/17/2025 to 1/13/2026, POC Summary, and progress notes. The MDSC stated the SSD is the facility's hospice coordinator. The MDSC stated: - The calendar of visits indicated HP 2 LVN was scheduled to visit Resident 3 on 12/23/2025, 12/30/2025, and 1/9/2026 and the HP 2 HA was scheduled to visit on 1/1/2026. The MDSC stated the sign-in sheet did not indicate the LVN visited Resident 3 on 12/23/2025, 12/30/2025, and 1/9/2026. The MDSC stated sign-in sheet did not indicate the HA visited Resident 3 on 1/1/2026. The SSD verified the POC summary, which indicated SN visits 1 to 2x a week and as needed and HA visits 2x a week. The MDSC stated HP 2 LVN should have visited Resident 3 on 12/23/2025, 12/30/2025, and 1/9/2026 and the HP 2 HA on 1/1/2026 according to the calendar of visits to ensure Resident 3's needs were assessed and met to prevent delay in the provision of hospice care the resident needs. - The MDSC stated there were no HP 2 LVN on 12/30/2025 1/2/2026, 17/2026, 1/10/2026, and 1/13/2026 and HA notes on 12/19/2025, 12/23/2025, 12/26/2025, 1/2/2026, 1/6/2026, 1/9/2026, and 1/13/2026 in Resident 3's clinical records or hospice binder. The MDSC stated HP 2 staff are supposed to complete and place their visit (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	notes in the binder as soon as the visit is completed to Resident 3 to ensure the facility staff would be aware of any new updates or changes in the POC to be able to continue to provide the necessary Resident 3 needed. The MDSC stated if HP 2 did not provide new updates or changes with the facility staff, it placed Resident 3 at risk for a delay in providing the necessary care the resident needed. The MDSC stated the Medical Records Director (MRD) audits the clinical records to ensure it the notes are readily available for all staff to review so the facility would be aware of what services were provided to Resident 3 while HP 2 LVN and HA were in the facility and to ensure Resident 3 receives the necessary care the resident needs. During an interview on 1/15/2026 at 8:30 a.m., the MRD stated she had been following up with HP 2 regarding the LVN and HA notes for Resident 3 to be placed in the hospice binder. and upload as well in Resident 3's electronic health record (EHR). The MRD stated the progress notes should have been readily available so the staff would be aware of what care was provided to the resident. During an interview on 1/16/2026 at 4:00 p.m. with the Director of Nursing (DON), the DON stated hospice providers have a schedule of visits provided to the facility and should be followed accordingly. The DON stated if HP 2 staff are not able to visit as scheduled, it should be indicated in the notes or in the calendar. The DON stated the RN/LVN and HA notes were supposed to be part of the resident's medical record and should be readily available in the hospice binder and can be uploaded in the EHR. The DON stated HP 2 LVN should have visited Resident 3 as scheduled on 12/23/2025, 12/30/2025, and 1/9/2026 and the HA on 1/1/2026 to ensure Resident 3's needs and services required were met. The DON stated the LVN and HA notes should have been readily available in the Resident 3's medical record regardless of if paper or in the EHR so the staff would be aware of the services provided to the resident by HP 2 staff placing Resident 3 at risk for a delay in the provision of end-of-life care and services the resident needed. During a review of the facility's policy and procedure (P&P) titled, Hospice Services, last reviewed on 4/24/2025, the P&P indicated the facility supports resident choice and provides coordinated care for residents receiving hospice services, ensuring all care is delivered safely, respectfully, and in compliance with federal and state regulations. Hospice care will be integrated into the facility care plan through interdisciplinary coordination between the facility team and hospice agency. The P&P further indicated: - Purpose: - Accurate documentation, communication, and plan-of-care implementation. - Clear coordination between the facility and hospice provider. - Coordination of Care: - The facility will coordinate with hospice staff to ensure clear communication of resident status and symptom changes, and consistency of the hospice plan with facility care delivery. - Hospice staff will sign in/out per facility protocol and communicate with nursing upon arrival and departure. - Hospice Responsibilities: - Hospice agency is responsible to providing hospice related services including RN case management visits and hospice aid services. - Documentation Requirements: - Facility medical record must include nursing notes reflecting symptom monitoring.

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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 maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by failing to ensure: 1. Urinals (a portable container designed to collect urine from individuals who are unable to reach a toilet) were labeled with a resident identifier for two randomly sampled residents (Resident 109 and 91). 2. The resident's nasal cannula (NC - a small plastic tube, which fits into a patient's nostrils for providing supplemental oxygen) tubing and hand-held nebulizer (HHN, a small machine that turns liquid medicine into a mist that can be easily inhaled) were not touching the floor for one (1) out of eight (8) sampled residents (Resident 21) reviewed under infection control. 3. A bath blanket was not used to soak up leaking water from the laundry room floor affecting the adjacent resident occupied room for three sampled residents (Residents 33, 39, and 72). These deficient practices had the potential to spread communicable diseases among residents, staff, and visitors. 4. Resident 53 and 130's clean clothing placed in a clear plastic bag was not placed on the floor. 5. Licensed Vocational Nurse (LVN) 4 wore a gown while administering medication to Resident 122 who was on enhanced barrier precaution isolation (EBP - infection control steps in nursing homes requiring staff to wear gowns and gloves during high-contact care [e.g., bathing, dressing, changing linens] for residents with wounds or medical devices). 6. Certified Nursing Assistant (CNA) 1 and CNA 2 wore a gown while transferring Resident 4, who was on enhanced barrier precaution isolation, from bed to wheelchair using a Hoyer lift (a mechanical device used by caregivers to safely move people with limited mobility from one place to another). 7. CNA 5 wore a gown while providing continence and morning care to Resident 66, with an order for enhanced barrier precaution. These deficient practices had the potential to cause cross-contamination (the unintentional transfer of harmful bacteria, viruses, or allergens from one surface, food item, or person to another) of infection among residents and staff. Cross-reference F584 and F921.Findings: 1.a. During a review of Resident 109's admission Record (AR), the AR indicated the facility admitted the resident on 12/6/2025 with diagnoses that included hemiplegia (total paralysis [the loss of muscle function in part or all of the body, making a person unable to move affected areas voluntarily] of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial paralysis or weakness on one side of the body) following cerebral infarction (stroke, when the blood supply to part of the brain is suddenly interrupted or reduced), chronic kidney disease (damage to the kidneys [body part that filters blood]), difficulty walking, and diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 109's Minimum Data Set (MDS – resident assessment tool), dated 12/12/2025, the MDS indicated the resident was able to understand others and make himself understood. The MDS further indicated the resident required substantial / maximal assistance from staff for bathing, dressing, and toileting. During a review of Resident 109's Care Plan (CP) regarding bladder incontinence, initiated 12/10/2025, the CP indicated interventions to monitor for signs and symptoms of UTI. 1.b. During a review of Resident 91's AR, the AR indicated the facility admitted the resident on 7/15/2025 and most recently readmitted the resident on 9/10/2025 with diagnoses that included dementia (a progressive state of decline in mental abilities), repeated falls, and epilepsy (chronic disorder that causes recurrent seizures [abnormal electrical activity in the brain]). During a review of Resident 91's MDS, dated [DATE], the MDS indicated the resident was able to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	understand others and sometimes was able make himself understood. The MDS further indicated the resident required substantial / maximal assistance from staff for bathing, dressing, and toileting. During a review of Resident 91's CP regarding bladder incontinence, initiated 9/5/2025, the CP indicated interventions to monitor for signs and symptoms of UTI. During a concurrent observation and interview on 1/12/2026 at 11:50 a.m., observed Resident 109 lying in bed awake and Resident 91 lying in bed sleeping in the shared room. Observed an unlabeled urinal placed on Resident 109's bedside rolling table. Observed an unlabeled urinal hanging from the foot of Resident 91's bed. Resident 109 stated the night shift staff brought the urinal into the room. Resident 109 stated the facility staff usually label the urinals but this time they did not. During a concurrent observation and interview on 1/12/2026 at 11:56 a.m., observed Certified Nursing Assistant (CNA) 12 enter the shared room of Resident 109 and 91. CNA 12 stated the facility process is that all urinals are labeled to prevent confusion and prevent the sharing of urinals between residents. CNA 12 stated it was important to ensure urinals are not shared for infection control reasons and to prevent the spread of infection between residents. CNA 12 stated Resident 109 and 91's urinals were not labeled, but they should have been. During a concurrent interview and record review on 1/16/2026 at 2 p.m. with the Director of Nursing (DON), the facility's policy and procedure (P&P) regarding infection control and urinals were reviewed. The DON stated urinals are resident specific and the facility P&P indicates urinals are labeled with the room and name of the resident to ensure that the urinals are not accidentally used on another resident and to prevent cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect). The DON stated the facility's P&Ps were not followed when Resident 109 and 91's urinals were not labeled potentially resulting in the spread of bacteria and organisms resulting in resident UTIs. During a review of the facility P&P titled, General Infection Control, last reviewed 4/24/2025, the P&P indicated, (facility name) is committed to preventing and controlling infections to protect residents, staff, and visitors. Purpose. To provide guidance for infection prevention, monitoring, and control practices, reducing the risk of infection transmission in the facility. During a review of the facility P&P titled, Urinal Labeling, last reviewed 4/24/2025, the P&P indicated, Policy Statement.All resident urinals must be clearly labeled with the resident's room number to prevent cross contamination, infection, and misplacement. Purpose. To ensure resident safety, infection prevention, and proper identification of personal care items. Procedure. 1. Labeling. a. Each urinal must have a label with the resident's room number. 3. Staff Responsibilities. a. Replace any urinal with missing labels. 4. Infection Control. a. Urinals are considered resident-specific items and must not be shared. b. Follow Standard Precautions during handling. 2. During a review of Resident 21's admission Record, the admission Record indicated the facility originally admitted the resident on 2/5/2025 and readmitted in the facility on 12/10/2025, with diagnoses including chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), atrial fibrillation (an irregular heartbeat which can lead to blood clots and stroke [loss of blood flow to a part of the brain]), ack of coordination, and dependence on supplemental oxygen. During a review of Resident 21's History and Physical (H&P) dated 12/12/2025, the H&P indicated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 21 had the capacity to understand and make decisions. During a review of Resident 21's MDS, dated [DATE], the MDS indicated Resident 21 was able to understand others and make her needs known had an intact cognition (having the ability to think, learn, and remember clearly). The MDS indicated Resident 246 required setup or clean-up assistance with eating; supervision or touching assistance with oral hygiene partial/moderate assistance to substantial maximal assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 21 was on oxygen therapy while a resident in the facility. During a review of Resident 21's Order Summary Report dated 1/16/2026, the Order Summary Report indicated the following physician's orders: 12/14/2025: Oxygen (O2) at three (3) liters per minute (L/min – a unit of measurement) to keep oxygen saturation (O2 sat - a measurement of how much oxygen the blood is carrying as a percentage) equal to 92 percent (% - a unit of measurement) and greater may titrate up to five (5) L/min via NC to keep O2 sat equal to 92% and greater. 12/12/2025: Levalbuterol hydrochloride (a type of medication given thru HHN used by people who have a hard time breathing due to certain lung conditions) inhalation nebulization solution 1.25 milligrams (mg – a unit of measurement) per three (3) milliliters (ml – a unit of measurement) 1 dose inhale daily at bedtime for wheezing (a high-pitched whistling or rattling sound when breathing). 12/12/2025: Levalbuterol hydrochloride inhalation nebulization solution 1.25 mg per 3 ml 1 dose inhale orally every four (4) hours as needed for wheezing or respiratory distress. During a review of Resident 21's CP on risk for ineffective airway clearance, shortness of breath, respiratory distress, and respiratory infection initiated on 9/16/2025 and last revised on 11/14/2025, the CP indicated to administer oxygen and breathing treatment as ordered and to monitor any sudden increase in body temperature and report to the physician as a few of the interventions to maintain Resident 21's effective airway clearance as evidenced by no shortness of breath daily. During a concurrent observation and interview on 1/12/2026 at 12:50 p.m., inside Resident 21's room observed Resident 21 lying in bed alert and responds appropriately with O2 at 5 L/min via NC with the NC tubing touching the floor. Observed that Resident 21's HHN set up mouthpiece was inside the plastic storage bag and the tubing was hanging outside the plastic storage bag and touching the floor. During a concurrent observation and interview on 1/12/2026 inside Resident 21's room with CNA 9, CNA 9 stated Resident 21's NC tubing and HHN tubing were touching the floor. CNA 9 stated that the NC and HHN tubing should not be touching the floor. CNA 9 stated the floor is dirty and it can get the tubing dirty. CNA 9 stated it was an infection control issue. During a concurrent observation and interview on 1/12/2025 at 1 p.m., inside Resident 21's room with LVN 7, LVN 7 stated Resident 21's NC and HHN tubing were touching the floor. LVN 7 stated the NC tubing and HHN tubing should not be touching the floor as the floor is contaminated and placed Resident 21 at risk for getting respiratory infection due to the contaminated tubing. During a concurrent interview and record review on 1/6/2026 at 9:38 a.m., Resident 21's physician's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tasks. During a review of Resident 72's AR, the AR indicated Resident 72 originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including DM and chronic myeloproliferative disease (a group of long-term blood cancers where the bone marrow makes too many blood cells). During a review of Resident 72's H&P, dated 12/31/2025, the H&P indicated Resident 72 lacks the capacity to understand and make her needs known. During a review of Resident 72's MDS, dated [DATE], the MDS indicated Resident 72 was dependent upon staff for all activities of daily living requiring maximum assistance of staff to complete daily tasks. During a concurrent observation and interview on 1/14/2025 at 12 p.m. with the Director of Maintenance (DOM), Resident 33, Resident 39, and Resident 72's room was observed with loose floorboards. The DOM pulled out a closet drawer containing a white substance. The DOM stated the closet drawer is dirty and stated the white substance was a result of water damage and can be a potential infection control issue for the residents in the room. During a concurrent observation and interview on 1/14/2026 at 2:30 p.m. with the Director of Maintenance (DOM), the laundry room was observed. There were two wash basins on the laundry room floor placed under leaking pipes. One pipe leaked water into a wash basin. Another pipe leaked soap suds into the other wash basin. There was a water puddle in front of the washing machines. The DOM stated the water had been leaking for several weeks. A bath blanket was present on the laundry room floor. The DOM stated the blanket was placed on the floor to absorb the leaking water. The DOM stated the leaking pipes in the laundry room caused water damage to Resident 33, Resident 39, and Resident 72's room. The DOM stated the water damage in Resident 33, Resident 39, and Resident 72's room included loose and damp laminate floor tiles, warped wood on the drawers and closet panels, and wall damage. The DOM stated the leaking water was a safety and infection control risk. During an interview on 1/15/2026 at 12:30 p.m. with the DON, the DON stated the water damage in the residents' rooms can create an infection control concern because the moisture can promote mold and bacteria growth, putting our residents at risk. During a review of the facility P&P titled, General Infection Control, last reviewed 4/24/2025, the P&P indicated, (facility name) is committed to preventing and controlling infections to protect residents, staff, and visitors. Purpose. To provide guidance for infection prevention, monitoring, and control practices, reducing the risk of infection transmission in the facility. During a review of the facility's P&P titled, Infection Control and Prevention dated 12/2023, the policy and procedure indicated, identifying possible infection or potential complications. During a review of the facility's P&P undated, titled General Maintenance and Plant Operations, the P&P indicated maintaining a safe, clean and functional physical environment for resident. All facility systems, equipment and structures shall be maintained in good working order . Preventive maintenance schedules shall be established equipment inspected may include plumbing . 