

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555703	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Ridgeway Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 523 Hayes Lane Petaluma, CA 94952	
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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the rights of three of 18 sampled residents (Residents 11, 12, and 23) were considered when nursing staff did not inform them of the medications being administered during their medication administration process. This failure limited the residents' ability to participate in their care, ask questions, and make informed decisions regarding the medications they received. 1. A review of Resident 11's admission record (facility demographic) indicated she was admitted to the facility in January 2026 with medical diagnosis which included malignant neoplasm of the vulva (cancer that originates in the external female genitalia) and acute diastolic (congestive) heart failure (when the heart muscle becomes stiff and does not relax). A review of Resident 11's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 4/24/26, indicated her Brief Interview of Mental Status (BIMS-a cognition [the processes of thinking and reasoning] assessment) score was 12, which indicated her cognition was moderately impaired (a score of 1-7 indicates cognition is severely impaired, 8-12 indicates cognition is moderately impaired, and 13-15 indicates cognition is intact). During an interview on 6/16/26 at 9:30 a.m., Resident 11 stated on one occasion during medication administration the nurse did not tell her what she was given. Resident 11 stated she refused all the medications because the nurse would not explain to her what they were. Resident 11 further stated that she did not like not being educated in regard to her medications and stated it was her right to know. 2. A review of Resident 12's admission record indicated he was admitted to the facility in December 2025 with medical diagnosis which included metabolic encephalopathy (a disease of the brain that changes brain function or structure) and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). A review of Resident 12's MDS dated [DATE], indicated his BIMS score was two, which indicated his cognition was severely impaired. During an observation on 6/17/26 at 8:36 a.m., Licensed Nurse F (LN F) was observed mixing Resident 12's crushed medications in pudding. Resident 12 was difficult to arouse and LN F simulated Resident 12 until he opened his eyes. LN F stated, [Resident 12] I have your cookies. Eat your cookies. Resident 12 proceeded to eat the pudding. LN F did not inform Resident 12 that he received medications. 3. A review of Resident 23's admission record indicated he was admitted to the facility in August 2021 with medical diagnosis which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebrovascular disease (a condition that affects blood flow and blood vessels in the brain) and hypertensive heart disease (heart condition caused by unmanaged high blood pressure). A review of Resident 23's MDS dated [DATE], indicated his BIMS score was 15, which indicated his cognition was intact. During an observation on 6/17/26 at 8:36 a.m., LN F was observed administering Resident 23's his medications. LN F informed Resident 23 that his seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555703 If continuation sheet Page 1 of 14

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	uncontrolled jerking, blank stares, and loss of consciousness) medication was included but did not explain any other medications to him. Resident 23 proceeded to take his medication and stated, I don't know what I take- I just take them. During an interview on 6/18/26 at 8:23 a.m., LN A stated when medications were administered it was important to inform residents what they were receiving so that they were aware. LN A further stated, It is their [the resident] right to know. Even if they are non-verbal or don't understand, we are expected to still explain their medications to them. During an interview on 6/18/26 at 11:34 a.m., the Director of Nursing (DON) confirmed that nurse staff should inform residents of what medications they were receiving during medication administration. The DON stated, It's the patient's [resident] right to know what they are taking. A review of the facility's policy and procedures titled, Resident Rights, revised 2021, indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: be informed of, and participate in, his or her care planning and treatment.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect four of 18 sampled residents' (Resident 47, Resident 62, Resident 69, and Resident 87) personal privacy when: 1. Resident 87's document, titled, Resident Functional Status Checklist, was posted on a dresser stored in a public facility hallway, 2. Resident 69's electronic medical record was left open and visible on a computer screen located on top of a medication cart in a public facility hallway, and; 3. The alternate meal requests for Resident 62 and Resident 47, which included protected health information, were disposed of in the regular kitchen trash without undergoing shredding or proper destruction procedures. These deficient practices had the potential to result in unauthorized disclosure of residents' protected health information and violated their right to personal privacy. 