STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555732	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Fe Heights Healthcare Center, LLC	2309 N Santa Fe Ave Compton, CA 90222

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on observation, interview, and record review, the facility failed to ensure the rights and dignity of residents were honored when the facility failed to ensure the following for two out of six sampled residents (Resident 3 and Resident 4): 1. Certified Nursing Assistant (CNA) 3 did not watch television on her personal cellular phone device with earphones in each ear as she fed Resident 3 his lunch meal. 2. A bioethics committee meeting (a committee designed to support patient rights and help the resident, and the health-care team make decisions about health care) was held on the behalf of Resident 3, who was deemed unable to make medical decisions as indicated by the physician's History and Physical, dated 2/10/2025, prior to the administration of psychotropic medications (drugs that affect the brain and nervous system, altering mood, behavior, and cognitive function). 3. A public guardian (a person or organization appointed by the court to manage the care and finances of people who are unable to do so for themselves) was obtained, or a bioethics committee met on the behalf of Resident 4, who was deemed unable to make medical decisions as indicated by the physician's History and Physical, dated 8/29/2023. These failures had the potential for Resident 3 to exhibit feelings of worthlessness and mistrust in the nursing staff for the provision of quality care. These failures resulted in the administration of psychotropic medications and changes to the plans of care for both Resident 3 and Resident 4 without the consultation of sound and reasonable decision-making parties or representatives. Cross Reference F689 and F552. Findings: a. During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included dysphagia (difficulty swallowing), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 3's Minimum Data Set ([MDS], a resident assessment tool), dated 11/22/2024, the MDS indicated Resident 3's cognitive skills (ability to think and reason) for daily decision making was intact. The MDS indicated Resident 3 required substantial or maximal assistance (helper provides more than half of the effort) for eating, toileting, oral hygiene, and dressing, and when performing personal hygiene. During a review of Resident 3's History and Physical (H&P), dated 2/10/2025, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3's Order Summary Report, dated 2/11/2025, the Order Summary Report indicated Resident 3 was ordered Haloperidol (an antipsychotic) tablet 5 milligrams ([mg]-a unit of measurement) one tablet orally in the morning related to schizoaffective disorder on 3/25/2024. During a review of Resident 3's Impaired Nutrition Care Plan, initiated 2/4/2025, the care plan indicated Resident 3 was at risk for aspiration (when food, liquid, or other material accidentally enters the lungs instead of being swallowed) and the facility was to assist with and feed Resident 3 his meals, and check Resident 3's mouth after meal for pocketed food and debris. During an observation on 2/11/2/2025 at 1:04 p.m., in Resident 3's room, Certified Nursing Assistant (CNA) 3 was observed seated in a chair with her back faced away from the entrance of the room. Resident 3's bed side table was positioned in front of her. CNA 3's personal cellular phone device and Resident 3's meal tray was positioned on top of Resident 3's bed side table. CNA 3 had both earphones in each ear. CNA 3 proceeded to scoop the contents of Resident 3's meal plate onto a spoon and feed it into Resident 3's mouth while she continued to watch her personal cellular phone device. CNA 3 continued to watch her personal cellular phone device with earphones in both ears until CNA 3 heard the State Agency Surveyor call CNA 3's attention on the third attempt. During an interview on 2/11/2025 at 2:06 p.m. with CNA 3, CNA 3 stated she watched Tik Tok on her personal cellular phone and had both earphones in her ears while she fed Resident 3. CNA 3 stated this was not an acceptable practice because she would not have been able to see or hear if Resident 3 choked (when a person cannot speak, cough, or breathe because something is blocking the airway) and stated it was not a safe way to feed any resident. CNA 3 stated that feeding Resident 3 while watching her cellular phone did not honor Resident 3's dignity and well-being. b. During a concurrent interview and record review on 2/11/2025 at 1:22 p.m. with the Social Services Director (SSD), Resident 3's H&P, dated 2/10/2025, was reviewed. The H&P indicated Resident 3 did not have the capacity to make medical decisions. The SSD stated she was responsible for handling the applications for public guardians and ensuring residents had a responsible party to represent the residents who did not have the decision-making capacity to guide his or her own medical care. The SSD stated if a resident did not have a responsible party or a public guardian to represent the resident, then the bioethics committee would meet to make medical decisions on the behalf of the resident. The SSD stated Resident 3 did not have a responsible party or a public guardian, and the bioethics committee should have met to guide the care of Resident 3 before any medical decisions were made and before the administration of psychotropic medications. The SSD stated Resident 3 had the right to have sound medical decisions made on his behalf, especially if the physician deemed the resident unable to make his own medical decisions. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. During a review of Resident 4's Admission Record, the Admission Record indicated Resident 4 was originally admitted to the facility on [DATE]. Resident 4's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety (a feeling of uneasiness) disorder, and depression (a mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities). During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4's cognitive skills was severely impaired. The MDS indicated Resident 4 required partial or moderate assistance (helper provides less than half of the effort) for eating, toileting, oral hygiene, and dressing, and when performing personal hygiene. During a review of Resident 4's Order Summary Report, dated 2/11/2025, the Order Summary Report indicated Resident 4 was ordered Risperdal (an antipsychotic) oral tablet 0.5 mg tablet by mouth in the morning for psychosis (a mental health condition characterized by a loss of contact with reality) on 12/10/2024. During a concurrent interview and record review on 2/11/2025 at 1:22 p.m. with the SSD, Resident 4's H&P, dated 8/29/2023, was reviewed. The H&P indicated Resident 4 did not have the capacity to make medical decisions. The SSD stated Resident 4 did not have a responsible party or a public guardian, and the bioethics committee should have met to guide the care of Resident 4 before any medical decisions were made and before the administration of psychotropic medications. The SSD stated an application for public guardianship for Resident 4 should have been started in year 2023. The SSD stated she did not realize Resident 4's application for public guardianship was not started and Resident 4 was not on her list of residents that needed a public guardian. The SSD stated Resident 4 had the right to have sound medical decisions made on his behalf, especially if the physician deemed the resident unable to make his own medical decisions (in 2023). During a review of the facility's Policy and Procedure (P&P), titled, Quality of Life- Dignity, revised 8/2009, the P&P indicated the facility was to ensure all residents were always treated with dignity and respect. The P&P indicated treated with dignity meant the resident would be assisted in maintaining and enhancing his or her self-esteem and self-worth. During a review of the facility's P&P, titled, Psychoactive Medication Informed Consent, revised 3/2024, the P&P indicated the facility was to ensure informed consent would be obtained from the resident's representative if the resident was not capable of giving informed consent. During a review of the facility's P&P, titled, Informed Consent - Psychotropic Medications and Restraint Devices, revised 3/2015, the P&P indicated the following: 1. The facility was to ensure informed consent would be obtained from the resident's representative if the resident was not capable of giving informed consent. 2. If the physician could not identify an appropriate surrogate decision-maker, court appointment of a conservator with medical decision-making authority or referral to the Public Guardian may be required. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. If an agreement could not be reached about a surrogate decision-maker, and there is disagreement among potential surrogate decision-makers about the appropriate course of treatment, the physician should seek the assistance of an ethics committee and social services in the resolution of such disagreement.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on interview and record review, the facility failed to ensure informed consent for the administration of psychotropic medications (drugs that affect the brain and nervous system, altering mood, behavior, and cognitive function) were properly and accurately obtained for two out of six sampled residents (Resident 3 and Resident 4). These failures resulted in the administration of psychotherapeutic medications and changes to the plans of care for both Resident 3 and Resident 4 without the consultation and knowledge of sound and reasonable decision-making parties or representatives. Findings: a. During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included dysphagia (difficulty swallowing), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 3's Minimum Data Set ([MDS], a resident