4. During a review of Resident 53's admission Record (AR), the AR indicated the facility admitted the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident on 4/1/2025, and readmitted the resident on 10/14/2025, with diagnoses including dementia (a progressive state of decline in mental abilities), depression (a serious mood disorder causing persistent sadness and loss of interest in activities, affecting how a person feel, think, and handle daily life, unlike normal mood swings), and anxiety disorder (a mental health condition where persistent, excessive worry, fear, or dread about everyday situations interferes with daily life, going beyond normal occasional stress and causing intense physical and emotional symptoms like a racing heart, restlessness, or panic, making it hard to function). During a review of Resident 53's H&P, dated 4/1/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 53's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a state where an individual's mental processes—such as memory, reasoning, attention, language, and problem-solving—are functioning normally without significant impairment or decline). During a review of Resident 53's CP Report titled, Resident has chosen to remain unvaccinated against respiratory syncytial virus (RSV - a common virus that can infect the nose, throat, and lungs, and can make it harder to breathe), last revised on 11/6/2025, the CP indicated an intervention of infection preventionist/designee to provide education to staff regarding monitoring for signs and symptoms and education and procedure to promote decreased risk of exposure to the resident. During a concurrent observation and interview on 1/12/2026 at 10:11 a.m. with LVN 5, inside Resident 53's room, observed Resident 53's clean clothing placed in a clear plastic bag placed on the floor at the right side of the resident's bed. LVN 5 stated the clean clothes inside the clear plastic bag should not be placed on the floor to prevent infection to the resident. LVN 5 stated the clean clothes should have been placed on the resident's closet. During an interview on 1/14/2026 at 2:54 p.m. with the MDSC, the MDSC stated Resident 53's clean clothes placed inside a plastic bag should not have been placed on the floor as the floor is considered contaminated and can cause infection to the resident. During an interview on 1/16/2026 at 10:06 a.m. with the DON, the DON stated the clean clothes of Resident 53 placed inside a clear plastic bag should not be on the floor it should be on their respective assigned cabinets to promote dignity and respect to belongings of the residents, leaving the clean clothes placed inside a clear plastic bag on the floor can cause infection to residents. During a review of the facility's recent P&P titled, General Infection Control Program, last reviewed on 4/24/2025, the P&P indicated the facility is committed to preventing and controlling infections to protect residents, staff, and visitors. The facility maintains an infection control program in accordance with CDC, CMS, and state regulations. During a review of the facility's recent P&P titled, Linen Storage, last reviewed on 4/24/2025, the P&P indicated the facility ensures that all clean and soiled linens are stored, handled, and transported safely to prevent contamination and maintain infection control standards. Proper linen management protects residents, staff, and the environment. Procedure 1.Clean Linen Storage - Clean linens must be stored in designated, dry, well-ventilated areas. - Shelves must be at least 8-12 inches off the floor and away from walls to allow air circulation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During a review of Resident 130's AR, the AR indicate the facility admitted the resident on 1/9/2026, with diagnoses including immunodeficiencies (conditions where the immune system is weakened, missing components, or not functioning properly, reducing the body's ability to fight infections and diseases), urogenital candidiasis (a fungal infection caused by an overgrowth of Candida yeast (most commonly Candida albicans) in the genital or urinary tract), and dependence on renal dialysis (a life-sustaining medical treatment that filters waste, toxins, and excess fluids from the blood when the kidneys can no longer function properly). During a review of Resident 130's H&P, dated 1/12/2026, the H&P indicated the resident cannot make own decisions but can make needs known. During a review of Resident 130's Order Summary Report (OSR), dated 1/12/2026, the OSR indicated an order for enhanced barrier precautions- staff to utilize gowns and gloves for high-contact resident care activities. Every shift for end stage renal disease (ESRD - the final, permanent stage of kidney failure where kidneys function at less than 10–15% of normal capacity) with dialysis. During a review of Resident 130's CP Report titled, Resident requires enhanced barrier precautions to prevent spread of multi-drug-resistant organisms (MDROs, bacteria or germs resistant to multiple common antibiotics, making them difficult or impossible to treat) ., last revised on 1/12/2026, the CP indicated a goal of resident will remain free from signs/symptoms of MDRO infection. During a concurrent observation and interview on 1/12/2026, at 9:30 a.m., with LVN 6, inside Resident 130's room, observed Resident 130's clean clothing placed in a clear plastic bag placed on the floor at the left side of the resident's bed. LVN 6 stated the clean clothes inside the clear plastic bag should not be placed on the floor to prevent infection to the resident. LVN 6 stated the clean clothes should have been placed on the resident's closet. During an interview on 1/14/2026, at 2:54 p.m., with the MDSC, the MDSC stated Resident 130's clean clothes placed inside a plastic bag should not have been placed on the floor as the floor is considered contaminated and can cause infection to the resident. During an interview on 1/16/2026, at 10:06 a.m., with the DON, the DON stated the clean clothes of Resident 130 placed inside a clear plastic bag should not be on the floor it should be on their respective assigned cabinets to promote dignity and respect to belongings of the residents, leaving the clean clothes placed inside a clear plastic bag on the floor can cause infection to residents. During a review of the facility's recent P&P titled, General Infection Control Program, last reviewed on 4/24/2025, the P&P indicated the facility is committed to preventing and controlling infections to protect residents, staff, and visitors. The facility maintains an infection control program in accordance with CDC, CMS, and state regulations. During a review of the facility's recent P&P titled, Linen Storage, last reviewed on 4/24/2025, the P&P indicated the facility ensures that all clean and soiled linens are stored, handled, and transported safely to prevent contamination and maintain infection control standards. Proper linen management protects residents, staff, and the environment. Procedure 1.Clean Linen Storage - Clean linens must be stored in designated, dry, well-ventilated areas. - Shelves must be at least 8-12 inches off the floor and away from walls to allow air circulation. 6. During a review of Resident 122's AR, the AR indicated the facility admitted the resident on (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/2/2023, and readmitted the resident on 7/21/2025, with diagnoses including cellulitis (a skin infection that causes swelling and redness) of the right and left lower limb, cirrhosis of the liver (the permanent scarring (fibrosis) of the liver, where healthy tissue is replaced by scar tissue, making it harder for the liver to function properly, leading to potential liver failure over time), and bullous pemphigoid (a rare, chronic autoimmune disorder, most common in older adults, that causes large, tense, itchy, fluid-filled blisters to form on the skin). During a review of Resident 122's H&P, dated 7/22/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 122's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition. During a review of Resident 122's OSR, dated 7/22/2025, the OSR indicated an order of enhanced barrier precautions- staff to utilize gowns and gloves for high-contact resident care activities related to wounds. During a review of Resident 122's CP Report titled, Resident requires enhanced barrier precautions to prevent the spread of MDROs secondary to wound, last revised on 5/5/2025, the CP indicated a goal of resident will remain free from signs and symptoms of MDRO infection and intervention to o staff to utilize gowns and gloves for high-contact resident care. During a concurrent observation and interview on 1/14/2026, at 8:30 a.m., observed LVN 4 prepare medications in from of Resident 122's room and administered the medication to the resident without wearing a gown. LVN 4 stated he should have worn a gown when he passed the medication to prevent cross-contamination to residents. During an interview on 1/14/2026, at 3:39 p.m., with the MDSC, the MDSC stated LVN 4 should have worn a gown when passing the medication to EBP resident to prevent spread of infection among residents. During an interview on 1/16/2026, at 10:06 a.m., with the DON, the DON stated LVN 4 should have worn a gown while administering medications to Resident 122 to prevent the spread of infection among residents. During a review of the facility's recent P&P titled, Enhanced Barrier Precaution (EBP), last reviewed on 4/24/2026, the P&P indicated the facility implements Enhanced Barrier Precautions (EBP) for residents who are at risk for or have known/suspected transmissible infections. EBP is designed to minimize exposure to infectious agents beyond standard precautions. Purpose To provide clear guidance for preventing infection transmission in residents requiring additional protection measures, while maintaining dignity, safety, and quality of care. Procedure Assessment and Identification - EBP is implemented based on physician's orders, infection control recommendations, and facility protocols. 2. Personal Protective Equipment (PPE) - Staff must wear gloves, gowns, masks, and eye protection as indicated when providing direct care. - PPE is donned before entering the resident area and removed before leaving. - Hand hygiene must be performed before and after all resident contact and after removing PPE. 7. During a review of Resident 4's AR, the AR indicated the facility admitted the resident on 3/13/2017, and readmitted the resident on 11/7/2025, with diagnoses including dementia (a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	progressive state of decline in mental abilities), acute kidney failure (a sudden, rapid, and often reversible loss of kidney function, usually occurring within hours or days), and extrarenal uremia (a functional syndrome where waste products (like urea) build up in the blood due to causes outside the kidney, rather than direct kidney damage). During a review of Resident 4's H&P, dated 5/8/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 4's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (a profound decline in mental abilities—such as memory, reasoning, planning, and understanding—that is severe enough to interfere with daily life, independence, and self-care). The MDS indicated the resident was dependent to needing supervision assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 4's OSR, dated 11/17/2025, the OSR indicated an order of enhanced barrier precautions- staff to utilize gowns and gloves for high-contact resident care activities related to wound. During a review of Resident 4's CP Report titled, Resident requires enhanced barrier precautions to prevent the spread of MDROs secondary to wound, initiated on 6/5/2025, the CP indicated a goal of resident will remain free from signs and symptoms of MDRO infection and intervention to o staff to utilize gowns and gloves for high-contact resident care. During a concurrent observation and interview on 1/13/2026, at 7:02 a.m., with CNA 1 and CNA 4, inside Resident 4's room, observed CNA 1 and CNA 4 transferred Resident 4 from the bed to the wheelchair using a Hoyer lift without

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its antibiotic stewardship program (a coherent set of actions which promote using antimicrobials responsibly) that includes antibiotic (ATB - a medicine that fights bacterial infections by killing bacteria or stopping them from multiplying) use protocols and a system to monitor antibiotic use for three of three sampled residents (Residents 35, Resident 7, and Resident 101) reviewed for antibiotic use by failing to ensure: 1. Resident 35's Cephalexin (also known as Keflex, a type of antibiotic that can treat various bacterial infections) and Fluconazole (a type of antibiotic that can treat various bacterial infections) had monitoring for its adverse effects (an undesired, harmful, or unexpected result caused by a medical treatment, such as a drug, surgery, or intervention). 2. Resident 7's Ertapenem (also known as Ivanz, a type of antibiotic that can treat various bacterial infections) andˆZyvox (also known as linezolid, a type of antibiotic that can treat various bacterial infections) had monitoring for its adverse effects. 3. Resident 101 met the criteria for the use of cephalexin and levofloxacin (a type of antibiotic that can treat various bacterial infections) and there was monitoring for adverse side effects for the ATBs use. These deficient practices placed Resident 35, Resident 7, and Resident 101 at risk for adverse side effects and development resistance to antibiotics which may lead to multidrug resistant organisms (MDRO - organisms primarily bacteria that have developed resistance to multiple classes of antibiotics making infections difficult to treat) resistance to antibiotics. Findings: 1. During a review of Resident 35's admission Record (AR), the AR indicated the facility admitted the resident on 7/13/2010, and readmitted the resident on 12/23/2023, with diagnoses including end stage renal disease (ESRD - the final, permanent stage of kidney [body part that filters blood] failure where kidneys function at less than 10–15% of normal capacity), acute cholecystitis (the sudden swelling, inflammation, and irritation of the gallbladder [body part that stores and releases digestive fluid that breaks down fats], usually caused by a gallstone blocking the flow of bile), and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 35's History and Physical (H&P), dated 11/1/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 35's Minimum Data Set (MDS - a resident assessment tool), dated 12/3/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's mental abilities—such as memory, thinking, reasoning, and judgment—are functioning normally and have not experienced significant decline or impairment). The MDS indicated the resident was on a high-risk drug class antibiotic. During a review of Resident 35's Order Summary Report (OSR), the OSR indicated an order for: 12/8/2025 - Cephalexin Oral Capsule 500 milligrams (mg - a unit of weight) (Cephalexin). Give one (1) capsule by mouth every six (6) hours for right lower leg (RLL) venous wound (a shallow, slow-to-heal open sore that typically develops on the lower leg, usually just above the ankle) infection prophylaxis (ppx - action taken to prevent disease, especially by specified means or against a specified disease) for 10 Days First dose from E-kit (a secured, tamper-evident box or electronic cabinet containing a pre-stocked, limited supply of essential medications and emergency supplies) (Two [2] 250 mg capsules). 10/6/2025 Fluconazole Oral Tablet 150 mg (Fluconazole). Give 150 mg by mouth one time a day every Monday for infection ppx for 2 months. During a review of Resident 35's Resolved Care Plan (CP) Report indicating the resident verbalized urge to void (emptying the bladder) and lower abdominal pain of 3/10 (mild, nagging, or annoying painˆthat is noticeable and distracting but does not prevent you from performing daily activities, working, or sleeping), resolved on 12/19/2025, the CP indicated an intervention of Fluconazole 150 mg once and Keflex 500 mg orally (PO) three times a day (TID) for (X) 5 days and (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fluconazole 150 mg PO once for urinary tract infection (UTI - an infection in any part of the urinary system)/vaginitis (an inflammation of the vagina or vulva, commonly caused by infections) ppx. During a concurrent interview and record review on 1/14/2026, at 2:13 p.m., with the Minimum Data Set Coordinator (MDSC), Resident 35's Medical Diagnosis, OSR, Medication Administration Record (MAR), Progress Notes, and CP were reviewed. The MDSC stated the indication for antibiotic on the use of Fluconazole did not specify what type of infection the facility is trying to prevent. The MDSC also stated the monitoring for adverse effect on the use of Cephalexin and Fluconazole was incomplete. The MDSC stated the licensed staff should be monitoring residents for adverse effects on the use of antibiotics every shift. The MDSC stated the failure of the staff to monitor for adverse effect on the use of antibiotic on the resident can predispose the resident to antibiotic resistance and if there is an adverse reaction to the resident the physician will not be able to mitigate the issue causing undue stress and harm to the resident. During an interview on 1/16/2026 at 10:06 a.m. with the Director of Nursing (DON), the DON stated it was important to monitor for adverse effect on the use of Cephalexin and Fluconazole on Resident 35 to prevent any adverse reactions during the shift and to report to the doctor in a timely manner to mitigate the situation. The DON stated that not monitoring for adverse effect of an antibiotic increases the risk of the resident to antibiotic resistance. During a review of the facility's recent policy and procedure (P&P) titled, Antibiotic Stewardship and Use, last reviewed on 4/24/2025, the P&P indicated to provide safe, effective, and evidenced-based antibiotic therapy while reducing unnecessary or inappropriate antibiotic use in residents. Procedure 1. Assessment and Prescription Orders must include: Drug name and dose Route of administration Duration and frequency Indication for therapy 2. Administration Observe allergic reactions or adverse effects Document administration, dose, and resident response in the EHR. 3. Observationˆ Licensed staff must observe residents for: Side effects (nausea, diarrhea, rash, etc.) Signs of antibiotic resistance or secondary infections ˆ During a review of the facility's recent P&P titled, Monitoring and Management of Adverse Reactions, last reviewed on 4/24/2025, the P&P indicated all residents shall be monitored for adverse reactions to medications, treatments, or foods. Any suspected adverse reactions will be addressed promptly to ensure resident safety. Procedure 1. Monitor Residents a. Observe residents after medication or treatment for signs of adverse reactions. 