1. A review of Resident 87's admission record (facility demographic) indicated he was admitted to the facility in March 2025 with medical diagnosis which included fracture of unspecified part of neck of the left femur (a break in the upper portion of the thigh bone) and diabetes mellites (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). Resident 87's admission record indicated he was discharged in November 2025. During an observation on 6/15/26 at 10:59 a.m. in Zinfandel hallway across from room [ROOM NUMBER] and next to room [ROOM NUMBER], a dresser was stored with a document titled, Resident Functional Status Checklist, posted on its side. The document disclosed Resident 87's name, room number, mobility status, and diet and feeding orders. During an observation and concurrent interview on 6/15/26 at 11:01 a.m., Certified Nurse Assistant D (CNA D) confirmed that the dresser in Zinfandel hallway had Resident 87's functional status document posted on its side. CNA D further confirmed that Resident 87's document was posted in a public hallway. CNA D stated Resident 87's privacy was not protected. During an observation and concurrent interview on 6/15/26 at 11:10 a.m., CNA E confirmed that the dresser in Zinfandel Hallway had Resident 87's functional status document posted on its side. CNA E further confirmed that Resident 87's document was posted in a public hallway. CNA E stated that Resident 87's private information was not protected and needed to be removed. CNA E confirmed it was a HIPAA (Health Insurance Portability and Accountability Act, a law designed to protect sensitive patient health information from being disclosed without the patient's consent or knowledge) violation. During an interview and concurrent photograph review on 6/18/26 at 11:34 a.m., the Director of Nursing (DON) reviewed the photograph taken of Resident 87's functional status document that was posted on the outside of a dresser stored in the hallway. The DON stated that staff should have ensured that Resident 87's functional status checklist was not in public view. The DON confirmed the document should not be accessible to the public and further stated it violated Resident 87's rights to privacy. The DON did not agree that Resident 87's posted document was a violation of HIPAA. 2. A review of Resident 69's admission record indicated he was admitted to the facility in September 2021 with medical diagnosis hemiplegia (total paralysis of the arm, leg, and trunk on the same side of (continued on next page)		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN [Licensed Practical Nurse]/LVN [Licensed Vocational Nurse], and Job Description: Certified Nursing Assistant [CNA], all dated 2024, indicated, Agree not to disclose resident's protected health information and promptly report suspected or known violations of such disclosure to the Administrator.		

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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 store food in a sanitary manner for a census of 74 residents when:1. A kitchen staff member prepared food without the required facial hair covering,2. The kitchen and food storage floors had blackened debris on painted, worn, and tiled surfaces, 3. Opened food containers requiring refrigeration were improperly stored on shelves in the food storage room,4. Raw poultry in the refrigerator was not properly labeled with preparation and expiration dates,5. Food items were opened, undated, and missing use-by dates in the food storage area,6. Daily kitchen cleaning was not documented; the log had missing entries, and the kitchen equipment and environment were not clean,7. Expired paper test strips were used to test the sanitation solution concentration in the red buckets,8. Handwashed plastic food bins were stacked while still wet, preventing proper drying, and were left on an unclean sink surface, and;9. The dishwashing machine was not tested for quality assurance at the start of the day shift before first use.These failures had the potential to result in foodborne illnesses and spread of infections in a vulnerable resident population.During a concurrent observation and interview on 6/15/26 at 8:48 a.m. with the Dietary Services Manager (DSM), [NAME] 1 was observed preparing food without a required beard covering. The DSM stated that [NAME] 1 should have been wearing a beard cover and instructed him to put one on before continuing meal preparation.During a concurrent observation and interview on 6/15/26 at 8:50 a.m. with the Dietary Services Manager (DSM), the kitchen floors were observed with black debris buildup, areas of exposed concrete where the floor coating was missing, and raised sections of floor coating with debris underneath. Black debris was also noted on the floor tiles in the dry storage room. The DSM stated he had been in the position for only one month and was actively working with staff to ensure daily kitchen cleaning to prevent foodborne illness. The DSM added that the facility was aware of the floor condition and had plans for a kitchen renovation within the next year.During a concurrent observation and interview on 6/15/26 at 9:08 a.m. with the Dietary Services Manager (DSM), two opened containers of teriyaki glaze and two opened containers of