

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555663	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Lindsay Gardens Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 W. Tulare Road Lindsay, CA 93247	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement and revise a comprehensive care plan (CP) for three of 33 sampled residents (Resident 61, Resident 81 and Resident 36). This failure had the potential to result in Resident 61, Resident 81, and Resident 36 having an unrecognized change in condition and adverse health outcomes. Findings: During a concurrent observation and interview on 1/6/26 at 12:10 p.m. with Dietary Manager Assistant (DMA) in the kitchen, Resident 61's lunch meal plate contained a taco with a flour tortilla and ground pork, lettuce and tomatoes, a number (#) 12 scoop (1/3 cup) of beans and one slice of wheat bread. DMA stated Resident 61 requested an alternate meal versus the planned renal/CCHO (Consistent Carbohydrate) diet of 3 oz (ounces) of pork, 1 oz. pear sauce, #12 scoop polenta (cornmeal), 1/2 cup broccoli, one wheat roll, 1/2 cup diet (sugar free) canned pears. DMA stated the facility did not have meal alternatives available that have been evaluated and/or modified for therapeutic diets. DMA stated the Dietary Manager instructed dietary staff to serve Resident 61 the available meal alternative whenever he asked for it because he had a signed contract/form. DA showed the alternative meals available to serve to Resident 61 upon his request that was posted on a board located inside DMA's office in the kitchen that indicated, Mon [Monday] &ndash; grilled cheese & tomato soup, Tue [Tuesday] &ndash; Tacos, Wed [Wednesday] &ndash; Chicken Nuggets, Thur [Thursday] Chef Salad, Fri [Friday] &ndash; Pizza, Sat [Saturday] Chicken Patty.Sun [Sunday] &ndash; Soup & Biscuit. DMA stated those alternatives were provided by the Dietary Manager and they were not incorporated into a facility policy and procedure or typed up and posted, but that was the alternative meal schedule that kitchen staff followed. During a concurrent observation and interview on 1/6/26 at 12:26 p.m. with Resident 61 in his room, Resident 61 was lying in bed covered with a blanket. Resident 61 stated he did not want to eat because he was not feeling well. During an interview on 1/7/26 at 4:06 p.m. with Resident 61, Resident 61 stated he was feeling better today. Resident 61 stated he wants to eat everything. Resident 61 stated he liked tacos and beans. Resident 61 stated he did not care if tomatoes were on his tacos or not as that was not so important to him. Resident 61 was asked if he might be willing to follow some things on a therapeutic diet while other food items he may want served in an authentic manner (not modified), and he said yes, while nodding his head up and down. During a review of Resident 61's Diet Waiver, dated 3/7/23, the diet waiver form indicated, I understand that my doctor, registered dietician, or speech therapist for reasons for my health and medical treatment, has ordered or recommended a diet of: CCHO/Renal related to the diagnoses of Chronic Kidney Disease. I understand that not following the prescribed diet may be detrimental to my (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 12/31/25 was reviewed. The CP indicated Oxygen: Resident requires the use of oxygen continuous related to shortness of breath. Wheezing, CHF [congestive heart failure, chronic condition of heart being unable to pump adequate amount of blood] date initiated 12/31/25. Administer oxygen at 2L [liter] via NC [nasal cannula] date initiated 12/31/25. Monitor oxygen saturation [oxygen levels in blood] via pulse oximetry [device used to measure oxygen levels] daily and PRN [as needed]. date initiated 12/31/25. ADON stated she was not able to find results of resident being monitored for oxygen saturation and stated the last oxygen saturation was documented on 10/17/25. ADON stated there were no recent oxygen saturation results documented and stated they were not implementing the CP and they should have been. During a review of the facility's P&P titled, Care plans, Comprehensive person-Centered, dated 2022, the P&P indicated, A Comprehensive, person-centered care plan that includes measurable objectives and time-tables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview and record review, the facility failed to: 1. Obtain a physician's order for two of six sampled residents (Resident 36 and Resident 84) prior to oxygen use. This failure had the potential for Resident 84 and Resident 36 to have serious health outcomes, including hypoxia (lack of oxygen) or oxygen toxicity (too much oxygen) causing lung damage and confusion. 