4. Documentation a. Document the reaction, interventions, and provider notification in the EHR. During a review of the facility-provided Cephalexin Manufacturer's Guidance, undated, the Information indicated a warning and precautions of: - Contraindicated in patients allergic to cephalosporins. - Use caution in penicillin-allergic patients. - Adjust dose in renal impairment. 2. During a review of Resident 7's AR, the AR indicated the facility admitted the resident on 10/2/2024, and readmitted the resident on 11/25/2025, with diagnoses including infection and inflammatory reaction due to indwelling urethral catheter (a thin, hollow tube left inside the body (usually the bladder via the urethra) to continuously drain urine into a collection bag, used when a person can't urinate normally due to retention, incontinence, or for accurate output monitoring during surgery or illness), extended spectrum beta lactamase (ESBL - it is a special enzyme (a type of protein) produced by certain types of bacteria (germs) that makes them highly resistant to many common antibiotics) resistance, and pneumonia (PNA - an infection/inflammation in the lungs). During a review of Resident 7's H&P, dated 11/26/2025, the H&P indicated the resident had the capacity to understand and make decision. During a review of Resident 7's MDS, dated [DATE], the MDS indicated the resident usually had the ability to make self-understood and understand others and had severe cognitive impairment (a profound, often irreversible, loss of mental capacity—comparable to advanced dementia or Alzheimer's—where a person can no longer live independently). The MDS indicated the resident had an indwelling catheter. During a review of Resident 7's OSR, the OSR indicated an order for: 1/30/2025 Ertapenem Sodium Injection Solution Reconstituted (Ertapenem Sodium). Inject 1 gram (gm - a unit of weight) intramuscularly (IM - it is a method of giving medication directly into a large muscle) one time only for Infection (UTI) until 11/30/2025 12:59 Mix with 3.2 milliliters (ml - a unit of (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	volume) lidocaine (medication used to temporarily block pain signals in a specific, localized area of the body) from E-kit. 11/25/2025 Zyvox Oral Tablet 600 mg (Linezolid). Give 1 tablet by mouth two times a day for ATB PNA until 11/28/2025 23:59. During a review of Resident 7's CP Report titled, The resident is on antibiotic therapy., last revised on 11/26/2025, the CP indicated an intervention to administer antibiotic medications as ordered by physician. Monitor/document side effects and effectiveness every (q) shift and to monitor/document/report if needed (PRN) adverse reactions to antibiotic therapy. During a concurrent interview and record review on 1/14/2026 at 2:13 p.m. with the MDSC, Resident 7's Medical Diagnosis, OSR, MAR, Progress Notes, and CP, were reviewed. The MDSC stated the monitoring for adverse effect on the use of Ertapenem and Zyvox was incomplete. The MDSC stated the licensed staff should be monitoring residents for adverse effects on the use of antibiotics every shift. The MDSC stated the failure of the staff to monitor for adverse effect on the use of antibiotic on the resident can predispose the resident to antibiotic resistance and if there is an adverse reaction to the resident the physician will not be able to mitigate the issue causing undue stress and harm to the resident. During an interview on 1/16/2026 at 10:06 a.m. with the DON, the DON stated it was important to monitor for adverse effect on the use of Ertapenem and Zyvox on Resident 7 to prevent any adverse reactions during the shift and to report to the doctor in a timely manner to mitigate the situation. The DON stated that not monitoring for adverse effect of an antibiotic increases the risk of the resident to antibiotic resistance. During a review of the facility's recent P&P titled, Antibiotic Stewardship and Use, last reviewed on 4/24/2025, the P&P indicated to provide safe, effective, and evidenced-based antibiotic therapy while reducing unnecessary or inappropriate antibiotic use in residents. Procedure 1. Assessment and Prescription Orders must include: Drug name and dose Route of administration Duration and frequency Indication for therapy 2. Administration Observe allergic reactions or adverse effects Document administration, dose, and resident response in the EHR. 3. Observationˆ Licensed staff must observe residents for: Side effects (nausea, diarrhea, rash, etc.) Signs of antibiotic resistance or secondary infections ˆ During a review of the facility's recent P&P titled, Monitoring and Management of Adverse Reactions, last reviewed on 4/24/2025, the P&P indicated all residents shall be monitored for adverse reactions to medications, treatments, or foods. Any suspected adverse reactions will be addressed promptly to ensure resident safety. Procedure 1.Monitor Residents a. Observe residents after medication or treatment for signs of adverse reactions. 4.Documentation a. Document the reaction, interventions, and provider notification in the EHR. During a review of the facility-provided Cephalexin Manufacturer's Guidance, undated, the Information indicated a warning and precautions of: - Contraindicated in patients allergic to cephalosporins. - Use caution in penicillin-allergic patients. - Adjust dose in renal impairment. During a review of the facility-provided Highlights of Prescribing Information (HPI) on the use of Ivanz (ertapenem for injection), for intravenous or intramuscular use, with initial U.S. approval in 2001, the HPI indicated warnings and precautions of: - Serious hypersensitivity (anaphylactic) reactions have been reported in patients receiving B-lactams (a type of antibiotic). - Seizures (a sudden, temporary burst of uncontrolled electrical activity in the brain that disrupts its normal, everyday functioning) and other central nervous system adverse experiences have been reported during treatment. - Clostridioides difficile (also known as C-diff, a type of bacteria)-associated diarrhea (ranging from mild diarrhea to fatal colitis): Evaluate if diarrhea occurs. ˆ During a review of the facility-provided HPI on the use of Zyvox (linezolid) injection, for intravenous use, Zyvox (linezolid) tablets, for oral use, Zyvox (linezolid) for oral suspension, with initial U.S. approval in 2000, the HPI indicated warnings and precautions of: - Clostridioides difficile-Associated Diarrhea: Evaluate if diarrhea occurs. - Potential interactions producing elevation of blood pressure: monitor blood pressure. - Rhabdomyolysis (serious, potentially life-threatening medical condition involving the rapid breakdown of damaged skeletal muscle tissue): If signs or symptoms of rhabdomyolysis are observed, discontinue ZYVOX and initiate appropriate therapy. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 101's AR, the AR indicated the facility originally admitted the resident on 3 8/2024 and readmitted in the facility on 10/16/2025 with diagnoses including chronic pain syndrome, anxiety disorder (a mental health condition where excessive fear and worry interfere with daily life, causing significant distress), and polyneuropathy (a disorder affecting multiple nerves in the body causing numbness, pain, and weakness). During a review of Resident 101's History and Physical (H&P), dated 5/4/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 101's MDS, dated [DATE], the MDS indicated Resident 101 had an intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand others and make his needs known. The MDS indicated Resident 101 received antibiotic. During a review of Resident 101's Order Summary Report dated 1/16/2026, the Order Summary Report indicated the following physician's orders: 1/7/2026: cephalexin (Keflex) oral capsule 250 mg, give two (2) capsules by mouth one time only for cellulitis (a skin infection that causes swelling and redness) of left elbow until 1/7/2026 10:59 a.m. dose from emergency kit. 1/7/2026: cephalexin 500 mg oral capsule give 1 capsule by mouth 3 times a day for cellulitis of left elbow for seven (7) days. 1/12/2026: levofloxacin 500 mg give 1 tablet by mouth in the evening for infection of the left elbow and increased white blood cell (WBC - a part of the immune system that protects the body from infection) for 7 days. During a review of Resident 101's care plans (CP) titled: Left elbow cellulitis, initiated on 1/7/2026, the CP indicated Keflex 500 mg 3 times a day for 7 days and monitor for any adverse effects of antibiotic therapy and notify the physician as a few of the interventions to resolve the resident's signs and symptoms and to be free from complications. The resident is on antibiotic therapy levofloxacinˆtablet 500 mg give 1 tablet by mouth in the evening for infection of the left elbow and increased WBC for 7 days, initiated on 1/12/2026, the CP indicated to administer antibiotic as ordered by the physician and to monitor and document side effects and effectiveness every shift as a few of the interventions to minimize the resident's risk for any discomfort or adverse side effects of antibiotic therapy. During a concurrent observation and interview on 1/12/2026 at 9:36 a.m. inside Resident 101's room, Resident 101 stated he is currently taking an antibiotic for swelling and yellow colored lesion on his left elbow. Resident 101 stated it has been 1 week since the lesion started, but it did not have an opening, and the swelling was less as evidenced by the presence of dry skin around the yellow lesion. Resident 101 denied any pain or tenderness around the area. During an interview on 1/13/2026 at 6:53 a.m. with Licensed Vocational Nurse (LVN) 12, LVN 12 stated if residents are on antibiotic therapy, licensed nurses (LNs) are supposed to monitor the residents for adverse side effects every shift for the duration of the therapy plus another 3 days and document in the progress notes as the residents could have adverse reactions. LVN 12 stated if the residents are not monitored every shift for adverse reactions, it could result in a delay in physician notification resulting in a delay in resident care. During an interview on 1/14/2026 at 3:27 p.m. with the Infection Preventionist (IP), Resident 101's Surveillance Data Collection Form, dated 1/7/2026, for the use of cephalexin for cellulitis of the left elbow was reviewed. The IP stated when a resident receives an order for antibiotic, she usually checks the following day if the resident meets the criteria by using the Surveillance Data Collection Form and notifying the physician. The IP stated she checks the physician's order, the eInteract Change of Condition (also known as COC, a communication tool used by healthcare workers when there is a change of condition among the residents) form, and any applicable tests or laboratory results. The IP stated Resident 101's Surveillance Data Collection Form indicated Resident 101 had swelling on the left elbow and the temperature was 98.1 degrees Fahrenheit (F - a unit of measurement for temperature). The IP stated Resident 101 did not meet the criteria for the use of cephalexin as the resident has to meet the required 4 signs and symptoms sub criteria. The IP stated if Resident 101 did not meet the criteria for the use of cephalexin it placed the resident at risk for development of resistance to a lot of antibiotics which may lead to development of MDRO. During a follow up interview on 1/16/2026 at 9:30 a.m. with the IP, Resident 101's Surveillance Data Collection Form for (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the use of levofloxacin for infection of the left elbow and increased WBC, dated 1/13/2026, and Resident 101's laboratory results were reviewed. The IP stated she discontinued Resident 101's levofloxacin on 1/15/2026 after speaking with the physician that the resident did not meet the criteria. The IP stated the physician should have been notified as soon as the order was received that Resident 101 did not meet the criteria for the levofloxacin while there was still an active order for the cephalexin. The IP stated the last WBC result for Resident 101 was 10/25/2025. The IP stated the nurse who received the order for levofloxacin should have notified the physician that there was no current WBC result for Resident 101. The IP stated not notifying the physician timely about Resident 101 not meeting the criteria placed Resident 101 at risk for development of MDROs which makes it harder to treat other infections in the future. During a concurrent interview and record review on 1/16/2026 at 10:28 a.m. with the MDSC, Resident 101's physician orders, CP, progress notes, COC form, dated 1/7/2026, laboratory results, and Surveillance Data Collection Forms for cephalexin and levofloxacin were reviewed. a. The MDSC stated Resident 101 had a physician's order for cephalexin 500 mg oral capsule give 1 capsule by mouth 3 times a day for cellulitis of left elbow for 7 days, the CP indicated to monitor for adverse effect of the antibiotic therapy and notify the physician. The MDSC stated the Surveillance Data Collection Form dated 1/7/2026 indicated Resident 101 met only 1 criterion out of 4 required signs and symptoms sub criteria for the use of cephalexin. The MDSC stated the Surveillance Data Collection Form indicated that 1 of the 4 sub criteria is 1 of the constitutional criteria indicated in the back such as fever of above 100 F, increased WBC, acute changes in mental status, and acute decline with ADLs. The MDSC stated the COC form dated 1/7/2026 indicated Resident 101's temperature was 98.1 F, vital signs are within range and had no complaints of pain or discomfort. The MDSC stated Resident 101 did not meet the criteria for the use of cephalexin for cellulitis of the left elbow and the physician should have notified. The MDSC stated continued use of the antibiotic if Resident 101 does not meet the criteria placed Resident 101 at risk for resistance to multiple types of antibiotics which makes future infections difficult to treat. The MDSC stated there was no documentation that Resident 101was monitored for adverse side effects of cephalexin on 1/7/2026 3 p.m. to 11 p.m. shift, 1/8/2026 7 a.m. to 3 p.m. shift and 3 p.m. to 11 p.m. shift, 1/11/2026 11 p.m. to 7 a.m. shift, 1/12/2026 11 p.m. to 7 a.m. shift and 1/13/2026 7 a.m. to 3 p.m. shift. The MDSC stated the LNs are supposed to monitor residents on antibiotics every shift for the duration of the therapy plus another 3 days to ensure there were no adverse side effects and document in the progress notes. The MDSC stated the LNs should have monitored Resident 101 for any adverse side effects for the use of cephalexin as Resident 101 could have adverse reaction, which could result in delay in physician notification and cause delay in resident care. b. The MDSC stated Resident 101 had a physician's order for levofloxacin 500 mg give 1 tablet by mouth in the evening for infection of the left elbow and increased WBC for 7 days, the CP indicated to monitor and document side effects and effectiveness every shift. The MDSC stated the Surveillance Data Collection Form, dated 1/13/2026, indicated Resident 101 met only 1 criterion out of 4 required signs and symptoms sub criteria for the use of levofloxacin. The MDSC stated the Surveillance Data Collection Form indicated that 1 of the 4 sub criteria is 1 of the constitutional criteria indicated in the back such as fever of above 100 F, increased WBC, acute changes in mental status, and acute decline with ADLs. The MDSC stated the COC form dated 1/13/2026 indicated Resident 101's temperature was 97.2 F, and Resident 101 did not complain of any pain or discomfort. The MDSC stated the last laboratory result for WBC for Resident 101 was 10/25/2025. The MDSC stated Resident 101 did not meet the criteria for the use of levofloxacin for infection of the left elbow and increased WBC and the physician should have been notified timely. The MDSC stated continued use of the antibiotic if Resident 101 does not meet the criteria, it placed Resident 101 at risk for resistance to multiple types of antibiotics which makes future infections difficult to treat. The MDSC stated there was no documentation that Resident 101 was monitored for adverse side effects of levofloxacin on 1/12/2026 11 p.m. to 7 a.m. shift and 1/13/2026 7 a.m. to 3 p.m. shift. The MDSC stated the LNs are (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	supposed to monitor residents on antibiotics every shift for the duration of the therapy plus another 3 days to ensure there were