barbecue sauce, each requiring refrigeration after opening per manufacturer instructions, were found stored on open shelves in the dry storage room. The DSM reviewed the labels, confirmed the items should have been refrigerated after opening to prevent foodborne illness, and stated they needed to be discarded.During a concurrent observation and interview on 6/15/26 at 9:12 a.m. with the Dietary Services Manager (DSM), raw poultry marinating in a stainless steel container was stored in the refrigerator without a labeled preparation date or an accurate expiration/use-by date. The DSM stated staff should have labeled the poultry with the preparation date and an expiration or use-by date before storing it to prevent foodborne illness.During a concurrent observation and interview on 6/15/26 at 9:16 a.m. with the Dietary Services Manager (DSM), an opened bag of bagels and an opened bag of bread were found resealed without labels indicating the date opened or a use-by date. The DSM stated staff should have labeled both items when first opened with the date and included a use-by date. The DSM confirmed the bagels and bread needed to be discarded to prevent foodborne illness.During a concurrent observation and interview on 6/15/26 at 9:27 a.m. with the Dietary Services Manager (DSM), the June 2026 Kitchen Cleaning and Prep Log showed missing entries/blank spaces on June 3, 4, 10, and 11, 2026. Verification of cleaning and sanitizing the griddle, steam table, cook prep table, cook prep sink, can opener, and knives on June 11, 2026, was not recorded. The DSM stated the logs should have been completed daily on each shift to verify cleaning and sanitization. He added that he was working with staff and providing additional training to ensure (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	routine daily cleaning to prevent foodborne illness. During a concurrent observation and interview on 6/15/26 at 9:30 a.m. with the Dietary Services Manager (DSM), [NAME] 1 demonstrated how he tested the sanitization solution in the red buckets. [NAME] 1 used a paper test strip from a container labeled with a 6/01/23 expiration date. After testing, [NAME] 1 stated the concentration was acceptable. When asked whether expired test strips were appropriate to use, the DSM stated they were not, that expired strips needed to be discarded, and that the sanitization solution had to be retested with non-expired strips to ensure proper sanitization and prevent foodborne illness. During a concurrent observation and interview on 6/15/26 at 10:08 a.m. with the Dietary Services Manager (DSM), plastic food bins used for meal preparation were observed stacked while still wet after handwashing, preventing the interior surfaces from drying, and placed on an unclean sink surface. The DSM stated the bins should have been separated and air-dried on a clean surface to prevent foodborne illness. During a concurrent observation and interview in the kitchen on 6/17/26 at 10:15 a.m. with the Registered Dietician (RD), the Dietary Services Manager (DSM) reported the dishwasher had not been tested for the required minimum water temperature and sanitization solution concentration prior to first use on the day shift after breakfast. The RD confirmed the dishwasher was required to be tested and documented at the beginning of each shift. The RD stated testing before first use was essential to ensure proper sanitization of dishes and to prevent foodborne illness. During a review of the facility's policy titled, Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices, revised November 2022, the policy indicated, Hair nets or caps and/or beard restraints are worn when cooking, preparing or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens. During a review of the facility's policy titled, Sanitization, revised November 2022, the policy indicated, The food service area is maintained in a clean and sanitary manner. All utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use of proper cleaning. Food preparation equipment and utensils that are manually washed are allowed to air dry. During a review of the facility's policy titled, Food Receiving and Storage, revised November 2022, the policy indicated, Non-refrigerated foods are stored in a designated dry storage unit. Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded. During a review of the facility's DRY GOODS STORAGE GUIDELINES, dated 2023, the guidelines indicated the following in regard to the storage of barbecue sauce, This storage length is to be followed unless you have manufacturer's recommendation indicating otherwise. BBQ sauce. UNOPENED ON SHELF. 1 year. OPENED ON SHELF. N/A. OPENED, REFRIGERATED. 4 months. Storage guidelines are based on the [app for U.S. Department of Health and Human Services]. During a review of the facility's policy titled, REFRIGERATED STORAGE GUIDE, dated 2023, the guidelines indicated the following in regard to the storage of poultry, Meat Taken From Freezer to Thaw. Poultry. Maximum Refrigeration Time Once Meat Has Thawed. 