2. Follow physician's orders for one of six sampled resident (Resident 84) when oxygen saturation levels were not monitored. This failure had the potential to result in missed early signs of low blood oxygen levels which could lead to potential organ damage, especially to the heart and brain. Findings: 1. During an observation on 1/5/26 at 12:22 p.m. in the facility dining room, Resident 36 was sitting at the dining table having her lunch. Resident 36 was using a nasal cannula (NC - a thin tubing with two prongs that are placed in the nose to deliver oxygen) with an empty oxygen tank attached to her wheelchair. During a concurrent observation and interview on 1/5/26 at 12:25 p.m. with Licensed Vocational Nurse (LVN) 6 in the facility dining room, LVN 6 checked the oxygen tank attached to Resident 36's wheelchair, LVN 6 stated the tank was empty and should have changed before bringing Resident 36 to the dining room. During a concurrent interview and record review on 1/7/26 at 2:08 p.m. with Assistant Director of Nurses (ADON), Resident 36's Physician orders (PO) were reviewed. ADON stated she could not find an order for oxygen for Resident 36. ADON stated Resident 36 is receiving oxygen and should have had an order before it was administered. During a concurrent observation and interview on 1/8/26 at 9:33 a.m. with Resident 84 in Resident 84's room, Resident 84 was receiving oxygen at 3 liters via a NC. Resident 84 stated she had been wearing continuous oxygen for years. During a concurrent interview and record review on 1/8/26 at 9:39 a.m. with LVN 8, Resident 84's PO, (undated) were reviewed. The PO indicated, Resident 84 did not have an order for oxygen. LVN 8 stated Resident 84 did not have a physician order for continuous oxygen use and should have had one. During an interview on 1/8/26 at 10:59 a.m. with Director of Nursing (DON), DON stated Resident 84 did not have a physician order for the use of oxygen and should have had one. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated 2010, the P&P indicated, 1. Verify that there is a physician's order for this procedure, Review the physician orders or facility protocol for oxygen administration. 2. During a review of Resident 84's Order Review Report (ORR), dated 7/14/25, the ORR indicated, Monitor Pulse Oximetry [device used to monitor oxygen levels] q [every] shift: If O2 [oxygen] < [less than] 90 % [percent] administer O2 via NC. During a concurrent observation and interview on 1/8/26 at 9:33 a.m. with Resident 84 in Resident 84's room, Resident 84 was receiving oxygen at 3 liters via a nasal canula. Resident 84 stated she had been wearing continuous oxygen for years. Resident 84 stated staff check her vital signs once (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	per night. Resident 84 stated she thinks staff need to check her oxygen levels more often. During a concurrent interview and record review on 1/8/26 at 9:39 a.m. with LVN 8, Resident 84's Medication Administration Record (MAR), dated January 2026 was reviewed. The MAR indicated Resident 84 did not have any oxygen saturation monitoring documented. LVN 8 stated resident oxygen saturation levels are checked in the mornings and during medications administration and should be documented in the resident MAR. LVN 8 stated Resident 84 did not have any oxygen saturation levels documented in her MAR. LVN 8 stated Resident 84's oxygen saturation levels should have been documented each shift. During a concurrent interview and record review on 1/8/26 at 10:58 a.m. with DON, Resident 84's MAR, dated December 2025 was reviewed. The MAR indicated, Monitor Pulse Oximetry q shift. If O2 < 90 % administer O2 via NC. The MAR had an X in each box that was meant to be documented in from 12/1/25 through 12/31/25. DON stated the X on the MAR indicated that the task was not completed. DON stated Resident 84's oxygen saturations had not been documented in the chart and should have been. During a review of the facility's P&P titled Oxygen Administration, dated October 2010, the P&P indicated, The purpose of this procedure is to provide guidelines for safe oxygen administration.1. Verify there is a physician's order for this procedure. Review the physician's orders or facility protocol.Assessment.Before administering oxygen, and while the resident is receiving oxygen therapy, assess the following.vital signs.oxygen saturation.Documentation.the following information should be recorded in the resident's medical record.3. The rate of oxygen flow, route and rationale.6. All assessment data obtained.		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) was scheduled to work in the facility for at least eight consecutive hours a day, seven day per week. This failure had the potential to adversely affect resident care. Findings: During an interview on 1/7/26 at 8:58 a.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated, there was an RN that worked on weekends, but was not sure if there was an RN scheduled to work on weekdays. During an interview on 1/7/26 at 9:03 a.