no adverse side effects and document in the progress notes. The MDSC stated the LNs should have monitored Resident 101 for any adverse side effects for the use of levofloxacin as Resident 101 could have adverse reaction, which could result in delay in physician notification and cause delay in resident care. During an interview on 1/16/2026 at 4:30 p.m. with the DON, the DON stated the LNs are supposed to monitor residents on antibiotic therapy every shift for the duration of the antibiotic plus another 3 days and document in the progress notes to ensure the residents were not experiencing any adverse effects. The DON stated residents with new orders for antibiotic are screened by the IP the day the order was received or the next business day if the use of antibiotic therapy is appropriate using the Surveillance Data Collection Form. The DON stated that if a resident did not meet the criteria the physician should be notified and document in the progress notes the physician's response. The DON stated the LNs should have monitored Resident 101 for adverse side effects of cephalexin and levofloxacin every shift and documented in the progress notes as Resident 101 could have adverse reaction during the shift, which could result in delay in physician notification leading to a delay in the care the resident needed. The DON stated that the physician should have been notified by the LNs who received the order that Resident 101 did not meet the criteria for cephalexin and levofloxacin as the resident can develop resistance to most antibiotics. During a review of the facilities policy and procedure (P&P) title, Surveillance for Infections, last reviewed on 4/24/2025, the P&P further indicated that the IP or designated infection control personnel is responsible for gathering and interpreting surveillance data. The P&P further indicated: The surveillance should include a review of any or all of the following information to help identify possible indicators of infections: a. Laboratory records b. Skin care sheets c. Infection control rounds or interviews d. Verbal reports from staff e. Infection documentation records f. Temperature logs g. Pharmacy records h. Antibiotic review i. Transfer log/summaries During a review of the facility's P&P titled, Antibiotic Stewardship, last reviewed on 4/24/2025, the P&P indicated that antibiotics will be prescribed and administered under the guidance of the facility's Antibiotic Stewardship Program (ASP). The P&P further indicated: The ASP monitors the use of antibiotics in the residents. Orientation, training and education of staff will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects individual residents and the overall community. During a review of the facility's P&P titled, Antibiotic Stewardship and Use, last reviewed on 4/24/2025, the P&P indicated: The facility promotes appropriate use of antibiotics to treat infections, prevent antimicrobial resistance, and ensure resident safety. Antibiotics are used only when clinically indicated and in accordance with physician orders, facility protocols, and current clinical guidelines. The facility provides safe, effective, and evidence-based antibiotic therapy while reducing unnecessary or inappropriate use of antibiotics in residents. Orders must include the drug name and dose, route of administration, duration and frequency, and indication for therapy Observe the residents for allergic reactions or adverse effects. Document administration, dose, and resident response in the EHR. Licensed staff must observe residents for side effects (nausea, diarrhea, rash, etc.), signs of antibiotic resistance or secondary infections. Report any adverse reactions immediately to the prescribing provider. Discontinue or adjust therapy according to culture and sensitivity results, clinical response, and physician or interdisciplinary team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the patients) recommendations. Antibiotic use is monitored monthly by the IDT and Quality Assurance and Performance Improvement team. Metrics include appropriateness of therapy, duration of compliance, and adverse reactions. Non-compliance triggers corrective action, retraining, and policy review. During a review of the facility's P&P titled, Monitoring and Management of Adverse Reactions, last reviewed on 4/24/2025, the P&P indicated all residents shall be monitored for adverse reactions to medications, treatments, or foods. Any suspected adverse reactions will be addressed promptly to ensure resident safety. The P&P further indicated: Observe residents after medication or treatment for (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	signs of adverse reactions. Document the reaction, interventions, and provider notification in the EHR. During a review of the facility-provided manufacturer's guideline for cephalexin, undated, the manufacturer's guideline indicated the following warning and precautions: Contraindicated in patients allergic to cephalosporins. Use caution in penicillin-allergic patients. Adjust dose in renal impairment.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a functional and sanitary environment when water leaks were present in the laundry area, active water leaks from pipes resulting in wet floors a bath blanket used to soak up leaked water and wash basins placed under leaking pipes to catch water and soap suds. This deficient practice created a potential risk for slips, falls, and unsanitary conditions and had the potential to affect residents, staff and visitors. Cross-reference F584 and F880. Findings: During a concurrent observation and interview on 1/14/2025 at 12 p.m. with the Director of Maintenance (DOM), Resident 33, Resident 39, and Resident 72's room was observed with loose floorboards. The DOM pulled out a closet drawer containing a white substance. The DOM stated the closet drawer is dirty and stated the white substance was a result of water damage and can be a potential infection control issue for the residents in the room. During a concurrent observation and interview on 1/14/2026 at 2:30 p.m. with the Director of Maintenance (DOM), the laundry room was observed. There were two wash basins on the laundry room floor placed under leaking pipes. One pipe leaked water into a wash basin. Another pipe leaked soap suds into the other wash basin. There was a water puddle in front of the the washing machines. The DOM stated the water had been leaking for several weeks. A bath blanket was present on the laundry room floor. The DOM stated the blanket was placed on the floor to absorb the leaking water. The DOM stated the leaking pipes in the laundry room caused water damage to Resident 33, Resident 39, and Resident 72's room. The DOM stated the water damage in Resident 33, Resident 39, and Resident 72's room included loose and damp laminate floor tiles, warped wood on the drawers and closet panels, and wall damage. The DOM stated the leaking water was a safety and infection control risk. During a review of maintenance work orders logs dated 12/7/2025 and 1/6/2026 the logs indicated, please check pipe leaking in the laundry, type of repair dated 12/7/2025 indicated, checked and tightened clamp fixed. During an interview on 1/15/2026 at 12:30 p.m. with the DON, the DON stated the water damage in the residents' rooms can create an infection control concern because the moisture can promote mold and bacteria growth, putting our residents at risk. During a review of the facility P&P titled, General Infection Control, last reviewed 4/24/2025, the P&P indicated, (facility name) is committed to preventing and controlling infections to protect residents, staff, and visitors. Purpose. To provide guidance for infection prevention, monitoring, and control practices, reducing the risk of infection transmission in the facility. During a review of the facility's policy and procedure (P&P) titled, Infection Control and Prevention dated 12/2023, the policy and procedure indicated, identifying possible infection or potential complications. During a review of the facility's policy and procedure (P&P) undated, titled General Maintenance and Plant Operations, the P&P indicated maintaining a safe, clean and functional physical environment for resident. All facility systems, equipment and structures shall be maintained in good working order . Preventive maintenance schedules shall be established equipment inspected may include plumbing .

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the food services department when a fly (a type of insect) was observed flying around the trayline (an area where foods were assembled from the steamtable to resident's plate), dishwashing area, and food storage area during lunch service.This failure had the potential to result in 130 of 132 residents, who received food from the kitchen, to acquire food borne illnesses (illness caused by consuming contaminated foods or beverages) by consuming potentially contaminated food.Findings: During an observation on 2/27/2026 at 11:12 a.m. of the dishwashing area, observed a fly flying around the area.During an observation on 2/27/2026 at 11:38 a.m. of the food storage area, observed a fly flying around the area. Observed the back door open.During a concurrent observation and interview on 2/27/2026 at 12:04 p.m. of the trayline area with the Dietary Supervisor (DS), observed a fly flying around the area. The DS stated there was a fly flying around the trayline area and he (DS) was trying to drive it away from the area.During an observation on 2/27/2026 at 1:11 p.m., of the trayline, observed a fly flying around trayline. During an interview on 2/27/2026 at 1:12 p.m. with the DS, the DS stated the facility should not have flies in the kitchen because the fly might end up falling on the food and could cause cross-contamination (transfer of harmful bacteria from one place to another). The DS stated residents could get sick of diarrhea, stomach pain, and stomach issues as a potential outcome of cross-contamination. During a review of the facility's policy and procedure (P&P) titled Pest Control Policy, dated 4/24/2025, the P&P indicated the facility is committed to maintaining a clean, safe, and sanitary environment that is free from pests. An effective pest control program is implemented to protect the environmental safety of residents, staff, visitors, and food service operations, while complying with all applicable federal, state and local regulations. The P&P further indicated Purpose: To prevent, monitor, and control pests in all areas of the facility using safe, effective, and environmentally responsible methods. This policy applies to all departments, including resident care areas, dietary services, storage areas, office and common spaces.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained a resident's dignity for one (1) of 1 sampled resident (Resident 39) reviewed for dignity by failing to ensure Certified Nursing Assistant (CNA) 8 was not standing over the resident while assisting the resident during mealtime. This deficient practice had the potential to negatively affect Resident 39's psychosocial wellbeing. Findings: During a review of Resident 39's admission Record, the admission Record indicated the facility originally admitted Resident 39 on 7/21/2015 and readmitted in the facility on 6/2/2018 with diagnoses including dementia (a progressive state of decline in mental abilities), diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), and muscle wasting and atrophy (weakening, shrinking, and loss of muscle). During a review of Resident 39's History and Physical (H&P), dated 5/4/2025, the H&P indicated Resident 39 had the capacity to understand and make decisions. During a review of Resident 39's Minimum Data Set (MDS - a resident assessment tool), dated 12/5/2025, the MDS indicated Resident 39 was able to understand others and make her needs known but had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 39 required substantial/maximal assistance with eating. During a concurrent observation and interview on 1/12/2026 at 1:16 p.m. with CNA 8, inside Resident 39's room, Resident 39 was lying in bed with the head of the bed elevated to seat the resident in an upright position. Observed CNA 8 assisting Resident 39 with lunch while standing over the resident. CNA 8 stated staff should be sitting at eye level while assisting residents with eating to respect the dignity of the residents. CNA 8 stated that she forgot to get a chair and that she should be sitting at eye level while assisting the resident with eating to respect Resident 39's dignity. During a concurrent observation and interview on 1/12/2026 at 1:18 p.m. with Licensed Vocational Nurse (LVN) 10, outside Resident 39's room with LVN 10, LVN 10 stated CNA 8 was standing over the resident while assisting Resident 39 with eating lunch. LVN 10 stated staff should be sitting at eye level while assisting the residents with eating as it was a dignity issue. LVN 10 stated CNA 8 should have grabbed a chair and sat at eye level while feeding Resident 39 to preserve the resident's dignity and also for resident safety to ensure the resident was not exhibiting signs of choking or coughing. During a concurrent interview and record review on 1/16/2026 at 10:08 a.m. with the MDS Coordinator (MDSC), Resident 39's MDS was reviewed. The MDSC stated that Resident 39 required substantial/maximal assistance with eating. The MDSC stated that the staff should be assisting the residents with eating at eye level and sitting down. The MDSC stated it was important that the staff sit at eye level while assisting the residents with eating to preserve the residents' dignity and to closely observe or monitor if the resident was chewing the food properly and/or if there were signs of choking or aspiration (the accidental inhalation of foreign material into the lungs). The MDSC stated CNA 8 should have grabbed a chair and sat down while assisting Resident 39 with eating for safety and dignity. During a review of the facility's policy and procedure (P&P) titled, Dignity, last reviewed on 4/24/2025, the P&P indicated the facility affirms each residents rights to be treated with dignity and respect, in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feeling of self-worth and self-esteem. The P&P further indicated: - Every resident is treated with dignity, respect, and consideration, and is supported on maintaining individuality, self-worth, and quality of life. - The facility shall avoid behaviors or practices that demean, humiliate, or infantilize residents. - All staff shall uphold resident dignity in all interactions and care activities. During a review of the facility's P&P titled, Feeding Assistance Policy, last reviewed on 4/24/2025, the P&P indicated that the facility ensures residents who need help with eating receive safe, respectful assistance that supports nutrition, hydration, and dignity. The P&P further indicated: - Feeding assistance is provided in a safe, patient, and respectful manner. - Proper (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	positioning, food consistency, and pacing are followed. - Staff providing feeding assistance receive appropriate training. - Residents are observed for choking or distress.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to keep the call light (an alerting device for nurses or other nursing personnel to assist a patient when in need) within reach of one of two sampled residents (Resident 94) reviewed under environment task. The deficient practice had the potential to result in the resident`s inability to summon health care worker for help as needed. Findings: During a review of Resident 94's admission Record (AR), the AR indicated the facility admitted the resident on 1/20/2024, and readmitted the resident on 7/20/2025, with diagnoses including muscle weakness, history of falling, and cognitive communication deficit (trouble participating in conversations). During a review of Resident 94's History and Physical (H&P), dated 7/22/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 94's Minimum Data Set (MDS, a resident assessment tool), dated 10/10/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's brain is functioning normally, without any significant decline or impairment in thinking, memory, or reasoning). The MDS indicated the resident required substantial to set up assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 94's Fall Risk Evaluation (FRE), dated 1/11/2026, the FRE indicated the resident was high risk for falls. During a review of Resident 94's Care Plan (CP) Report titled, The resident is high risk for falls related to (r/t) gait (the movement a person undertake when walking)/balance problems, hypotension (low blood pressure), unaware of safety needs, vision/hearing problems, last revised on 10/31/2025, the CP indicated an intervention to be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. During a concurrent observation and interview on 1/12/2026, at 10 a.m., with Restorative Nursing Assistant (RNA) 1, inside Resident 94's room, observed Resident 94's call light button was on the floor. RNA 1 stated the call light should always be within the reach of the resident so they can call for help when needed. During an interview on 1/14/2026, at 3:07 p.m., with the Minimum Data Set Coordinator (MDSC), the MDSC stated the call light of Resident 94 should always be within the reach of the resident so they can call for assistance. The MDSC stated the failure of the staff to keep the call light within reach can predispose the resident to accident such as a fall while reaching for them. During an interview on 1/16/2026, at 10:06 a.m., with the Director of Nursing (DON), the DON stated the staff should have kept the call light within the reach of Resident 94 to ensure the resident can call for help if needed. The DON stated it was everyone's responsibility to ensure the call light is within reach. They should be checking their placement every time they are rounding on the residents. The DON added the resident can fall while reaching for the call light button on the floor that can cause injury to the resident. During a review of the facility's recent policy and procedure (P&P) titled, Resident Call Light Use and Monitoring, last reviewed on 4/24/2025, the P&P indicated the facility ensures that all residents have ready access to call light systems to request assistance. Staff are responsible for promptly responding to call lights to ensure resident safety, comfort, and quality of care. Procedure 1. Call Light Availability - Each resident room must have a functional call light within reach of the resident's bed and bathroom. - Call lights must be checked at the beginning of each shift and after any maintenance or repair.