2 days. Storage guidelines are based on the [app for U.S. Department of Health and Human Services]. During a review of the facility's employee training materials titled, Labeling and Dating for food safety, presented to kitchen staff by the facility's Registered Dietician (RD) during the Labeling and Dating, employee training on 1/22/26, the document indicated, From [a nationally recognized food and beverage safety training program]: Here are the guidelines for labeling and dating food to keep it safe: Dating. Dating food reduces the risk that you serve food that may be potentially unsafe if kept for too long. For time-temperature control for safety (TCS) foods, mark the date or day by which the food needs to be sold, eaten, or thrown out if it will be held for longer than 24 hours. You can store TCS foods for up to seven days, with the day you opened the container or package counting as day 1. Serving food after seven days can potentially (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	make someone sick since bacteria have had plenty of time to grow to unsafe levels from time-temperature abuse. For multi-ingredient dishes, mark the date of the earliest - or first-prepared ingredient. During a review of the facility's kitchen employee training material multiple choice test dated 6/11/26, indicated, 1. What must be on every food label? . B. Product name, prep date, discard date. 2. When does Day 1 start for the 7-day rule? . C. The day the food is prepared/opened. 4. What should you do if a food item has no label? . D. Throw it away. During a review of the facility's Dietary Aide job description, dated February 2024, indicated, Check and record chlorine concentration and water temperature of dishwashing machine at the beginning of shift. Sweep, mop and maintain floors. During a review of the facility's Cook job description, dated October 2016, indicated, Maintain kitchen and cooking area in a safe, orderly, clean and sanitary environment. Maintain quaternary solution in sanitizer buckets. make sure all cleaning schedules are followed. During a review of the facility kitchen staff training titled, CLEANING LOGS TRAINING, dated 3/31/26, indicated, Importance of Cleaning and Proper Documentation. Why cleaning is important. Prevents foodborne illness. Keeps residents safe. Meets health regulations. Maintains professional standards. Risks of Not Completing Logs. Food safety risks. Why Logs Matter. Proof of completed tasks. Helps track compliance. How to Fill Logs Correctly. Complete daily. Use initials/signature . During a review of the [Name of laboratory] manufacturer guidelines for the paper test strips used by the facility to test the efficacy and safety of the sanitization solution concentration in the red bucks in the kitchen indicated the following, The shelf life of [brand of test strips] pH paper is 3 years from the date of manufacture. The color chart is marked with the expiration and lot number for that specific roll. Our pH paper will remain accurate until the expiration date listed.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of abuse to the Department for one of 18 sampled residents (Resident 2). This had the potential to result in harm and continued risk of abuse to Resident 2 and other residents of the facility as a result of the Department being unable to initiate an investigation timely. Record review of Resident 1's admission record (facility demographic) indicated he was admitted on [DATE] with medical diagnoses which included left femur fracture (broken thigh bone) and chronic obstructive pulmonary disease (a progressive lung condition that makes it difficult to breathe). The Department received a report from an anonymous agency on 6/08/26 at 3:59 p.m., that indicated Resident 2 reported Certified Nursing Assistant F (CNA F) wanted him to wear a diaper and got frustrated with him and him on the left side of the face with the diaper. Record review of a facility document titled, SBAR [Situation, Background, Assessment, Recommendation, a standardized communication tool used in nursing and healthcare settings to facilitate clear, concise, and structured information exchange between team members] Communication Form, dated 6/16/26 at 9:30 p.m., indicated, @ [at] around 2100 [9 p.m.] [police department officer] came in to building & told that the pt. [patient] called & reported that he was hit in the face w/ [with] a brief by a lady CNA [CNA F]. DON [Director of Nursing] made aware. During an interview with the Director of Nursing (DON) and Administrator (ADM) on 6/16/26 at 3 p.m., both confirmed their awareness of the allegation. They indicated that Reside3nt 2 had not informed any facility staff regarding the incident but did contact law enforcement, who subsequently notified them of the resident's allegation. The DON and ADM acknowledged that they had not reported the abuse allegation to the Department. During a second interview with the Administrator (ADM) on 6/16/26 at 3:26 p.m., he stated that the facility did not report the abuse allegation made by Resident 1 to the Department, as they believed it was the responsibility of the police department. This understanding stemmed from the fact that the allegation was not initially made to facility staff, but directly to the police. The ADM further stated that it was the police who subsequently informed the facility about the incident involving CNA F. Record review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, last revised in September, 2022, indicated, If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility. 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury.		