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 stated there was an RN that worked weekends and the RN working on weekdays was the Director of Nursing (DON). During an interview on 1/7/26 at 9:10 a.m. with LVN 7, LVN 7 stated the facility had an RN who worked daily. LVN 7 stated the RN working was the DON. During an interview on 1/7/26 at 9:28 a.m. with Human Resources/Payroll Manager (HR/PM) and Administrator, Administrator stated she had been working in this facility since June 2025 and the facility has not had an RN working on the floor consistently. Administrator stated they utilize the DON for coverage. HR/PM stated the facility had one DON and two RN's. HR/PM stated there have been days when there was not an RN on the unit besides the DON. During an interview on 1/7/26 at 9:49 a.m. with Administrator, Administrator stated this was a 99-bed facility and the census averaged over 60 residents at all times. Administrator stated the facility did not have an RN to work daily on the weekdays and they should have had an additional RN besides the DON. During a concurrent interview and record review on 1/8/26 at 11:39 a.m. with HR/PM, RN 1 and RN 2's Time Sheets (TS) dated 10/1/25 to 1/7/26 were reviewed. The TS indicated, there were no RN's working in the facility on 10/1/25, 10/2/25, 10/3/25, 10/8/25, 10/9/25, 10/10/25, 10/13/25, 10/14/25, 10/15/25, 10/16/25, 10/17/25, 10/21/25, 10/22/25, 10/24/25, 10/27/25, 10/29/25, 11/4/25, 11/5/25, 11/6/25, 11/7/25, 11/10/25, 11/11/25, 11/13/25, 11/14/25, 11/18/25, 11/19/25, 11/20/25, 11/21/25, 11/25/25, 11/26/25, 12/1/25, 12/2/25, 12/3/25, 12/4/25, 12/5/25, 12/8/25, 12/9/25, 12/10/25, 12/11/25, 12/12/25, 12/15/25, 12/16/25, 12/17/25, 12/22/25, 12/23/25, 12/24/25, 12/30/25, 12/31/25 and 1/1/26. HR/PM stated there were multiple days per week when there was no RN working 8 consecutive hours besides the DON. Policy requested, facility failed to provide.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure:1. The facility's 3-compartment procedure for manual dishwashing was followed by one of one sampled dietary aide (DA) 1 who washed one piece of foodservice equipment via the 3-compartment sink.2. One of five observed dietary employees (DA 2) washed their hands after a cross-contamination incident during the lunch tray line meal service for residents. These failures had the potential to place residents at risk of foodborne illness who received meals from the kitchen. Findings:1. During a concurrent observation and interview on 1/6/26 at 11:25 a.m. with DA 1 in the kitchen, DA 1 was observed washing a large mixing food container in the first sink of the 3-compartment sink. DA 1 then removed the container and placed it in the 3rd compartment sink that contained a sanitizing solution. DA 1 stated she did not use the 2nd compartment to rinse off the container after washing it because there was no foam on the container. During an interview on 1/6/26 at 3:55 p.m. with Dietary Manager Assistant (DMA), DMA stated DA 1 reported the above to her, and DMA stated she should have rinsed off the container in the 2nd compartment prior to placing the container in the 3rd compartment to sanitize. During a review of the facility's policy and procedure (P&P) titled, 3-Compartment Procedure For Manual Dishwashing, dated 2023, the P&P indicated, Procedure: The first compartment is for washing. Fill the first compartment with detergent per manufacturers instructions and hot water. Replace water when it becomes cloudy or dirty, the suds are gone, or when temperature falls below 110 degrees F [Fahrenheit]. The second compartment is for rinsing. Fill the second compartment with clean, clear hot water, (110 degrees F-120 degrees F). Immerse washed items and rinse thoroughly, making sure all detergent is removed. Replace water when it becomes cloudy or dirty, or when temperature falls below 110 degrees F. The third compartment is for sanitizing. During a review of the FDA Food Code (FDAFC), dated 2022, the FDAFC indicated, If washing in sink compartments. washed UTENSILS and EQUIPMENT shall be rinsed so that abrasives are removed and cleaning chemicals are removed or diluted through the use of water. During a review of the FDA Food Code Annex (FDAFCA), dated 2022, the FDAFCA indicated, It is important to rinse off detergents, abrasive, and food debris after the wash step to avoid diluting or inactivating the sanitizer. 2. During a concurrent observation and interview on 1/6/26 at 11:45 a.m. with DA 2 in the kitchen, DA 2 wore blue gloves and placed her hands in her pants pockets, removed her gloved hands from her pockets and proceeded to pick up a plate cover for a residents' lunch meal service. DA 2 then proceeded to cross her arms touching her skin and shirt and continued with lunch tray line, without removing her gloves to wash her hands and put on a clean pair of gloves. During an interview on 1/6/26 at 11:47 a.m. with DA 2, DA 2 stated she should not have placed her hands (even with gloves) in her pockets or touched her body. DA 2 stated, It's unsanitary. During an interview on 1/6/26 at 4 p.m. with DMA, DMA stated DA 2 reported the above to her, and DMA stated she should have removed her gloves and washed her hands. During a review of the facility's P&P titled, Hand Washing Procedure, dated 2023, the P&P indicated, Hand washing is important to prevent the spread of infection. When Hands Need To Be Washed: .after touching your hair or face. During a review of the FDAFC, dated 2022, the FDAFC indicated, When to Wash. Food employees shall clean their hands and exposed portions of their arms. immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and. to prevent cross contamination when changing tasks. Before donning gloves to initiate a task that involves working with food.		