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to ensure resident's medical records were updated to show documented evidence that advance directives (a legal document indicating resident preference on end-of-life treatment decisions) were discussed with one of three sampled residents (Resident 14) reviewed for advance directive by failing to provide the advance directive formulation information to the resident or the resident representative (RP). The deficient practice violated the resident's rights and/or representative's right to be fully informed of the option to formulate their advanced directives. Findings: During a review of Resident 14's admission Record (AR), the AR indicated the facility admitted the resident on 4/18/2023, and readmitted the resident on 12/22/2025, with diagnoses including depressive episodes (a period of at least two weeks characterized by a persistent, intense low mood, loss of interest in activities (anhedonia), and low energy, which significantly interferes with daily life) and anxiety disorders (mental health conditions involving excessive, persistent, and uncontrollable fear or worry that goes beyond normal, everyday stress). During a review of Resident 14's History and Physical (H&P), dated 12/24/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 14's Minimum Data Set (MDS, a resident assessment tool), dated 10/31/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had severe cognitive impairment (a profound, often irreversible, loss of mental capacity-comparable to advanced dementia or Alzheimer's-where a person can no longer live independently). The MDS indicated that the resident and family participated in the assessment and goal setting of care. During a review of Resident 14's Advance Directive Acknowledgement Form (ADAF), dated 4/25/2023, the ADAF had missing initials of the resident or representative on the following statements: 1. I have been given written materials about my right to accept or refuse medical treatments. 2. I have been informed of my rights to formulate Advance Directives. 3. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this care facility. 4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law. The ADAF indicated the resident have not executed an Advance Directive. The form was not signed; it just indicated RP via phone interdisciplinary team (IDT, is a group of professionals from different fields-such as doctors, nurses, social workers, and therapists-who work together, sharing information to create and implement a single, comprehensive care plan for a patient). During a concurrent interview and record review on 1/14/2026 at 1:01 p.m., with Social Services Specialist (SSS) 1, Resident 14's ADAF was reviewed. SSS 1 stated the form was not completed as the initials of the resident or resident representative was missing on the statement clause of the Form, the signature of the resident or representative was not affixed on the form. SSS 1 stated it was important to have the clause statements initialed by the resident or representative to ensure the information was provided to them. SSS 1 stated their failure to complete the ADAF had violated the resident's right to formulate an advance directive since they were not sure if the information was provided to the resident or representative. During a concurrent interview and record review on 1/14/2026, at 1:30 p.m., with the Minimum Data Set Coordinator (MDSC), reviewed Resident 14's ADAF. The MDSC stated the form was obsolete and there were missing initials of the resident or representative on the ADAF that can support if the required information for advance directive formulation was provided to the resident or representative. The MDSC stated the ADAF should have been initialed and signed by the resident or representative to ensure the information was provided to them. During a concurrent interview and record review on 1/16/2026, at 10:06 a.m., with the Director of Nursing (DON), reviewed Resident 14's ADAF, and policy titled, Advanced Healthcare Directive. The DON stated that Resident 14`s ADAF was missing initials of the resident or representative acknowledging the advance healthcare formulation information was provided to them. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON stated Resident 14`s ADAF was not signed. The DON stated the failure of the staff to complete the ADAF had violated the right of the resident to formulate an advance directive and it was not aligned with their policy regarding wet signature attestation of the ADAF. During a review of the facility's recent policy and procedure (P&P) titled, Advance Healthcare Directive, last reviewed on 4/24/2025, the P&P indicated the facility respects resident rights to make healthcare decisions, including end-of-life care, through Advance Healthcare Directives (AHDs). The facility ensures that all residents and/or responsible parties are informed, documented, and supported in their healthcare choices. Purpose To: - Ensure resident's healthcare preferences are documented and honored - Comply with federal and state regulations regarding advance directives - Facilitate communication between residents, families, and care team Procedure 1. Discussion and Education - Social Services and Nursing staff provide information, answer questions, and offer forms. 2. Documentation - Document the discussion, resident/family decisions, and consent/refusal in the resident record. During a review of the facility's recent P&P titled, Advance Directive Acknowledgement Form and EHR Documentation Policy, last reviewed on, the P&P indicated the facility is committed to ensuring that all residents' rights regarding advance directives are respected and documented in compliance with federal and state regulations. Every resident has the right to make decisions regarding their medical care, including the completion of advanced directives. Proper documentation of discussions and acknowledgement form is the Electronic Health Record (EHR) is required to maintain compliance and continuity of care. Purposeˆ To establish clear guidelines for the timely documentation of Advance Directive Acknowledgement Forms following discussion with residents, families, or responsible representatives. DEFINITIONS - Acknowledgement Form: Form signed by the resident and/or responsible representative confirming that the facility has provided information about advance directives and the resident's rights. POLICY GUIDELINES 2. Completion of Acknowledgement Form - The resident or responsible representative shall sign the Advance Directive Acknowledgement Form to confirm the discussion has taken place - If a resident declines to complete or sign, the refusal must be documented in the EHR.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to document a significant change of condition (COC, isˆthe formal written record of any significant, non-temporary change in a resident's physical, mental, or emotional healthˆ[e.g., sudden confusion, falls, weight loss]) on a resident's physical condition that had deteriorated for one of three sampled residents (Resident 81) by failing to do a change of condition documentation on a resident that was sent to the emergency room (ER) for right lower leg (RLL) venous ulcer (aˆshallow, slow-healing open soreˆthat typically forms on the lower leg, usually around the ankle) with green exudate (a thick, protein-rich fluid that oozes out of blood vessels and collects in nearby tissues during inflammation, injury, or infection), fouls smell, with serosanguinous (a common type of fluid that drains from a healing wound, incision, or injury) drainage on 12/21/2025. This deficient practice had violated the resident's responsible party's right to be informed of the care services provided. Findings: During a review of Resident 81's admission Record (AR), the AR indicated the facility admitted the resident on 6/2/2023, and readmitted the resident on 12/31/2025, with diagnoses including cellulitis (a skin infection that causes swelling and redness) of the right and left lower limb and acute osteomyelitis (inflammation of bone or bone marrow, usually due to infection) of the left ankle and foot. During a review of Resident 81's History and Physical (H&P), dated 1/2/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 81's Minimum Data Set (MDS, a resident assessment tool), dated 9/3/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (having a sound mind or sharp thinking). The MDS indicated the resident had two venous and arterial ulcers (a painful, open sore that develops on the skin, usually on the lower legs, feet, or toes, due to a severe lack of oxygen-rich blood reaching that area). During a review of Resident 81's Progress Notes (PN), dated 12/21/2025, the PN indicated during routine treatment, RLL venous ulcer was observed with green exudate and foul smell with serosanguinous drainage. The physician was notified and advised to send the resident to ER for further evaluation. Endorsed to Registered Nurse (RN) supervisor. During a concurrent interview and record review on 1/14/2026 at 3:22 p.m., with the Minimum Data Set Coordinator (MDSC), reviewed Resident 81's Medical Diagnosis, COC, and PN. The MDSC stated that Resident 81 was transferred to the ER for RLL venous ulcer with green exudate, fouls smell, and serosanguinous drainage on 12/21/2025. The MDSC stated she (MDSC) cannot find the COC for Resident 81 on 12/21/2025. The MDSC stated the COC entails identifying the changes in the resident's health status, obtaining vital signs, assessment for mental status or behavior, documentation of skin changes, immediate action taken, and the notification of the primary physician and the resident representative of the change in condition of the resident. The MDSC stated she (MDSC) did not find all the components mentioned in the PN. The MDSC stated it was important to do a COC on Resident 81 to have a complete account of what happened that day and for notification of the physician to intervene appropriately and to honor the resident representative's right for informed care of their family member. During an interview on 1/16/2026 at 10:06 a.m., with the Director of Nursing (DON), the DON stated the licensed staff should have done a COC on Resident 81, when the resident got sent to ER for RLL venous ulcer with green exudate, fouls smell, and serosanguinous drainage on 12/21/2025 to ensure safe transfer to the receiving facility. The DON stated during COC, residents are assessed, and interventions are placed to mitigate the situation, the COC documents the full account of the events and the people involved during the significant event. The DON stated the licensed staff did not follow their policy for COC. The DON stated the failure of the licensed staff to do COC on Resident 81 had placed the resident at risk for unaccounted information necessary to understand the resident's significant change in condition and had violated the right of the resident representative to informed care. During a review of the facility's recent policy and procedure titled, Change in Condition, last reviewed on 4/24/2025, the P&P (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated the facility will promptly recognize, assess, and respond to any change in a resident's physical, cognitive, or emotional condition to ensure timely medical interventions and maintain resident safety. Procedure 1. Recognition a. All staff must observe and report any changes in resident status, including but not limited to: i. Vital Signs ii. Mental status or behavior iii. Skin changes, wounds, or pressure injuries iv. Appetite, hydration, or intake changes v. Mobility or functional ability 1. Immediate Action a. Licensed nursing staff shall assess the resident promptly. b. Notify the physician or authorized practitioner according to severity and facility protocol. c. Implement immediate interventions as needed to stabilize the resident. 1. Documentation a. Document the change, assessment, interventions, and provider notifications in the HER or medical records. 1. Communication a. Inform the resident and/or responsible party of changes per facility policy.

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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 interview, and record review, the facility failed to develop and implement a baseline care plan (an initial, temporary care document that is developed within 48 hours of a resident's admission, providing essential, person-centered care instructions to staff to ensure safety and continuity of care while a more comprehensive plan is developed) on the use of Duloxetine (a medication to treat depression [a mood disorder that causes a persistent feeling of sadness and loss of interest]) for one of one sampled resident (Resident 130) reviewed for the use of antidepressant medication (prescription medications designed to treat depression, anxiety, and other mood disorders by balancing chemicals in the brain). The deficient practice had a potential for adverse effects (an undesired effect of a drug or other type of treatment, such as surgery) of the use of psychotropic medications (medications that affect the mind, emotions, and behavior) on residents. Findings: During a review of Resident 130's admission Record (AR), the AR indicated the facility admitted the resident on 1/9/2026, with diagnoses including depression, abnormalities of gait (the movement a person undertake when walking) and mobility, and muscle weakness. During a review of Resident 130's History and Physical (H&P), dated 1/12/2026, the H&P indicated the resident did not have the ability to make decisions but can make needs known. During a review of Resident 130's Order Summary Report (OSR), dated 1/9/2026, the OSR indicated an order for Duloxetine HCl oral capsule delayed release sprinkle 30 milligrams (mg, a unit of weight) (Duloxetine HCl). Give 30 mg by mouth in the morning for depression monitor for behavior (m/b) verbalization of sadness. During a concurrent interview and record review on 1/14/2026 at 11 a.m., with the Minimum Data Set Coordinator (MDSC), reviewed Resident 130's Medical Diagnosis, OSR, and Care Plan. The MDSC stated there was an order for Duloxetine on Resident 130. However, there was no baseline care plan developed and implemented on the resident. The MDSC stated it was important to develop and implement a baseline care plan on the use of Duloxetine, a psychotropic medication, to know what the plan of care for the medication use and the interventions to prevent the adverse effects of the medication and its Blackbox warning, meaning the medication can cause serious adverse effects on the resident and even death. The MDSC stated the failure of the licensed staff to develop and implement a baseline care plan on the use of Duloxetine on the resident had predisposed the resident to the adverse effects of the resident. During an interview on 1/16/2026 at 10:06 a.m., with the Director of Nursing (DON), the DON stated the licensed staff should have developed and implemented a baseline care plan on the use of Duloxetine on Resident 130 within 48 hours of admission to ensure the licensed staff know how to care for and administer the medication safely to the resident. The DON stated the failure of the staff to develop and implement a baseline care plan on the use of Duloxetine on the resident can result to missed identification of the drug's adverse effects and reporting to the attending physician to mitigate the problem. During a review of the facility's recent policy and procedure titled, Baseline Care Plan, last reviewed on 4/24/2025, the P&P indicated the facility develops a Baseline Care Plan for each resident upon admission to ensure their immediate needs, preferences, and safety are addressed while a comprehensive care plan is developed. Procedure 1. Development of Baseline Care Plan - Completed within 24-48 hours of admission. - Based on: - Physician orders