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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 develop and revise care plans for one of 18 sampled residents (Resident 6) when: 1. Resident 6 did not have a care plan that addressed a re-occurring infection and the ongoing administration of antibiotics (a medication used to treat or prevent bacterial infections) treatment, and; 2. Resident 6 did not have a care plan that followed a change of condition. These failures had the potential to result in inadequate management of Resident 6's health needs, leading to possible worsening of the infection, delayed recovery, or other complications due to the lack of appropriate care planning for ongoing antibiotic treatment and changes in condition. A review of Resident 6's admission record (facility demographic) indicated he was admitted to the facility in March, 2020, with medical diagnosis which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction (stroke), and Wernicke's encephalopathy (an acute neurological [related to the nervous system, which includes the brain, spinal cord, and nerves that control body functions, movement, and sensation] disorder). A review of Resident 6's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 6/2/26, indicated his Brief Interview of Mental Status (BIMS-a cognition [the processes of thinking and reasoning] assessment) score was three, which indicated his cognition was severely impaired (a score of 1-7 indicates cognition is severely impaired, 8-12 indicates cognition is moderately impaired, and 13-15 indicates cognition is intact). 1. A review of Resident 6's progress note type, Infection Note, dated 6/02/26 at 9:52 a.m. indicated, [Resident 6] was diagnosed with pneumonia [PNA, an infection/inflammation of the lungs] and started on PO [by mouth] Amoxicillin-Pot Clavulanate [an antibiotic] Oral Tablet 875-125 MG [milligram-metric unit of measurement, used for medication dosage and/or amount] on 4/26/26 but MD [Medical Doctor] change it to patient [Resident 6] still showing symptoms of PNA residual, following symptoms of cough and chest X-ray [an imaging test] findings of a left lower lobe/lingular [sections of the left lung] infiltrate [presence of abnormal substances that build up in the lung tissue] on the repeated xray on 5/15/26 and 5/29/26 still shows infiltration to left lower lobe. A review of Resident 6's order recap report indicated the following order with a start date of 5/29/26, Amoxicillin-Pot Clavulanate Tablet 875-125 MG Give 1 tablet by mouth every 12 hours for pneumonia, confirmed on xray + cough for 7 days. A review of Resident 6's Medication Administration Record (MAR) dated 5/26 and 6/26 indicated the order for amoxicillin-pot clavulanate tablet 875-125 mg was administered 5/29/26 through 6/05/26. A review of Resident 6's care plan report with a print date of 6/18/26, indicated no evidence that a current antibiotic and/or pneumonia care plan was developed or revised. 2. A review of Resident 6's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition [COC] among the residents) form, dated 4/2/26, indicated the change of condition reported was, Resident [Resident 6] partially slide off the bed. The form further indicated, Resident [Resident 6] found by CNA [Certified Nurse Assistant] on his bedroom hanging down from the bed without touching the floor. His head was between the bed and the nightstand. A review of Resident 6's care plan report with a print date of 6/18/26, indicated no evidence that a care plan was developed after the change of condition [partially slid off the bed] was reported. During an interview on 6/18/26 at 4:35 p.m., Licensed Nurse E (LN E) stated that a care plan was expected to be initiated when a resident had an infection. LN E further confirmed that a care plan was also required when a resident was receiving antibiotic treatment. LN E stated, The purpose of the care (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Ridgeway Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 523 Hayes Lane Petaluma, CA 94952	
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan is to discuss treatment with the team and how to implement care. During an interview and concurrent record review on 6/18/26 at 4:50 p.m., the Director of Nursing (DON) reviewed Resident 6's care plan report and confirmed that a care plan was not developed after he partially slid off the bed. The DON stated that she expected a care plan to follow the reported COC. The DON also confirmed that Resident 6's PNA and antibiotic treatment was not care planned. The DON stated she expected a revised care plan since the infection re-occurred and was previously care planned and documented as resolved. The DON stated that the purpose of initiating and revising a care plan was to review and address the underlying cause of the identified problem. The DON further stated that reviewing current interventions and considering additional interventions prevented that problem from happening again. A review of the facility's policy and procedures titled, Care Plans, Comprehensive Person-Centered, revised 2022, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change. The interdisciplinary team reviews and updates the care plans when there has been a significant change in the resident's condition when the desired outcome is not met. A review of the facility's document titled, Job Description: Registered Nurse [RN], dated 2024, indicated, Review resident care plans for appropriate resident goals, problems, approaches, and revisions based on nursing needs. A review of the facility's document titled, Job Description: LPN [Licensed Practical Nurse]/LVN [Licensed Vocational Nurse], dated 2024, indicated, Review care plans daily to ensure that appropriate care is being rendered. Inform the Nurse Supervisor of any changes that need to be made on the care plan. Review resident care plans for appropriate resident goals, problems, approaches, and revisions based on nursing needs.