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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. Based on observation, interview and record review, the facility failed to follow infection control standards when: 1. A Water Management Program (WMP) was not implemented, for 32 of 32 sampled residents, when risk for growth of opportunistic waterborne pathogens (germs that grow well in water) was not assessed, areas for growth were not identified, and measures to prevent and monitor growth were not identified within the facility's water system. This failure had the potential to result in serious illness or death of residents, visitors and staff. 2. Licensed Vocational Nurse (LVN) 4 failed to use aseptic technique for one of four sampled residents (Resident 5) when she introduced a syringe in Resident 5's mouth and then reintroduced the used syringe into the clean medication container. This failure had the potential to contaminate the medication container with bacteria and microorganisms. Findings: 1. During a concurrent interview and record review on 1/7/26 at 10:55 a.m. with Infection Preventionist (IP), the facility's policy and procedure (P&P) titled, Legionella [bacteria that can grow in man-made water systems like cooling towers and plumbing, especially in warm water] Water Management Program, dated September 2022 was reviewed. The P&P indicated, 5. The water management program includes the following elements: . b. A detailed description and diagram of the water system in the facility. c. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria. d. The identification of situations that can lead to Legionella growth. e. Specific measures used to control the introduction and/or spread of Legionella. f. The control limits or parameters that are acceptable and that are monitored; g. A diagram of where control measures are applied; h. A system to monitor control limits and the effectiveness of control measures; i. A plan for when control limits are not met and/or control measures are not effective; and j. Documentation of the program. IP stated the facility does not have documentation of the water management program. IP was unable to verbalize areas within the facility that were assessed for risk, measures used to mitigate risk, acceptable control limits and parameters of the measures used, and how control limits and parameters were monitored. During an interview on 1/7/26 at 11:07 a.m. with Maintenance Director (MD), MD stated he did not have training regarding the WMP and prevention of Legionella growth. MD was unable to verbalize areas of the facility that were at risk for bacteria growth in the water system. MD was unable to verbalize measures used to mitigate and monitor the risk of growth. MD was unable to identify control limits and parameters for the measures used. MD stated there was no diagram or documentation of description of the facility water system with identified areas of concern for growth. During a review of the Center for Disease Control (CDC) document titled, Toolkit for Controlling Legionella in Common Sources of Exposure (LCT - Legionella Control Toolkit), dated 12/26/24, the LCT indicated, [S] Sediment [Mineral build-up in a water system that uses up disinfectant and encourages growth of bacteria] and biofilm [layer produced by germs that stick to and grow on moist surfaces; provides an environment for growth of bacteria including Legionella], Temperature [T], water Age [A], and disinfectant Residuals [R] (STAR) are the key factors that affect Legionella growth in potable [water that is safe for ingestion] water systems. A comprehensive WMP allows water system operators to layer a series of complementary control measures to create environmental conditions that prevent bacterial intrusion, growth, and transmission. Develop or refine a WMP with the following guidelines in mind: . Monitor temperature, disinfectant residuals, and pH [potential of hydrogen - measures a substance's acidity or alkalinity] frequently. Store hot water at temperatures above 140 degrees F [Fahrenheit] and ensure hot water in circulation does not fall below 120 degrees F. Store and circulate cold water at temperatures below the favorable range for Legionella (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	77&ndash;113 degrees F. Ensure a disinfectant residual [Chlorine (disinfectant added to tap water as a disinfectant to kill harmful bacteria) and Monochloramine (longer-lasting disinfectant)] is detectable throughout the potable water system. Flush low-flow piping runs and dead legs at least weekly and flush infrequently used fixtures (e.g., eye wash stations, emergency showers) regularly as-needed to maintain water quality parameters within control limits. Clean and maintain water system components, such as thermostatic mixing valves, aerators, showerheads, hoses, filters, and storage tanks, regularly. 2. During a review of Resident 5's Medication Administration Record, (MAR) dated 1/1/26 through 1/31/26, the MAR indicated, Morphine Sulfate (MS) (Concentrate) Oral Solution 20 mg (milligram)/ML (milliliter) (Morphine Sulfate Give 2.25 ml by mouth every 4 hours as needed for Severe pain 7-10 or SOB [shortness of breath] place under tongue or in cheek pocket. During an observation on 1/7/26 at 8:52 a.m. in Resident 5's room, LVN 4 administered Resident 5's MS oral liquid 2.25 ml under Resident 5's tongue. LVN 4 drew up one ml of MS in syringe and placed syringe under the tongue of Resident 5 and administered. LVN 4 with same syringe drew up another one ml of MS in the used syringe and administered under the tongue of Resident 5. LVN 4 then drew up another 0.25 ml of MS in same used syringe and administered the 0.25 ml under the tongue of Resident 5. LVN 4 then placed the used syringe in a plastic bag. During an interview on 1/7/26 at 9:56 a.m. with Director of Nursing (DON) and LVN 4, LVN 4 stated she had drawn up one ml of MS from container and then administered under Resident 5's tongue and then put the used syringe back into the MS container and drew up another one ml of MS and administered the morphine under the tongue of Resident 5 with the same syringe. LVN 4 stated she then used the same syringe to draw up 0.25 ml of MS and administered under the tongue of Resident 5. LVN 4 stated she should have disinfected the syringe in between putting the same syringe back into the container after administering the medication. DON stated LVN 4 should have cleaned the syringe after putting the syringe into Resident 5's mouth. During a review of the facility's P&P titled, Administering Medications, dated December 2012, the P&P indicated, Staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable.		