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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 comprehensive person-centered care plan (is a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for: 1. One of three sampled residents (Resident 66) during random observations conducted for medication pass observation and dining observations addressing the resident`s enhanced barrier precautions (EBP, an approach to the use of personal protective equipment (PPE) to reduce transmission of Multidrug-Resistant Organisms (MDROs) between residents in skilled nursing facilities (SNFs)). This deficient practice had a potential for cross-contamination (the process of making something dirty or poisonous, or the state of containing unwanted or dangerous substances) of infections to residents. 2. One of nine sampled residents (Resident 73) reviewed during the Accidents care area by failing to develop and implement a CP for the resident`s fall that occurred on 12/19/2025. This deficient practice had the potential to result in recurrent, preventable falls with injury to Resident 73. Findings: 1. During a review of Resident 66's admission Record (AR), the AR indicated the facility admitted the resident on 5/8/2021, and readmitted the resident on 9/6/2025, with diagnoses including type two diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) and dementia (a progressive state of decline in mental abilities). During a review of Resident 66's History and Physical (H&P), dated 5/30/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 66's Minimum Data Set (MDS, a resident assessment tool), dated 11/6/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had severe cognitive impairment (a significant loss in thinking, memory, and judgment, making it very difficult or impossible to live independently, handle daily tasks, understand complex information, or communicate effectively). During a review of Resident 66's Order Summary Report (OSR), dated 1/12/2026, the OSR indicated an order for Enhanced Barrier Precautions-Staff to utilize gowns and gloves for high-contact resident care activities. Every shift. During a concurrent observation and interview on 1/13/2026 at 6:45 a.m., with Certified Nursing Assistant (CNA) 5, inside Resident 66's room, observed CNA 5 providing incontinence care and morning care to the resident only wearing a mask and a glove. CNA 5 stated she should have worn a gown, glove, and a mask while providing incontinence care and morning care to the resident to prevent herself and the resident from cross-contamination of infection. CNA 5 stated she does not know why the resident was on enhanced barrier precaution. During a concurrent interview and record review on 1/15/2026 at 2:42 p.m., with Licensed Vocational Nurse (LVN) 4, reviewed Resident 66's Medical Diagnosis, OSR, and Care Plans. LVN 4 stated there was an order for enhanced barrier precaution isolation on the resident however, he (LVN 4) is not sure why the resident was placed on it. LVN 4 stated he (LVN 4) will check and will update the surveyor once clarified. LVN 4 also stated there was no care plan developed and implemented on enhanced barrier precaution for the resident. LVN 4 stated it is important to have a care plan for enhanced barrier precaution to know why the resident was placed on them and what interventions to do to provide appropriate care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/16/2026, at 10:06 a.m., with the Director of Nursing (DON), the DON stated the staff should have developed and implemented a care plan on enhanced barrier precautions for Resident 66 to ensure they know how to care for the resident on an enhanced barrier precaution and if they are not clear on why the resident was placed on enhanced barrier precaution, the licensed staff should have verified with the ordering physician the reason for isolation and document in the resident's record. The DON stated the failure of the staff to develop and implement a care plan on the use of enhanced barrier precaution led to confusion and lack of justification on the implementation of the enhanced barrier precaution to the resident. During a review of the facility's recent policy and procedure (P&P) titled, Enhanced Barrier Precaution (EBP), last reviewed on 4/24/2025, the P&P indicated the facility implements Enhanced Barrier Precautions (EBP) for residents who are at risk for or have known/suspected transmissible infections. EBP is designed to minimize exposure to infectious agents beyond standard precautions. Purpose To provide clear guidance for preventing infection transmission in residents requiring additional protection measures, while maintaining dignity, safety, and quality of care. Procedure 1. Assessment and Identification - EBP is implemented based on physician's orders, infection control recommendations, and facility protocols. 2. Personal Protective Equipment (PPE) - Staff must wear gloves, gowns, masks, and eye protection as indicated when providing direct care. - PPE is donned before entering the resident area and removed before leaving. - Hand hygiene must be performed before and after all resident contact and after removing PPE. 2. During a review of Resident 73's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], and most recently admitted on [DATE], with diagnoses that included aftercare following joint replacement surgery, history of falling, spinal stenosis (narrowing of one or more spaces within the spinal canal) of the cervical region (neck area), and post laminectomy syndrome (any lingering pain of unknown origin following back surgery). During a review of Resident 73's Minimum Data Set (MDS - a resident assessment tool), dated 11/12/2025, the MDS indicated Resident 73 was able to understand others and able to make herself understood. The MDS further indicated the resident required substantial / maximal assistance (helper does less than half the effort) with toileting, bathing, lower body dressing, moving from sit to stand, and toilet transfers; and partial / moderate assistance (helper does more than half the effort) with bathing, upper body dressing, oral and personal hygiene, rolling left to right, and moving from sitting to lying. During a review of Resident 73's History and Physical (H&P), dated 6/24/2025, the H&P indicated the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had the capacity to understand and make decisions. During a review of Resident 73's care plan (CP) titled The Resident is High risk for falls., initiated 11/12/2024, the CP indicated a goal that the resident's risk for falls will be minimized / eliminated, and the resident would be free from injury. During a review of Resident 73's CP titled Missed wheelchair slid off slowly to floor., initiated 12/16/2025, the CP indicated a goal to prevent future falls. During a review of Resident 73's e-Interact Change of Condition Evaluation form (COC), dated 12/19/2025, the COC indicated on the afternoon of 12/19/2025, Resident 73 was in the bathroom with the Certified Nursing Assistant (CNA) and the resident's left and right feet buckled inward resulting in a fall to the floor. During a concurrent observation and interview on 1/12/2026 at 10 a.m., observed Resident 73 sitting in a wheelchair at bedside. Resident 73 stated she has had many falls in the facility. Resident 73 stated her most recent fall was in the bathroom with CNA 11. During an interview on 1/13/2026 at 8:30 a.m. with CNA 11, CNA 11 stated Resident 73 had a fall in the bathroom about two to three weeks ago and had also had a fall a few days prior to that. CNA 11 stated Resident 73 was standing and both feet gave out resulting in the resident sliding to the floor. During a concurrent interview and record review on 1/13/2026 at 2:11 p.m. with LVN 1, LVN 1 reviewed Resident 73's COCs dated 12/16/2025 and 12/19/2025, and CPs. LVN 1 stated any time a resident's body reaches the floor, it is considered a fall. LVN 1 stated the facility process when a resident falls is to first assess the resident, then complete a COC and notify the physician to obtain any treatment orders, provide treatments and monitor the resident, CPs will be immediately updated with an actual fall CP with new interventions to prevent future falls, and the Interdisciplinary Team (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of their resident) including rehabilitation services and nursing will meet withing three to seven days after the fall. LVN 1 stated the importance of the post fall IDT meeting is to discuss the fall incident and to ensure new interventions are put in place to prevent future falls.ˆLVN 1 stated the IDT will ensure the actual fall CP is updated with the interventions. LVN 1 stated Resident 73 fell on [DATE] and 12/19/2025 and there was no documented evidence that there was a CP developed and implemented for the resident's actual fall on 12/19/2025, but there should have been. During a concurrent interview and record review on 1/16/2026 at 1:30 p.m. with the Director of Nursing (DON), the DON reviewed the facility policy and procedure (P&P) regarding fall prevention and CPs. The DON stated the facility process is when a resident falls, the RN assesses the resident, the physician is notified, interventions are put in place to prevent future falls, and the IDT meets within seven days. The DON stated the LN that completes the COC also completes an actual fall CP. The DON stated CPs are individualized and communicate to the staff how to care for a resident. The DON stated the importance of the IDT meeting is for the whole team including the rehab department, nursing, social services, the Assistant DON, and the DON to meet to discuss the resident's care and to update the actual fall CP with any new interventions to prevent future falls. The DON stated Resident 73 had falls on 12/16/2025 and 12/19/2025, but there was no actual fall CP developed and implemented for the 12/19/2025 fall. The DON stated the facility P&Ps were not followed potentially resulting in further falls with injury to Resident 73. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility P&P titled, Comprehensive Care Plan last reviewed 4/24/2025, the P&P indicated, Policy Statement. (facility name) develops a Comprehensive Care Plan (CCP) for each resident to ensure individualized, resident-centered care that addresses medical, psychosocial, functional, and safety needs. The CCP is developed by the Interdisciplinary Team (IDT) and updated regularly based on resident condition and preferences. Purpose .To provide a structured framework for delivery, coordination, and evaluation of resident care, ensuring compliance with CMS regulations and quality standards. Scope .Applies to all licensed and non-licensed nursing staff, certified nursing assistants, dietary staff, therapy staff, social services, and other IDT members involved in resident care. Procedure . 2. Components of the Care Plan . The CCP must include, but is not limited to:. Mobility, safety, and fall prevention interventions. 4. Review and Revision. CCP must be reviewed at least quarterly and updated: After significant change in resident condition. When new interventions or goals are identified. During a review of the facility P&P titled, Fall Management Program last reviewed 4/24/2025, the P&P indicated, POLICY STATEMENT.(facility name) is committed to minimizing the risk of resident falls through a structured Fall Management Program that includes prevention, monitoring, and post-fall evaluation. All falls will be reviewed by the Interdisciplinary Team (IDT) within 3-7 days to ensure timely interventions and continuous quality improvement. PURPOSE.To provide a systematic approach to: Prevent falls. Assess residents after a fall. Implement individualized interventions.Monitor outcomes and reduce fall-related injuries. 3. IDT POST-FALL REVIEW.The Interdisciplinary Team (IDT) shall review each fall within 3-7 days. Review will focus on: Cause(s) of the fall. Resident's current medical status and risk factors. Effectiveness of existing fall prevention interventions.Recommendations for revised interventions or care plan updates. 4. CARE PLAN AND INTERVENTIONS.Following the IDT review, individualized interventions will be implemented in the resident's care plan. Interventions may include: Adjustments to mobility or activity levels.Changes in room or equipment setup.Additional staff assistance. Referral to rehabilitation services.Education for resident and family. 5.MONITORING AND DOCUMENTATION. care plan updates must be documented in the Electronic Health Record (EHR).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to provide care consistent with professional standards of practice to prevent pressure ulcer/injury (ulcers that happen on areas of the skin that are under pressure from lying in bed, sitting in a wheelchair, or wearing a cast for a long period) to two of two sampled residents (Residents 130 and 72) reviewed for pressure ulcers by failing to: 1. Apply Resident 130's low air loss mattress (LALM, a special type of air mattress that uses a constant, gentle flow of air through microscopic holes to keep the skin dry and prevent pressure wounds) per physician's order. 2. Ensure Resident 72's LALM was set according to the resident`s weight or comfort. The deficient practices had the potential for development and worsening of pressure ulcers/injuries to residents. Findings: 1. During a review of Resident 130's admission Record (AR), the AR indicated the facility admitted the resident on 1/9/2026, with diagnoses including type two (2) diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), abnormalities of gait (the walking pattern in humans) and mobility, and muscle weakness. During a review of Resident 130's History and Physical (H&P), dated 1/12/2026, the H&P indicated the resident cannot make own decisions but can make needs known. During a review of Resident 130's Order Summary Report (OSR), dated 1/10/2026, the OSR indicated an order for: - LAL mattress for wound management: set per resident comfort. Every shift (Qshift) every shift. - Left heel stage two (2) pressure injury (PI, partial-thickness loss of skin, presenting as a shallow open sore or wound): cleanse with normal saline (ns, a sterile, salt-and-water solution (0.9% sodium chloride) that mimics the body's fluids, used to gently clean dirt, debris, and bacteria from cuts, scrapes, and burns without irritating skin, helping to promote healing and prevent infection), pat dry, apply Hydrogel (a water-based, gel-like dressing (around 90% water) that keeps wounds moist, promotes natural healing, relieves pain, and helps clean dead tissue without sticking), cover with dry dressing (DD) daily (Qd) & if needed (PRN) for (X) 30 days. Re-eval on 2/10/2026 as needed for 30 days. - Sacrococcyx stage two (2) PI: cleanse with ns, pat dry, apply Hydrogel, cover with DD Qd & PRN x 30 days. Reeval 2/10/2026 as needed for 30 days. During a review of Resident 130's Care Plan (CP) Report titled, The resident has pressure injury stage two (2) Left Buttock or potential for pressure injury development r/t medical comorbidities, initiated on 1/9/2026, the CP indicated an intervention to administer treatments as ordered and monitor for effectiveness. During an observation and interview on 1/13/2025, at 12:41 p.m., with Licensed Vocational Nurse (LVN) 6, observed with LVN 6 Resident 130's bed did not have LALM. LVN 6 stated Resident 130 had pressure ulcer on the heel and the sacrum. During an interview and record review on 1/13/2026 at 1:10 p.m., with LVN 6, reviewed Resident 130's Medical Diagnosis, OSR, Care Plan. LVN 6 stated there was an order to apply LALM for Resident 130. LVN 6 stated she (LVN 6) was not aware of the order until now. LVN 6 stated if she (LVN 6) was the one who received the order for LALM, she (LVN 6) will inform the Maintenance (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Department right away to prepare the LALM. LVN 6 stated the failure of the licensed staff to apply the LALM per physician's order predisposed the resident to delayed healing or worsening of the pressure injury the resident currently have. During an interview on 1/13/2026, at 1:19 p.m., with Maintenance Staff (MS) 1, MS 1 stated he (MS 1) just got informed today (1/13/2026) that Resident 130 had an order for LALM. During an interview on 1/14/2026, at 3:09 p.m., with the Minimum Data Set Coordinator (MDSC), the MDSC stated the licensed staff should have informed the Maintenance Department of the Resident 130's order for LALM. The MDSC stated the LALM should have been applied right away as soon as the order was placed to prevent the worsening of the pressure injury of the resident. The MDSC stated the resident's Braden Score (a standardized, evidence-based assessment tool commonly used in health care to assess and document a client's risk for developing pressure injuries) was 16 on 1/12/2026, which means that the resident was at risk for skin breakdown. During an interview on 1/16/2026 at 10:06 a.m., with the Director of Nursing (DON), the DON stated the staff should have carried out the doctor's order to place a LALM on Resident 130 on the same day the physician ordered the treatment. The DON stated their process for providing LALM to the resident starts with the licensed staff informing the Maintenance Department of the order form the physician's order to place a LALM on the resident. The DON stated there was a delay of treatment to the resident because the licensed staff failed to communicate the order to the Maintenance Department, that is why the LALM was not placed on the resident's bed. The DON stated the failure of the staff to apply the LALM on Resident 130 who has stage two (2) pressure injury on the left heel and the sacrococcyx predisposed the resident to development or worsening of the pressure injury of the resident. During a review of the facility's recent policy and procedure (P&P) titled, Pressure Relieving Devices Policy, last reviewed on 4/24/2025, the P&P indicated to provide guidance on the proper selection, use, and monitoring of pressure relieving devices to prevent and manage pressure injuries in residents at risk. Types of Pressure Relieving Devices 1.Support Surfaces (Mattress & Overlays) c. Low-air-loss mattress reduces moisture and shear in high-risk residents. Usage and Maintenance Devices must be: Properly set up and positioned according to manufacturer instructions. Inspected daily for damage, wear, or malfunction. Cleaned and sanitized per infection control policies. During a review of the facility's recent P&P titled, Pressure Ulcer Management, Treatment, and Prevention, last reviewed on 4/24/2025, the P&P indicated the facility is committed to the prevention, early identification, and effective treatment of pressure ulcers (pressure injuries) in all residents. The (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility implements evidence-based practices, individualized care plans, and ongoing staff education to minimize risk and promote skin integrity in compliance with CMS regulatory requirements (F686). Procedure 2. Prevention -Use pressure-relieving devices such as specialty mattresses, cushions, or heel protectors. 