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to provide services in accordance with professional standards of practice when: 1. 72-hour monitoring was not performed as required for one of 18 sampled residents (Resident 34) following a change of condition (COC), and; 2. Two Licensed Nurses (LN C and LN D) did not know how to check the function of the wander guard (an electronic wander management system) for a census of 74 residents. These failures had the potential to result in harm to residents by compromising their safety and well-being, as the lack of required 72-hour monitoring after a change of condition could delay the detection and response to health issues for Resident 34, and the inability of two licensed nurses to check the function of the wander guard system could put residents at risk of elopement or wandering without proper safeguards in place. 1. A review of Resident 34's admission record (facility demographic) indicated he was admitted to the facility in May 2026 with medical diagnosis which included cerebral infarction (stroke), and myelodysplastic syndrome (a group of bone marrow cancers where immature blood cells fail to mature). A review of Resident 34's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 5/13/26, indicated his Brief Interview of Mental Status (BIMS-a cognition [the processes of thinking and reasoning] assessment) score was 10, which indicated his cognition was moderately impaired (a score of 1-7 indicates cognition is severely impaired, 8-12 indicates cognition is moderately impaired, and 13-15 indicates cognition is intact). A review of Resident 34's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition [COC] among the residents) form, dated 5/29/26, indicated the change of condition reported was wandering and noted that Resident 34 was a danger to self or others. The SBAR further indicated that Resident 34 exited the building. A review of Resident 34's progress notes, type Nurse's Note, indicated no evidence that 72-hour (hr.) monitoring Q (every) shift was completed: 5/30/26 and 5/31/26 evening shift (PM), and; 6/01/26 day shift (AM). A review of Resident 34's SBAR form, dated 6/10/26, indicated, [Resident 6] Attempting to leave the compound. Patient [Resident 34] was trying to leave stating that he does not want to be here. The form also noted that Resident 34 was a danger to self or others. A review of a subsequent undated SBAR form, indicated another change of condition reported was that Resident 34 fell during his attempt to leave the property on 6/10/26. The form further indicated, Ground level fall [witnessed] sustained while attempting to leave the facility on foot. A review of Resident 34's progress notes, type, Nurse's Note, indicated no evidence that 72 hr. monitoring every shift was completed on 6/11/26 for PM shift. A review of Resident 34's care plan initiated on 6/03/26 indicated, Elopement: [Resident 34] is at risk for elopement/exit seeking/wandering r/t [related to] dementia or other cognitive behavior, exit seeking behaviors .[staff were expected to] If wandering or elopement attempt occur follow facility policy. Monitor for delayed injury/pain. Increased observation and frequent safety rounds. A review of Resident 34's care plan initiated on 6/10/26 indicated, Falls: [Resident 34] had a witnessed fall and is at risk for change in neurological [related to the nervous system, which includes the brain, spinal cord, and nerves that control body functions, movement, and sensation] status, injury, loss of range of motion, pain, recurring falls. [staff were expected to] Monitor for complications related to the fall. During an interview on 6/17/26 at 6:10 p.m., LN C stated 72 hr. monitoring every shift began after a change in condition was initiated. LN C confirmed that 72 hr. monitoring was expected to be completed every shift. LN C stated that 72 hr. monitoring was completed so that if any changes were observed, such as adverse reactions or further decline, the changes were communicated to the doctor and the care team. During an interview and concurrent (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record review on 6/18/26 at 11:34 a.m., the Director of Nursing (DON) stated she expected 72 hr. monitoring every shift to be completed after a change in condition. The DON further stated the monitoring was expected to be documented in the form of a progress note. The DON stated the purpose of 72 hr. monitoring was that any issues related to the change in condition were monitored further to ensure that the resident received the right treatments and interventions as needed. The DON reviewed Resident 34's progress notes and confirmed that 72 hr. monitoring was not completed on 5/30/26 and 5/31/26 for PM shift, 6/01/26 during AM shift, and 6/11/26 during PM shift. The DON referenced Resident 34's form titled, Nursing- Daily Skilled Charting Form, dated 6/01/26 at 12:13 a.m., and stated that form covered AM shift monitoring. The DON further acknowledged the form made no reference to the change in condition reported and monitoring thereof. 