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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 ensure one of two sampled residents (Resident 7) was provided dignified care when Resident 7's urine collection bag was not covered and was visible to other residents, staff and visitors. This failure had the potential to result in emotional distress for Resident 7. Findings: During an observation on 1/6/26 at 9:38 a.m. outside of Resident 7's room, a urine collection bag containing yellow liquid was hanging on the side of Resident 7's bed and was visible from the hallway. During a concurrent observation and interview on 1/6/26 at 9:43 a.m. with Licensed Vocational Nurse (LVN) 9, outside of Resident 7's room, a urine collection bag containing yellow liquid was hanging on the side of Resident 7's bed and was visible from the hallway. LVN 9 stated the collection bag needed a cover to provide privacy for Resident 7. During a review of Resident 7's Order Review Report (ORR), dated 1/8/26, the ORR indicated, Indwelling urinary (Foley [brand name of catheter, inserted into the bladder to drain urine]) catheter is in privacy bag and catheter leg strap on at all times. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated August 2009, the P&P indicated, 3. Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview and record review, the facility failed to ensure two of two sampled residents (Resident 99 and Resident 87) were provided privacy when 24 hour video surveillance was used to monitor Resident 99 and Resident 87 without written consent. This failure resulted in the violation of Resident 99 and Resident 87's right to privacy and confidentiality and the potential to result in emotional distress. Findings: During a concurrent observation and interview on 1/5/26 at 11:12 a.m. with Licensed Vocational Nurse (LVN) 9, in the doorway of Resident 99's room, a round shaped item was hanging on the wall at the foot of Resident 99's bed. LVN 9 stated the item was a video camera used to monitor Resident 99. LVN 9 stated the monitor screen was at the nurses station allowing all staff to monitor Resident 99. During an observation on 1/5/26 at 11:12 a.m. a monitor screen was sitting on the counter at the nurses station, Resident 99 was visible lying in his bed. During a concurrent interview and record review on 1/8/26 at 11:53 a.m. with Director of Nursing (DON), Resident 99's medical record (MR) was reviewed. DON stated there was no consent form for video surveillance for Resident 99. During a concurrent interview and record review on 1/8/26 at 11:55 a.m. with DON, Resident 99's MR was reviewed. DON stated there were no Interdisciplinary Team (IDT - group of health care providers that meet to discuss resident care) notes indicating Resident 99 gave consent for video surveillance. During a concurrent interview and record review on 1/8/26 at 11:57 a.m. with DON, Resident 99's MR was reviewed. DON stated there was no physician order for video monitoring of Resident 99. During a concurrent interview and record review on 1/8/26 at 11:59 a.m. with DON, Resident 99's Care Plan (CP), dated 10/27/25 was reviewed. The CP did not indicate use of video monitoring as an intervention for care of Resident 99. DON stated the use of video monitoring needed to be on Resident 99's CP. During a concurrent observation and interview on 1/7/26 at 2:53 p.m. with LVN 7, in the doorway of Resident 87's room, a small round item was on the bedside table next to Resident 87's bed. LVN 7 stated the item was a video camera. LVN 7 stated both Resident 87 and Resident 99 have video cameras in their rooms to monitor and help prevent falls. LVN 7 stated the monitor screen was kept at the nurses station so she and other staff could monitor the residents. During a concurrent interview and record review on 1/8/26 at 12:03 p.m. with DON, Resident 87's MR was reviewed. DON stated there was no consent form for video surveillance for Resident 87. During a concurrent interview and record review on 1/8/26 at 12:05 p.m. with DON, Resident 87's MR was reviewed. DON stated there were no IDT notes indicating Resident 87 gave consent for video surveillance. During a concurrent interview and record review on 1/8/26 at 12:07 p.m. with DON, Resident 87's MR was reviewed. DON stated there was no physician order for video monitoring of Resident 87. During a concurrent interview and record review on 1/8/26 at 12:10 p.m. with DON, Resident 87's CP, dated 10/14/25 was reviewed. The CP indicated, Baby monitor Date Initiated 10/29/24 under interventions. DON stated the video surveillance intervention was started in October of 2024. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated August 2009, the P&P indicated, 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . d. Privacy and confidentiality. 