2. During a review of Resident 72's admission Record, the admission Record indicated the facility originally admitted Resident 72 on 1/26/2021, and readmitted in the facility on 12/29/2025 with diagnoses including cognitive communication deficit (difficulty in talking, listening, or understanding), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (paralysis of the arm, leg, and trunk on one side of the body) following cerebral infarction (also known as stroke, loss of blood flow to a part of the brain) affecting left non-dominant side, and generalized muscle weakness. During a review of Resident 72's History and Physical (H&P) dated 12/31/2025, the H&P indicated Resident 72 did not have the capacity to understand and make decisions. During a review of Resident 72's Minimum Data Set (MDS, a resident assessment tool), dated 12/26/2025, the MDS indicated Resident 72 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was able to understand and make her needs known. The MDS further indicated Resident 72 required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 72 had a pressure-reducing device for bed, received PI care, and application of nonsurgical dressings. During a review of Resident 72's Order Summary Report dated 1/16/2026, the Order Summary Report indicated the following physician's orders: - 12/30/2025: sacrococcyx (connection point where the sacrum [the large, triangular bone at the base of the spine] meets the coccyx [commonly known as the tailbone]) stage three (3) PI (Full-thickness loss of skin. Dead and black tissue may be visible) cleanse with normals saline (NS – a mixture of sterile salt and water), pat dry, apply hydrogel (a water-based gel that create a moist environment, promoting natural healing, debridement [removal of dead tissue], and pain reduction for dry to lightly draining wounds), cover with dry dressing daily and as needed for 30 days. - 1/1/2026 for the use of LALM for wound management and to set per resident comfort every shift. During a review of Resident 72's car plan (CP) on presence of sacrococcyx stage three (3) PI initiated on 11/14/2025 and last revised on 12/9/2025, the CP indicated LALM for wound management and assess, record, monitor wound healing weekly as a few of the interventions to minimize risk of infection and for the PI to show signs of healing. During a review of Resident 72's electronic health record (EHR), the EHR indicated that Resident 72's current weight dated 1/11/2026 indicated 125 pounds (lbs. – a unit pf measurement). During a review of Resident 72's Braden Scale for Predicting Pressure Sore Risk form dated (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/29/2025 and 1/14/2026, the Braden Scale for Predicting Pressure Sore Risk form indicated that Resident 72 was at a high risk for developing pressure injuries. During an observation on 1/12/2026 at 11:22 a.m., inside Resident 72's room, Resident 72 alert observed, just stared and did not respond when talked to, lying on a LALM with setting at 250 lbs. Resident 72 stated was unable to tell if the LALM was comfortable or not. During a concurrent observation, interview, and record review on 1/12/2026 at 11:30 a.m. inside Resident 7's room with Licensed Vocational Nurse (LVN) 10, Resident 72's EHR was reviewed with LVN 10. LVN 10 stated Resident 72's LALM was set at 250 lbs., and that the resident's current in the EHR dated 1/11/2026 indicated 125 lbs. LVN 10 stated the licensed nurses (LNs) are supposed to ensure the resident's LALM was set according to resident weight per manufacturer's guidelines or per resident comfort if able to verbalize. During a concurrent interview and record review on 1/16/2025 at 4:30 p.m., Resident 72's physician's order, care plan, Braden Scale for Predicting Pressure Sore Risk forms, a photograph of the LALM setting on 1/12/2026, and the resident's current weight was reviewed with the Director of Nursing (DON). The DON stated that Resident 72 had a physician's order for the LALM for wound management for a Stage PI on the sacrococcyx area and was a high risk for development of PI as she mostly stays in bed, and the history of stroke. The DON stated Resident 72's current weight indicated 125 lbs. and the photograph indicated the LALM setting was at 250 lbs. The DON stated Resident 72 was unable to communicate with staff and unable to verbalize whether the LALM was comfortable or not. The DON stated the LNs are responsible in ensuring the LALM were set according to resident weight or comfort if able to verbalize. The DON stated Resident 72's LALM should have been set according to the resident's weight as it placed Resident 72 at risk for worsening of her PI in sacrococcyx area if the mattress was too firm. During a review of the facility provided manufacturer's guideline for LALM 1, undated, the manufacturer's guideline indicated: - Determine the patient's weight and set the control knob to that weight setting on the control unit. - Press the static button to shift between alternating mode and static mode. When in static mode, the indicator light will come on. The static mode will be started within approximately six (6) minutes. In alternating pressure mode, the air cells will alternate in then (10) minute cycles. - In static mode, the mattress provides a firm surface that makes it easier for the patient to transfer or reposition. The static mode will help ensure the patient does not bottom out when in a sitting position. During a review of the facility's policy and procedure (P&P) titled, Pressure Relieving Devices Policy, last reviewed on 4/24/2025, the P&P indicated a purpose to provide guidance on the proper selection, use, and monitoring of pressure relieving devices to prevent and manage pressure injuries on residents at risk. The P&P further indicated: - Device selection should be based on risk assessment, mobility and activity level, skin condition and existing PI, and physician or wound care specialist recommendations. - Devices must be properly set up and positioned according to manufacturer instructions. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Residents on pressure relieving devices must be monitored regularly for skin integrity and early signs of PI, device functionality, and resident comfort and tolerance. - Staff will receive training on proper use and adjustment of pressure relieving devices and recognizing device failure or ineffective pressure relief.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review the facility failed to ensure residents receiving enteral feeding (EF - also known as tube feeding, a method of supplying nutrients directly into the stomach) received appropriate care and services to prevent complications of enteral feeding for one (1) of one (1) sampled resident (Resident 72) reviewed for tube feeding when the water flush bag did not indicate the time the bag was started and the administration rate for the water flush. This deficient practice had the potential to result in altered nutritional status such as dehydration (when the body uses or loses more fluid than it takes in), malnutrition (a serious condition that happens when your diet does not contain the right amount of nutrients), and complications associated with enteral feeding such as gastrointestinal (GI - relating to stomach and intestines) problems such as abdominal pain and diarrhea. Findings: During a review of Resident 72's admission Record, the admission Record indicated the facility originally admitted Resident 72 on 1/26/2021,and readmitted in the facility on 12/29/2025, with diagnoses including cognitive communication deficit (difficulty in talking, listening, or understanding), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (paralysis of the arm, leg, and trunk on one side of the body) following cerebral infarction (also known as stroke, loss of blood flow to a part of the brain) affecting left non-dominant side, and generalized muscle weakness. During a review of Resident 72's History and Physical (H&P) dated 12/31/2025, the H&P indicated Resident 72 did not have the capacity to understand and make decisions. During a review of Resident 72's Minimum Data Set (MDS, a resident assessment tool), dated 12/26/2025, the MDS indicated Resident 72 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was able to understand and make her needs known. The MDS further indicated Resident 72 required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 72 received tube feeding while a resident in the facility. During a review of Resident 72's Order Summary Report dated 1/16/2026, the Order Summary Report indicated the following physician's orders: - 12/29/2025: Water flush at 50 milliliters per hour (ml/hr - a unit of measurement) every four (4) hours via gastrostomy tube (GT -a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) for hydration total of 300 ml per 20 hours on at 2 p.m. and off at 10 a.m. - 1/7/2026: Enteral feel order: in the afternoon enteral feeding: Enteral Feeding (EF) 1 at 50 ml/hr for 20 hours to provide 1000 ml per 1320 kilocalories (kcal - a unit of measurement for energy or calories) per 20 hours on at 2 p.m. Infuse feeding until volume is infused via pump. During a review of Resident 72's care plan (CP) titled, The resident required tube feeding, initiated on 2/9/2025, and last revised on 12/9/2025, the CP indicated to flush tube per order as one of the interventions to minimize risk for complications related to tube feeding. During an observation on 1/12/2026 at 11:28 a.m. and 1/13/2026 at 8:13 a.m., inside Resident 72's room, observed Resident 72's EF water flush bag was hanging from the EF pole and was only labeled with the date 1/12/2026 and Resident 72' s name. During a concurrent observation and interview on 1/13/2026 at 8:20 a.m., inside Resident 72's room with Licensed Vocational Nurse (LVN) 10, LVN 10 stated Resident 72's water flush bag indicated Resident 72's name and the dated 1/13/2026 but did not indicate the administration rate, frequency of the water flush, and the time it was hung. LVN 10 stated that when EF bags and water flush bags are changed, both bags need to be labeled with the resident's name, start date and time, administration rate, and frequency for the water flushes. LVN 10 stated Resident 72's water flush bag label should have indicated the administration rate, frequency of the water flush, and time started or hung so the staff would be aware if Resident 72 was receiving the correct amount of water to prevent dehydration. During a concurrent interview and record review on 1/16/2026 at 11:48 a.m., a photograph of Resident 72's water flush bag dated 1/12/2026 and 1/13/2026, and the package insert (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for Water Flush Bag (WFB) 1 dated 2024 were reviewed with the Director of Nursing (DON). The DON stated the photograph of the water flush bag did not indicate the administration rate and frequency for Resident 72's water flush as well as the time the bag was hung. The DON stated the package insert for WFB 1indicated that due to the risk of bacterial contamination and overall system accuracy, do not use the feeding set for greater than 24 hours. The DON stated that EF bottles and water flush bags should be labeled with the resident's name, start date and time, and administration rate and frequency when a new bag is hung. The DON stated Resident 72's water flush bag should have indicated the start time, administration rate and frequency so the staff would be aware of the correct amount of water flush the resident needed and that the water flush bag was not beyond the 24 hours recommended by the manufacturer. The DON stated if Resident 72 was not receiving the correct amount of water flushes, it would place the resident at risk for dehydration. The DON stated that as indicated in the manufacturer's recommendation, if WFB 1 was used beyond 24 hours, it placed Resident 72 at risk for bacterial contamination which may lead to health complications such as infection. During a review of the facility provided package insert for WFB 1 dated 2024, the package insert indicated that due to the risk of bacterial contamination and overall system accuracy, do not use the feeding set for greater than 24 hours. During a review of the facility's policy and procedure (P&P) titled, Enteral Nutrition (Tube Feeding), last reviewed on 4/24/2025, the P&P indicated the facility ensures a safe, accurate, and infection prevention compliant tube feeding administration, reduce aspiration risk, and ensure timely monitoring and response to complications. The P&P further indicated: - Before initiation or change, ensure that the order includes the formula, rate, bolus amount/frequency, flush volume/frequency, route, and any hold parameters. - For flushes and hydration, flush with the ordered amounts and frequency. - Document at minimum the formula, route, rate/bolus amount, and flushes.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pain management consistent with professional standards of practice and the resident's goals and preferences for one of five sampled residents (Resident 73) reviewed for unnecessary medication by failing to: 1. Ensure the Licensed Nurses (LN) administered as needed (PRN) acetaminophen (medication to treat mild pain) and hydrocodone - acetaminophen (an opioid [also called a narcotic - powerful pain-reducing medication) per the physician's orders and based on the assessed numeric pain rating scale (a standard pain scale with zero being no pain and ten [10] as the worst pain one can imagine) for Resident 73. 2. Ensure the LNs followed up with the physician to obtain an order for severe pain when Resident 73 complained of severe pain on the numeric pain scale. These deficient practices had the potential to result in mismanagement of resident pain resulting in limited resident participation in activities of daily living (ADLs -activities such as bathing, dressing and toileting a person performs daily), general activities, and mobility. Findings: During a review of Resident 73's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and most recently admitted on [DATE] with diagnoses including aftercare following joint replacement surgery, history of falling, spinal stenosis (narrowing of one or more spaces within the spinal canal) of the cervical region (neck area), osteoarthritis (OA - a progressive disorder of the joints, caused by a gradual loss of cartilage) of the right hip, and post laminectomy syndrome (any lingering pain of unknown origin following back surgery). During a review of Resident 73's Minimum Data Set (MDS - a resident assessment tool), dated 11/12/2025, the MDS indicated Resident 73 was able to understand others and able to make herself understood. The MDS further indicated the resident required substantial / maximal assistance (helper does less than half the effort) with toileting, bathing, lower body dressing, moving from sit to stand, and toilet transfers; and partial / moderate assistance (helper does more than half the effort) with bathing, upper body dressing, oral and personal hygiene, rolling left to right, and moving from sitting to lying. During a review of Resident 73's History and Physical (H&P), dated 6/24/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 73's Physician Order Summary, the Physician Order Summary indicated the following orders: - Hydrocodone - acetaminophen oral tablet five (5) - 325 milligrams (mg - a unit of measurement), give one (1) tablet by mouth every four (4) hours (hrs.) PRN for pain 4 to (-) six (6) out of (/) 10, dated 6/19/2025. ^^ - Acetaminophen oral tablet 325 mg, give two (2) tablets by mouth every 4hrs. PRN mild pain 1-3/10, dated 6/19/2025. - Pain Monitoring Scale: Monitor level of pain zero (0) to 10: 0 equals (=) none, 1-3 = mild pain; 4-6= moderate pain; 7-10= severe pain, every shift, dated 6/19/2025. During a review of Resident 73's Care Plan (CP) titled, The resident has an alteration in musculoskeletal status related to . Severe OA of right hip, initiated 11/16/2025, the CP indicated a goal that the resident would remain free from pain or at a level of discomfort acceptable to the resident with interventions that included to give analgesics (pain medication) as ordered by the physician. During a concurrent observation and interview on 1/12/2026 at 10 a.m. with Resident 73, observed Resident 73 sitting in a wheelchair at bedside. Resident 73 stated she has pain in her whole body and receives acetaminophen, but acetaminophen does not help. During a concurrent interview and record review on 1/14/2026 at 11:17 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 73's physician orders, Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 12/2025, and Progress Notes, for 12/2025, were reviewed. LVN 1 stated the facility process for administering PRN pain medication is the resident verbalizes a pain level based on the numeric pain scale from 1-10 and the LN administers the corresponding medication based on the reported pain level. LVN 1 stated the LN then documents the pain level and medication in the MAR at the time of administration. LVN 1 stated it was important to administer the PRN pain medication that corresponded to the resident's (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain level to meet the resident's pain management needs. LVN 1 stated Resident 73 had physician's orders for acetaminophen for mild pain of 1-3 and hydrocodone-acetaminophen for moderate pain 4-6. LVN 1 stated Resident 73 was not prescribed a medication to treat severe pain 7-10. LVN 1 reviewed Resident 73's MAR and progress notes and noted the following regarding the PRN administration of acetaminophen for mild pain 1-3 and hydrocodone - acetaminophen for moderate pain 4-6: - On 12/14/2025 at 8:46 p.m., hydrocodone - acetaminophen was not administered per the physician's order when Resident 73's pain level was 7. LVN 1 stated when the resident reported a severe pain level, the LN should have called the physician because the resident was not prescribed a PRN medication to treat the reported severe pain level, but they did not. - On 12/17/2025 at 1:13 p.m., hydrocodone - acetaminophen was not administered per the physician's order when Resident 73's pain level was 8. - On 12/18/2025 at 12:06 p.m., acetaminophen was not administered per the physician's order when Resident 73's pain level was 4. LVN 1 stated the LN should have administered hydrocodone - acetaminophen for moderate pain, but they did not. - On 12/19/2025 at 5:45 p.m., acetaminophen was not administered per the physician's order when Resident 73's pain level was 6. LVN 1 stated the proper corresponding PRN pain medication should have been administered per physician's orders to Resident 73, but it was not, potentially resulting in ineffective pain management leading to continued pain in the resident. During a concurrent interview and record review on 1/15/2026 at 1:50 p.m., with LVN 2, Resident 73's physician orders and MAR for 12/2025 were reviewed. LVN 2 stated the process for administering PRN pain medication is to ask the resident what pain level they have and then administer PRN pain medication for that pain level, then document on the MAR. LVN 2 stated on 12/17/2025 at 1:13 p.m. LVN 2 administered hydrocodone - acetaminophen to Resident 73 for a pain level of 8. LVN 2 stated LVN 2 did not remember what happened on 12/17/2025, but if she documented something in the MAR then that was what happened. LVN 2 stated Resident 73 usually requests pain medication by name. LVN 2 stated LVN 2 gave the hydrocodone - acetaminophen without looking at the pain level on the physician's order. LVN 2 stated LVN 2 should have first checked the physician's order and notified the physician that there was no physicians order to treat severe pain, but she did not. LVN 2 stated when LVN 2 did not administer PRN pain medication per the physician's order there was the potential that the resident would have more pain. During a concurrent interview and record review on 1/16/2026 at 1:30 p.m. with the Director of Nursing (DON), the facility's policy and procedures (P&P) titled, Pain Management, last reviewed 4/24/2025, and Medication Administration, last reviewed 4/24/2025, were reviewed. The DON stated pain is subjective and PRN pain medication is administered to correspond with the resident's reported numeric pain level. The DON stated pain levels are accurately documented in the MAR by the LN that administers the PRN Pain medication. The DON stated if a pain level is documented in the MAR, then that is considered to be the reported pain level. The DON stated when too little pain medication is administered there is the potential that pain will not be relieved resulting in continued suffering in the resident. The DON stated when pain is not managed well it may result in affecting a resident's mood and their entire being resulting in sleeping issues, a decrease in appetite, and a general decline in the resident. The DON stated acetaminophen and hydrocodone-acetaminophen were not administered to Resident 73 per the physician's orders and the facility's P&Ps were not followed. During a review of the facility's P&P titled, Pain Management, last reviewed 4/24/2025, the P&P indicated, Policy. Pain Management . Pain is subjective and is what the resident says it is, existing when and where the resident says it does. PURPOSE: . 