2. A review of Resident 34's order recap report dated 5/6/26 through 6/30/26 indicated an order was placed on 5/29/26 for, Wander Bracelet r/t [related to] wandering/exit seeking behaviors. Nurse to check placement and function q shift. A review of Resident 34's care plan initiated on 6/03/26 indicated, Elopement: [Resident 34] is at risk for elopement/exit seeking/wandering r/t dementia or other cognitive behavior, exit seeking behaviors . [staff were expected to] Check function of wander alarm per manufacturer recommendations. During an interview on 6/17/26 at 6:05 p.m., LN D stated, If you want to check if the wander guard is working you would bring the resident close to a doorway and the alarm should go off. LN D confirmed that there was no device to check the function of the wander guard. During an interview on 6/17/26 at 6:10 p.m., LN C stated that there was no device used to verify whether the wander guard was functioning. During an interview on 6/18/26 at 8:23 a.m., LN A stated that a device to check the function of the wander guard was stored in the medication room. LN A further stated that if a resident had a wander guard, it was expected to be checked daily, every shift, especially at night. LN A stated the purpose of checking the wander guard function was to ensure that it was working properly. During an interview on 6/18/26 at 11:34 a.m., the DON stated it was expected that licensed nursing staff knew how to check the function of the wander guard. The DON further stated that she expected the function of the wander guard to be checked daily, or as ordered. A review of the facility's policy and procedure (P&P) titled, Elopement and Wandering Policy, dated 2023, indicated, This facility ensures that resident who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care.The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement.implementing interventions to reduce hazards and risk, and monitoring for effectiveness.Adequate supervision will be provided to help prevent accidents or elopements.A review of the facility's P&P titled, Falls and Fall Risk, Managing, revised 2018, indicated, The staff will monitor and document each resident's response to interventions intended to reduce falling or risks of falling.A review of an undated facility provided document titled, Instructions- Resident Wristband Transmitter, indicated, Testing.It is very important to test your Resident Wristband Transmitters on a regular basis.The manufacturer recommends testing Resident Wristband Transmitters DAILY.To test Resident Wristband Transmitters: 1. Take Tag Tester and pass tester within proximity of resident wearing Resident Wristband Transmitter.TEST RESIDENT WRISTBAND TRANSMITTERS REGULARLY. A review of the facility's document titled, Job Description: Registered Nurse [RN], and Job Description: LPN [Licensed Practical Nurse]/LVN [Licensed Vocational Nurse], both dated 2024, indicated, Ensure that all personnel operate nursing service equipment in a safe manner.		

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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 interview and record review, the facility failed to accurately document the controlled drug inventory count for a census of 74 residents when:1. The inventory count was not signed off every incoming and outgoing shift by nursing staff (Licensed Nurse [LN] or Registered Nurse [RN]),2. The total number of medication cards (medication blister card, a multi-compartment medication packing system) was recorded with mathematical errors, and;3. The forms were illegible.These failures increased the facility's potential for diversions (the unlawful removal or misuse of prescription or controlled substances from their intended path, from manufacturer to patient) and led to a lack of accountability for inaccurately documented controlled drugs. During a concurrent interview and record review on 6/18/26 at 3:15 p.m., the Director of Nursing (DON) confirmed the facility documents titled, Controlled Drug Inventory Count, dated 3/30/26 through 6/05/26 was not recorded to her expectations. The DON stated nurse staff were expected to count the controlled drugs during shift change to ensure that the counts were correct according to the controlled drugs administered and any new controlled drugs added. The DON confirmed that 54 nurse signatures were incomplete from the forms. The DON also confirmed that documentation was illegible and with math errors. The DON verified it was difficult to obtain an accurate account of the controlled drugs because some of the documentation was illegible. The DON stated the importance of obtaining accurate documentation was to ensure that residents received their medications as ordered. The DON further explained that accurate documentation served as a safeguard to ensure that drug diversion was not occurring within the facility. The DON stated no one had audited the controlled drug inventory count. The DON further stated that performing the audits was her responsibility.A review of the facility's policy and procedure titled, Controlled Substances, revised 2022, indicated, The facility complies with all laws, regulations and other requirements related to.documentation of controlled medications.Controlled substances are counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals sign the designated controlled substance record.Controlled substance inventory is monitored and reconciled to identify loss or potential diversion.Nursing staff count controlled medication inventory as the end of each shift, using these records to reconcile inventory count.The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services.The director of nursing services documents irreconcilable discrepancies in a report to the administrator.		