3. Our facility will make ever effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity. During a review of the facility's P&P titled, Using Surveillance Equipment, dated December 2006, the P&P indicated, 1. Surveillance equipment is defined as any device that may monitor, record, or transmit sound, pictures, or other information . 2. Unless approved by the Administrator, and with the consent of the resident, surveillance equipment may not be installed in any resident room or treatment area.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to ensure one of 33 sampled residents (Resident 61) IDT (interdisciplinary team, group of health care professionals that meet to discuss resident care) comprehensive plan of care was updated and revised to reflect Resident 61's current health status, care needs and interventions. This failure had the potential for Resident 61 not to receive care that could negatively impact the quality of life/care. Findings: During a review of Resident 61's Nephrologist [a medical doctor who specializes in diagnosing, treating, and managing kidney diseases and disorders] Progress Note (NPN), dated 6/23/25, the NPN indicated, Acute [sudden onset] kidney injury [loss of kidney function] superimposed on chronic [long term] kidney disease [kidney's unable to filter waste and extra fluid from the blood as well as they should] and acute renal [kidney] failure and nutritional risk .good u/o [urinary output, which is a key indicator of proper kidney function].no edema [fluid retention], no swelling joints. During a concurrent interview and record review on 1/7/26 at 3:20 p.m. with Director of Nursing (DON), Resident 61's IDT comprehensive plan of care (CP) titled, renal failure r/t [related to] chronic kidney disease and acute renal failure, initiated on 6/27/25 with a target date of 3/16/26 was reviewed. The CP indicated, Interventions/Tasks: Monitor/document/report PRN [as needed] the following s/sx [signs and symptoms]: Edema, weight gain of over 2 lbs [pounds] a day. DON stated they have no way to monitor whether Resident 61 gained over 2 lbs of weight in a day since he was weighed one time a month. DON stated the CP needed to be updated and revised. During a concurrent interview and record review on 1/7/26 at 3:25 p.m. with DON, Resident 61's IDT CP titled, Nutritional Risk, date initiated 6/27/25 with a target date of 3/16/26, was reviewed. The CP indicated, Last Care Plan Review Completed 12/16/2025, Interventions/Tasks: Monitor intake and output [I&O's]. DON stated Resident 61 did not have an order for I&O's. DON stated nursing staff were not implementing Resident 61's I&O's as urinary output was not being quantified. DON stated Resident 61's CP needed to be updated and revised. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated March 2022, the P&P indicated, The comprehensive, person-centered care plan should: Describe the services that are to be furnished in an attempt to assist the resident attain or maintain that level of physical, mental, and psychosocial wellbeing that the resident desires or that is possible. The interdisciplinary team should review and updates the care plan: a. When there has been a significant change in the resident's condition; b. When the resident has been readmitted to the facility from a hospital stay, and c. At least quarterly, in conjunction with the required quarterly MDS [minimum data set] assessment.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Telephone Orders, when one of 33 sampled resident (Resident 10) physician telephone orders were not recorded in Resident 10's medical record. This failure resulted in Resident 10 not receiving recommended treatments and had the potential for skin breakdown. Findings: During an interview on 1/5/26 at 3:08 p.m. with Resident 10, Resident 10 stated he had an area on his buttocks that occasionally burns. During an interview on 1/7/26 at 3:01 p.m. with Licensed Vocational Nurse (LVN) 8, LVN 8 stated Resident 10's buttocks did not have any skin breakdown. LVN 8 stated Resident 10 did not have any treatments for his buttocks. LVN 8 stated a physician's order was required before applying a skin barrier cream. (creates a protective layer on skin to help prevent damage, rash and dryness). LVN 8 stated Physician 1 rounds on Thursdays with the Assistant Director of Nursing (ADON) and makes recommendations for residents with wounds and skin breakdown. LVN 8 stated the resident's primary physician is made aware of Physician 1's recommendations and orders are placed if the primary physician agrees. During a concurrent interview and record review on 1/7/26 at 3:08 