1. To accurately assess and achieve pain control. This does not necessarily mean the resident is pain free. 2. Acceptable (tolerable) pain control is defined by the resident. PROCEDURE: . 3. All subsequent pain evaluations will be documented on the Pain Evaluation in PCC [Point Click Care - an electronic medical record] and/or the MAR as applicable to, to include 1ocation, intensity rating, and response to pain management interventions. When a resident complains of pain, ask the resident to rate the level of pain using the Numerical Scale using a pain level of zero (none) to ten (severe). Document your findings on the Pain Evaluation in PCC and/or MAR as (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	applicable. Considerations: . Intermittent pain can be managed with intermittent (PRN) analgesic administration. Titration is the manipulation of dose (up or down) to attain the greatest pain control with the least amount of side effects. During a review of the facility's P&P titled, Medication Administration, last reviewed 4/24/2025, the P&P indicated, Policy. Medications will be administered as prescribed by the physician, and only by persons lawfully authorized to do so. ADMINISTRATION PROCESS. Medications are administered in accordance with the written orders of the attending physician. PRN drug administration requires the following information: . Reason for giving the dose.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that a resident who was receiving dialysis (clinical purification of blood as a substitute for the normal function of the kidney) treatment received services consistent with professional standards of practice for one of two sampled residents (Resident 11) investigated during a review of dialysis care area, by failing to complete the post-dialysis assessments form on 12/23/2025 per facility policy. This deficient practice placed Resident 11 at risk for developing complications related to renal disease such as swelling, high blood pressure, and uncontrolled bleeding which could result in death. Findings: During a review of Resident 11's admission Record (AR), the AR indicated that the facility originally admitted the resident on 10/15/2025, and readmitted on [DATE] with diagnoses including end-stage renal disease (ESRD-irreversible kidney failure), dependence on renal dialysis, and acute posthemorrhagic anemia (a type of anemia that develops suddenly after a person loses a large amount of blood quickly). During a review of Resident 11's History and Physical (H&P), dated 12/10/2025, the H&P indicated that the resident could not make own decisions but could make needs known. During a review of Resident 11's Minimum Data Set (MDS-a resident assessment tool), dated 10/22/2025, the MDS indicated the resident usually has the ability to make self-understood and understand others. The MDS further indicated that the resident required assistance from staff with upper and lower body dressing and personal hygiene and while a resident of the facility dialysis treatment was performed. During a review of Resident 11's Order Summary Report, dated 12/23/2025, the OSR indicated Enhanced Barrier Precautions-Staff to utilize gowns and gloves for high-contact resident care activities related to permacath (a flexible tube used for dialysis treatment) on right upper chest. During a review of Resident 11's Care Plan (CP) focused on needs dialysis related to ESRD, dated 11/10/2025, the CP indicated the resident with goals of minimizing signs and symptoms of complications from dialysis included interventions to: Check and change dressing daily at access site. Document. Monitor vital signs twice a shift after dialysis, on dialysis days. Monitor/document/report PRN (as needed) any signs and symptoms of infection to access site: Redness, swelling, warmth, or drainage. Monitor/document/report PRN for signs and symptoms of the following: Bleeding. During a concurrent interview and record review on 1/15/2026 at 3:20 p.m. with Licensed Vocational Nurse (LVN) 7, reviewed Resident 11's Dialysis Communication Records (DCR). LVN 7 stated Resident 11 has a permacath on his right upper chest. LVN 7 stated Resident 11`s DCR dated 12/23/2025 is incomplete. LVN 7 stated that he (LVN 7) documents on the DCR and on the nursing progress notes when he assesses residents upon their return from dialysis center and if he (LVN 7) did not document it then it was not done. LVN 7 stated he (LVN 7) was most likely the charge nurse who worked on 12/23/2025, but he (LVN 7) does not remember what he (LVN 7) did that day. LVN 7 stated the documentation is to show any treatment the resident received, also to show that the resident was checked for any complications after dialysis. LVN 7 stated this is to make sure the resident has no complications such as uncontrolled bleeding which could result in a blood loss and resident could die from it. LVN 7 stated it is important to check the resident right away after dialysis. During a concurrent interview and record review on 1/15/2026 at 4:57 p.m. with LVN 9, reviewed Resident 11's DCR and nursing progress notes, dated 12/23/2025. LVN 9 stated there was no documentation in the nursing progress notes and on the DCR, the time when Resident 11 returned from dialysis treatment, vital signs such as blood pressure, heart rate, pain, and catheter location to make sure it was checked and documented.ˆLVN 9 stated if it was not documented then it was not done. During an interview on 1/16/2026 at 2:35 p.m. with the Director of Nursing (DON), the DON stated after the resident arrives from dialysis treatment, the licensed nurses assess the resident`s vital signs and any change in condition after the dialysis treatment. The DON stated that the licensed nurse's documentation should be placed in the dialysis communication record or they should write a narrative in the nursing (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	progress notes. The DON stated licensed nurses check for any new orders from the dialysis centers, the dialysis access site for any bleeding, swelling, they check to see if a dressing is in place and if the dressing is intact. The DON stated the purpose of checking the resident's vital signs and signs and symptoms of complications is to check the well-being of the resident after undergoing dialysis which can be exhausting, and the transport back may have changed the resident's vital signs which is why it is critical that licensed nurse to check on the residents upon their return from dialysis center. The DON stated their facility policy was not followed when Resident 11 had dialysis on 12/23/2025. The DON stated unchecked or unmonitored vital signs and access site can cause potential harm to the resident such as hypotension (low blood pressure), bleeding, and these conditions need to be relayed to the doctor immediately. During a review of the facility-provided policy and procedure (P&P) titled, Hemodialysis Residents Policy, last reviewed and approved on 4/24/2025, the P&P indicated that the facility provides residents receiving hemodialysis with safe, accurate, and appropriate care, assessments, and interventions in coordination with the dialysis center to support optimal resident outcomes. I. admission and General Care - Care Planning: - Implement a care plan that includes: - Monitoring of risk factors - Access site assessment. II. Post-Hemodialysis and Ongoing Care - Vital Signs & Safety - Check vital signs post-dialysis or as ordered. III. Documentation Requirements - Dialysis Communication Record - Ensure completion and filling of the Dialysis Communication Record - Medical Record Documentation - Documentation should include: - Vital signs - Weight - Pertinent observations regarding resident status.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate administering of all drugs and biologicals) for one of one sampled resident (Resident 87) investigated under Medication Administration and Storage Labeling task by failing to ensure on 1/13/2026, Licensed Vocational Nurse (LVN) 3 documented the administration of oxycodone hydrochloride (a drug or chemical whose manufacture, possession, or use is regulated by a government) five (5) milligrams (mg- a unit of measurement) to Resident 87 immediately after administration in the Narcotic and Hypnotic Record (NHR - a document designed for dispensers of controlled substances to keep track of the pharmaceuticals as legally mandated). The NHR recorded a total of 10 tablets available, but only nine (9) tablets remained in the Resident 87`s oxycodone hydrochloride bubble pack (packaging that have a preformed plastic pocket or shell where a product sits securely in place). This deficient practice had the potential to result in the facility's inability to readily identify loss and drug diversion (illegal distribution or abuse of prescription drugs or their use for unintended purposes) of controlled medications and overdosing (quantities administered in far greater than recommended resulting in serious, harmful symptoms). Findings: During a review of Resident 87's admission Record (AR), the AR indicated that the facility admitted the resident on 9/21/2025, with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) with acute (sudden) exacerbation, dependence on supplemental oxygen, and cognitive communication deficit. During a review of Resident 87's History and Physical (H&P), dated 1/11/2026, the H&P indicated that the resident cannot make own decisions but can make needs known. During a review of Resident 87's Order Summary Report (OSR), dated 1/7/2026, the OSR indicated oxycodone hydrochloride (hcl) oral tablet five (5) mg, give one (1) tablet by mouth every four (4) hours as needed for pain management. During a concurrent observation, interview, and record review on 1/13/2026 at 11:11 a.m., inspected Medication Cart 1, Station 200 with LVN 3 and reviewed Resident 87's NHR for oxycodone five (5) mg tablet with LVN 3. LVN 3 stated she (LVN 3) forgot to sign the NHR that she gave oxycodone earlier because she (LVN 3) got busy. LVN 3 stated she (LVN 3) was going to sign it. LVN 3 stated she (LVN 3) should have signed it as soon as she (LVN 3) gave the medication to Resident 87 because it is part of the order and they are supposed to sign to show that it was given and accounted at the time they gave it. Observed Resident 87's oxycodone five (5) mg bubble pack has nine (9) tablets /doses left. LVN 3 stated that was why the NHR indicated 10 doses and the bubble pack shows nine (9) doses. During an interview on 1/16/2026 at 2:55 p.m. with the Director of Nursing (DON), the DON stated the licensed nurses should document the medications they have administered as soon as they are able to do. The DON stated narcotics are potent drugs and that accountability is required of what is administered as narcotics are closely tracked and documented. The DON stated that when the licensed nurses do not document timely, the staff could potentially administer extra dose when they should not be. The DON stated this places the resident at harm of overdosing.ˆ During a review of the facility-provided policy and procedure (P&P) titled, Controlled Drugs, last reviewed and approved 4/24/2025, the P&P indicated that Drugs with High abuse potential will be subject to special handling, storage, disposal, and record keeping. Procedure: 1). Controlled drugs, as defined according to the Controlled Substances Act of 1970 and subsequent laws, have been designated within a classification of all habit-forming drugs. 3). Schedule II: a). Drugs that have valid medical uses but are highly habit forming. A special prescription form is required for such drugs. G. The nurse has to enter the following information on the narcotic drug record immediately after a dose of a controlled drug is administered: 1). Date and time of administration, 2). Dose administered. 3). Signature of the nurse that administered the dose.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to discard Resident 116's Ativan (lorazepam - a medication used to treat anxiety and restlessness) when the bubble pack (packaging that have a preformed plastic pocket or shell where a product sits securely in place) slot number (#) 27 was damaged, the seal was broken, and covered with tape in one of three inspected medication carts (Medication Cart 1 Station 200). This deficient practice increased the risk that Resident 116 could have received medication that had become ineffective or toxic due to improper storage. Findings: During a concurrent observation and interview on 1/13/2026 at 11:12 a.m. with Licensed Vocational Nurse (LVN) 3, in Medication Cart 1 in Station 200, observed Resident 116's Ativan 0.5 milligrams (mg- a unit of measurement) bubble pack slot # 27 with damaged, the seal was broken, and was covered with tape. LVN 3 stated she (LVN 3) did not notice that the seal had been broken and covered with tape. LVN 3 stated this did not happen during her shift and she (LVN 3) does not know exactly when the tape was placed. LVN 3 stated it should have been discarded and destroyed. LVN 3 stated it is not their facility's practice to cover the bubble pack slot with tape once the seal is broken. During an interview on 1/16/2026 at 3:00 p.m. with the Director of Nursing (DON), the DON stated when the licensed nurses do the counting of the controlled medications, they should check the integrity of the container and make sure that it is sealed and secure for safety of the drugs. The DON stated that when the seal is broken or damaged it would affect the efficacy of the drug. The DON stated it should be properly sealed. The DON stated the LVN should have removed the tablet from the bubble pack placed inside a plastic container then stapled and handed it to her to be discarded.^ During a review of the facility-provided policy and procedure (P&P) titled, Medication Labels, last reviewed and approved 4/24/2025, the P&P indicated that Drugs will be labeled in accordance with state and federal laws. 16). Medication containers having soiled, damaged, incomplete, illegible, or makeshift labels are returned to the issuing pharmacy for relabeling or destroyed in accordance with the medication destruction policy. During a review of the facility-provided P&P titled, Controlled Drugs, last reviewed and approved on 4/24/2025, the P&P indicated that Drugs with high abuse potential will be subject to special handling, storage, disposal, and record keeping. Procedure: 1). Controlled drugs, as defined according to the Controlled Substances Act of 1970 and subsequent laws, have been designated within a classification of all habit-forming drugs. 5). Schedule IV: Drugs that have a valid medical use but have less abuse potential than Schedule III drugs. Examples of Schedule IV drugs include: (1). Ativan. During a review of the facility-provided P&P titled, Controlled Medications - Disposal, last reviewed and approved on 4/24/2025, the P&P indicated that Medications included in the Drug Enforcement Administration (DEA- a government agency that is fighting illegal drugs and serving as the primary agency for enforcing Controlled Substances Act) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility in accordance with federal, state laws and regulations. Procedure:. 3).When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It is destroyed in the presence of two licensed nurses, and the disposal is documented on the accountability record on the line representing that dose. The same process applies to the disposal of. doses of controlled substances wasted for any reason. 5). Schedule III, IV, V controlled substances are disposed according to CII policy.