p.m. with ADON, Resident 10's Progress Note (PN), dated 12/18/25 was reviewed. The PN indicated, Weekly wound assessment IDT [Interdisciplinary Team, healthcare professionals from different fields meet to coordinate resident care plans to ensure all aspects of resident physical, emotional and social needs are addressed], [Physician 1] in for weekly wound assessment, findings as follows. Sacro-coccyx [triangular shaped bone at the bottom of the spine, near buttocks] DTI [Deep Tissue Injury, damage to soft tissue underneath intact skin]. TX [treatment] recommendations: Cleanse with NSS [normal Saline Solution, a sterile, non-irritating solution used to rinse and clean wounds], pat dry, apply barrier cream daily. [Physician 2] and IDT notified of recommendations and agreed with plan of care. ADON stated Resident 10 should be getting barrier cream applied to his Sacro-coccyx area daily. During a concurrent interview and record review on 1/7/26 at 3:12 p.m. with ADON, Resident 10's Treatment Administration Record (TAR) dated December 2025 and January 2026 were reviewed. ADON stated there were no treatment records for Resident 10's recommended daily use of barrier cream to the Sacro-coccyx. During a concurrent interview and record review on 1/7/26 at 3:14 p.m. with ADON, Resident 10's Order Review Report (ORR), dated 1/7/26 was reviewed. ADON stated Resident 10 did not have any physician orders for barrier cream to the Sacro-coccyx. ADON stated she had called Resident 10's primary doctor to inform him of Physician 1's recommendations on 12/18/25. ADON stated she had received telephone orders but did not document the orders in Resident 10's medical record. ADON stated she should have placed the orders. During a review of the facility's P&P titled, Telephone Orders, dated February 2014, the P&P indicated, Verbal telephone orders may be accepted from each resident's Attending Physician. Orders must be reduced to writing, by the person reviewing the order, and recorded in the resident's medical record. The entry must contain the instructions from the physician, date, time, and the signature and title of the person transcribing the information. Telephone orders must be countersigned by the physician during his or her next visit.		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of 33 sampled residents (Resident 5) received treatment and services to bilateral feet. This failure resulted in Resident 5 having dry, flaky skin around toes, and feet, and long thickened untrimmed toenails and had the potential to cause skin breakdown and infection. Findings: During a review of Resident 5's admission Record (AR), dated 1/8/26, the AR indicated Resident 5 was admitted on [DATE]. During a concurrent observation and interview on 1/6/26 at 9:06 a.m. with Resident 5 and Certified Nursing Assistant (CNA) 2, in Resident 5's room, Resident 5's feet were exposed and had dry flakey skin around toes and the top and bottom of both feet. Resident 5's toenails were long, thick and untrimmed, Resident 5 stated she had not seen a podiatrist and no one has taken care of her feet. CNA 2 stated Resident 5's toenails were very thick and yellow and green with dry scaly skin around toes and feet. CNA 2 stated the nurses take care of the residents feet. During a concurrent observation and interview on 1/6/26 at 9:12 a.m. with Licensed Vocational Nurse (LVN) 2, in Resident 5's room, Resident 5's feet were exposed. LVN 2 stated Resident 5 had thick, long nails on both feet, flaky skin around feet and toes. LVN 2 stated the expectation would be for lotion around the feet and for her to see a podiatrist, and to contact hospice (end of life care). LVN 2 stated her skin and nails had not been attended to as needed. During an interview on 1/8/2026 at 3:02 p.m. with Director of Nursing (DON), DON stated Resident 5 had not been provided proper foot care and the staff are to alert licensed staff even if a resident is receiving hospice care and this had not been done. During a review of the facility's policy and procedure (P&P) titled, Foot Care, dated March 2018, the P&P indicated, Residents will receive appropriate care and treatment in order to maintain mobility and foot health. 1. Residents will be provided with foot care and treatment in accordance with professional standards of practice. 2. Overall foot care will include the care and treatment of medical conditions associated with foot complications. a4. Trained staff may provide routine foot care (e.g., toenail clipping) within professional standards of practice for residents without complicating disease processes. Residents with foot disorders or medical conditions associated with foot complications will be referred to qualified professionals.		

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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 one of two sampled resident (Resident 68) head of bed (HOB) was elevated during G-tube feeding (gastrostomy tube, a small flexible tube surgical inserted through the abdomen and placed into the stomach to deliver nutrition, fluids, and medication directly into stomach). This failure had the potential to cause aspiration (liquid or food enters into the lungs instead of the stomach) for Resident 68. Findings: During an observation on 1/6/26 at 9:01 a.m. in Resident 68's room, Resident 68 was laying in bed with Jevity 1.5 (formula) running at 60 ml (milliliters) per hour. Resident 68's HOB was positioned below a 30-degree angle (approximate 15 degrees). Resident 68's bed did not have a device to indicate the angle of the HOB. During a concurrent observation and interview on 1/6/26 at 9:05 a.m. with Certified Nursing Assistant (CNA) 1 in Resident 68's room, Resident 68's HOB was below a 30-degree angle while tube feeding was running at 60 ml/hour. CNA 1 stated Resident 68's HOB should have been elevated to 40 degrees while feeding was running. CNA 1 tried to find an indicator on Resident 68's bed to indicate the degree of the HOB. CNA 1 stated she could not find how elevated Resident 68's HOB was. CNA 1 stated, As long as her [Resident 68's] head isn't flat down during feedings. During an interview on 1/6/26 at 9:07 a.m. with Resident 68, Resident 68 stated her HOB is usually up, but today it isn't. During an interview on 1/6/26 at 9:08 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the HOB should be at a 90-degree angle when residents are receiving tube feedings. During a concurrent observation and interview on 1/6/26 at 9:10 a.m. with LVN 1 in Resident 68's room, Resident 68's HOB was below a 30-degree angle while tube feeding was running at 60 ml/hour. LVN 1 stated Resident 68's HOB was not elevated to a 30 degree angle. LVN 1 stated Resident 68's HOB should have been elevated during feedings. LVN 1 stated she could not tell how elevated Resident 68's HOB was because there was no indicator on Resident 68's bed. During a review of Resident 68's Order Review Report (ORR), dated 12/12/25, the ORR indicated, Enteral [tube feeding] Feed Order.TF [tube feeding] to run 17 hours/day. Jevity 1.5, run at 60 ml/ hour with 45ml/hour water flush. During a review of Resident 68's ORR, dated 12/10/25, the ORR indicated, KEEP HOB AT 45 DEGREES OR GREATER AT ALL TIMES. During a review of Resident 68's Care Plan Report (CPR), dated 12/9/25, the CPR indicated, Resident is at risk for enteral nutrition complications related to aspiration pneumonia [infection of lungs]. Interventions. HOB elevated to at least 30 degrees. During a review of the facility's policy and procedure (P&P) titled, Enteral Feedings - Safety Precautions, dated November 2018, the P&P indicated, To ensure the safe administration of enteral nutrition. Preventing Aspiration. 3. Elevate the head of the bed (HOB) at least 30 [degrees] during tube feeding and at least 1 [one] hour after feeding.		

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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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure its policy and procedure (P&P) titled, Foods Brought by Family/Visitors provided sufficient guidance on safe refrigerated food storage and was followed for labeling resident's outside food brought into the facility. These failures had the potential to place residents storing outside food in the employees' breakroom refrigerator at risk of foodborne illness. Findings: During an interview on 1/5/26 at 10:30 a.m. with Licensed Vocational Nurse (LVN) 9, LVN 9 stated residents food brought in from the outside was stored in the employee's refrigerator in the employee breakroom. During a concurrent observation and interview on 1/5/26 at 10:31 a.m. with LVN 9 in the employee's breakroom, inside the refrigerator a white plastic bag that was tied with a container inside, and had 101A noted on the outside of the white plastic bag. LVN 9 stated outside food was stored in the white plastic bag for the resident in room [ROOM NUMBER]A. LVN 9 stated the white plastic bag did not have a resident's name on it and was not dated with a use by date. LVN 9 observed a thermometer inside the refrigerator and LVN 9 stated, It's 24 degrees F [Fahrenheit]. LVN 9 stated he did not know if there was temperature monitoring of the refrigerator for staff to be able to identify when the temperature may be out of range and unsafe to store food. During a concurrent observation and interview on 1/5/26 at 10:33 a.m. with Dietary Aide (DA) 3 in the employee's breakroom, DA 3 observed the white plastic bag labeled 101A. DA 3 stated they were not allowed to store food brought in from family or visitors in the refrigerators in the kitchen. During an interview on 1/7/26 at 4:30 p.m. with Director of Nursing (DON), DON stated there was no temperature monitoring of the refrigerator located in the employee's breakroom used to store resident food brought in from outside of the facility by family/visitors and there should have been. During a review of the facility's P&P titled, Foods brought by Family/Visitors, dated 5/28/25, the P&P indicated, Food brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents. Policy Interpretation and Implementation: The dietician, nurse supervisor, or other designee will provide necessary education to the nursing staff on safe food handling practices and identify where this information is readily available for reference. The food service or nursing staff may assist with reheating or other preparation activities using safe food handling practices including safe reheating, hot/cold holding, handling of leftovers, and contamination avoidance. Food brought by family/visitors that is left with the resident to consume later is labeled and stores in a manner that is clearly distinguishable from facility prepared food. Containers are labeled with the residents name, the item and the use by date. During a review of the facility's P&P titled, Procedure For Refrigerated Storage, dated 2023, the P&P indicated, Refrigerator - 41 degrees F or lower.		