assessment tool), dated 11/22/2024, the MDS indicated Resident 3's cognitive skills (ability to think and reason) for daily decision making was intact. The MDS indicated Resident 3 required substantial or maximal assistance (helper provides more than half of the effort) for eating, toileting, oral hygiene, and dressing, and when performing personal hygiene. During a review of Resident 3's History and Physical (H&P), dated 2/10/2025, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a concurrent record review and interview on 2/11/2025 at 1:22 p.m. with the Social Services Director (SSD), Resident 3's H&P, dated 2/10/2025, was reviewed. The H&P indicated Resident 3 did not have the capacity to make medical decisions. The SSD stated she handled the applications for public guardians (a court-appointed person who helps people who can't care for themselves due to a medical or mental illness) and ensured residents had a responsible party (RP) to represent the residents who did not have the decision-making capacity to guide his or her own medical care. The SSD stated if a resident did not have a responsible party or a public guardian to represent the resident, then the bioethics committee would meet to make medical decisions on the behalf of the resident. The SSD stated Resident 3 did not have a responsible party or a public guardian, and the bioethics committee should have met to guide the care of Resident 3 before any medical decisions were made and before the administration of psychotherapeutic medications. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/11/2025 1:49 p.m. with Licensed Vocational Nurse (LVN) 3, Resident 3's Order Summary Report, dated 2/11/2025, and all of Resident 3's Informed Consents, dated 2024 and 2025, and were reviewed. The Order Summary Report indicated Resident 3 was ordered haloperidol (a psychotropic medication) tablet 5 milligrams ([mg]-a unit of measurement) one tablet orally in the morning related to schizoaffective disorder on 3/25/2024. There was no informed consent for Resident 3's daily order of haloperidol tablet 5 mg. LVN 3 stated the normal process was to obtain verification of informed consent from the resident's responsible party (RP). LVN 3 stated a new informed consent must be obtained whenever the dose of the psychotropic medication was increased or when the resident was readmitted from the General Acute Care Hospital (GACH). LVN 3 stated the informed consent for Resident 3 should have been verified with his responsible party upon readmission to the facility. LVN 3 stated the verification of informed consent was important because it ensured the RP was educated on the risks and the benefits of the psychotropic drug. b. During a review of Resident 4's Admission Record, the Admission Record indicated Resident 4 was originally admitted to the facility on [DATE]. Resident 4's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety (a feeling of uneasiness) disorder, and depression (a mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities). During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4's cognitive skills was severely impaired. The MDS indicated Resident 4 required partial or moderate assistance (helper provides less than half of the effort) for eating, toileting, oral hygiene, and dressing, and when performing personal hygiene. During a concurrent interview and record review on 2/11/2025 at 1:22 p.m. with the SSD, Resident 4's H&P, dated 8/29/2023, was reviewed. The H&P indicated Resident 4 did not have the capacity to make medical decisions. The SSD stated Resident 4 did not have a responsible party or a public guardian, and the bioethics committee should have met to guide the care of Resident 4 before any medical decisions were made and before the administration of psychotherapeutic medications. During a concurrent interview and record review on 2/11/2025 1:49 p.m. with LVN 3, Resident 4's Informed Consent form, dated 8/30/2023, and H&P, dated 8/29/2023, were reviewed. The Informed Consent form was left incomplete for Resident 4's order of Risperdal 0.5mg tablet by mouth for psychosis. The section allotted to indicate whom the informed consent was obtained from was left blank. LVN 3 stated the informed consent form was not accurately and properly completed. LVN 3 stated all informed consent forms should be completed accurately to ensure the resident or the resident's RP were explained the risks and the benefits of all prescribed psychotropic medications. LVN 3 stated Resident 4 had the right to have the risks and benefits of his prescribed psychotropics medications explained to an RP to ensure sound medical decisions were made for Resident 4. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/13/2025 at 8:20 a.m. with LVN 4, Resident 4's Physician Order, dated 9/24/2024, Informed Consent form, dated 9/24/2024. and H&P, dated 8/29/2023, were reviewed. The Physician Order indicated Resident 4 was ordered haloperidol 5mg intramuscular ([IM]-administered in the muscle) every eight hours as needed for agitation. The Informed Consent form indicated verification of informed consent was obtained from Resident 4 (the resident, himself) for the order of haloperidol 5 mg IM every eight hours as needed for agitation (a state of restlessness, unease, and distress that can manifest as physical and emotional symptoms). LVN 4 stated she transcribed and carried out the physician's order for the administration of haloperidol 5 mg IM and obtained verification of informed consent incorrectly. LVN 4 stated the H&P indicated he was not able to make his own medical decisions and Resident 4 was not able to obtain consent on his own. During a review of the facility's P&P, titled, Psychoactive Medication Informed Consent, revised 3/2024, the P&P indicated the facility was to ensure informed consent would be obtained from the resident's representative if the resident was not capable of giving informed consent. During a review of the facility's P&P, titled, Informed Consent - Psychotherapeutic Medications and Restraint Devices, revised 3/2015, the P&P indicated the following: 1. The facility was to ensure informed consent would be obtained from the resident's representative if the resident was not capable of giving informed consent. 2. If the physician could not identify an appropriate surrogate decision-maker, court appointment of a conservator with medical decision-making authority or referral to the Public Guardian may be required. 3. If an agreement could not be reached about a surrogate decision-maker, and there is disagreement among potential surrogate decision-makers about the appropriate course of treatment, the physician should seek the assistance of an ethics committee and social services in the resolution of such disagreement.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to ensure the call light was within reach for two of eight sampled residents (Resident 72 and 86). This deficient practice had the potential to result in a delay or an inability for the residents to obtain necessary care and services as needed. Findings: a. During a review of Resident 72's Admission Record, dated 2/13/2024, the admission record indicated Resident 72 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses which included type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic kidney disease (CKD - a longstanding disease in which the kidneys are damaged and cannot filter blood as well as they should), muscle wasting (weakening, shrinking, and loss of muscle), and difficulty walking. During a review of Resident 72's History and Physical (H&P), dated 12/5/2024, the H&P indicated Resident 72 had a fluctuating capacity to understand and make decisions. During a review of Resident 72's Minimum Data Set (MDS - a resident assessment tool), dated 1/30/2025, the MDS indicated Resident 72's cognition (ability to think, remember, and reason) was moderately impaired. The MDS indicated Resident 72 required moderate assistance (helper does less than half the effort) with bathing, toileting and personal hygiene. The MDS indicated Resident 72 required moderate assistance to walk 10 feet and utilized a wheelchair or walker to assist with mobility (the ability to move freely). During a review of Resident 72's Care Plan titled Risk for Falls, initiated on 7/23/2024, the care plan indicated Resident 72's fall risk was related to an abnormal gait (walk), mobility, and cognitive impairment. The care plan indicated Resident 72's goal was to be free of falls. The care plan interventions indicated to ensure Resident 72's call light was available and to utilize devices as appropriate to ensure Resident 72's safety. During a review of Resident 72's Care Plan titled Resident at Risk for Falls, initiated on 10/28/2024, the care plan indicated Resident 72's fall risk was related to psychoactive (affects how the brain works) drug use, weakness, and fatigue (tiredness and lack of energy). The care plan goals indicated Resident 72 would be free of falls and not sustain serious injury for 90 days. The care plan interventions indicated to ensure Resident 72's call light was within reach, encourage the use of the call light for assistance as needed, and ensure prompt responses to all requests for assistance. During an observation on 2/10/2025 at 10:55 a.m., in Resident 72's room, observed Resident 72 in bed with the call light hanging from the bedside nightstand. Resident 72 wore a yellow Fall Precaution bracelet on her left wrist. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/11/2025 at 2:15 p.m., in Resident 72's room, observed Resident 72 in bed. Observed Resident 72's call light device was not within reach, and hanging from the drawer of the bedside nightstand. During a concurrent observation and interview on 2/11/2025 at 2:20 p.m. with Certified Nursing Assistant (CNA) 1, Resident 72 was observed lying in bed with the call light device hanging from the nightstand drawer. CNA 1 stated the call light should not be on the nightstand because Resident 72 could not reach it. CNA 1 stated the call light should be on the bed next to Resident 72. CNA1 stated it was important to have the call light close to Resident 72 in order to call out for water, medications, or during an emergency. During an interview on 2/11/2025 at 2:28 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Resident 72's call light should have been within the resident's reach. LVN 3 stated the call light needed to be within reach in order for Resident 72 to call out for assistance and to prevent falls. During an interview on 2/13/2025 at 9:40 a.m., with the Director of Nursing (DON), the DON stated the nursing staff must ensure the call lights are within reach for the residents at all times. 48343 b. During an observation on 2/10/2025 at 8:57 a.m., in Resident 86's room, observed Resident 86 lying in bed. Resident 86's call light was observed on the floor behind Resident 86's bed. Resident 86's call light was not within reach. During a review of Resident 86's Admission Record, the admission record indicated Resident 86 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), muscle wasting (weakening, shrinking, and loss of muscle), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 86's MDS, dated [DATE], the MDS indicated Resident 86's cognitive skills for daily living was severely impaired. The MDS indicated Resident 86 required maximal (helper does more than half the effort) assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 86 required maximal assistance from staff for chair/bed-to-chair transfer (the ability to transfer to and from bed to chair and/or wheelchair). During a review of Resident 86's care plan with a focus of Resident at risk for decline in cognition, date initiated 1/6/2025, the care plan intervention indicated the facility would anticipate Resident 86's care needs, meet them, and provide the call light within reach. During an observation on 2/10/2025 at 2:00 p.m., in Resident 86's room, observed Resident 86's lying in bed supine position. Resident 86's call light was observed on the floor behind Resident 86's bed. Resident 86's call light was not within reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/11/2025 at 2:50 p.m., with CNA 2, in Resident 86's room, Resident 86 was observed lying in bed in a semi-Fowler's position (lying on the back with head and upper body raised), CNA 2 stated while Resident 86 was lying in bed, td the call light was observed on the floor behind the resident's bed, not within reach. CNA 2 stated Resident 86's call light should have been attached to the resident's bed and within reach. CNA 2 stated it was important the resident was able to reach and use the call light when needed and for an emergency. During an interview on 2/12/2025 at 10:45 a.m., LVN 1, LVN 1 stated the call light should be placed within resident reach and the near the resident's bedside. LVN 1 stated the call light was important for resident's to be able to communicate with the staff. LVN 1 stated the facility's licensed staff were responsible for checking the residents' call light and placing it within resident reach at the bedside. LVN 1 stated if the call light not within the resident's reach, the residents would not be able to use the call light and would not be able to call for help and assistance when needed. LVN 1 stated the call light not within reach was a resident safety issue, and placed residents at risk for falls and injury. During a review of the facility's job duties and responsibilities titled, Certified Nursing Assistant, not dated, the job duties and responsibilities for CNAs indicated CNAs were responsible for keeping the nurses' call system within easy reach of the resident. During a review of the facility's policy and procedures (P&P) titled, Answering the Call Light, revised August 2022, the P&P indicated when a resident is in the bed or confined to a chair, the call light must be within easy reach of the resident.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on interview and record review, the facility failed to notify the physician of a resident's low blood level concentration of phenobarbital (a drug used to control seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) for one out of six sampled residents (Resident 10). This failure increased the potential for Resident 10 to suffer from a bodily injury due to a seizure. Cross reference F656. Findings: During a review of Resident 10's Admission Record, the Admission Record indicated Resident 10 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 10's diagnoses included epilepsy (a chronic brain disorder characterized by recurrent seizures), status epilepticus (a life-threatening medical emergency that can occur in people with epilepsy), history of falling, schizophrenia (a mental illness that is characterized by disturbances in thought), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), and abnormalities of gait and mobility. During a review of Resident 10's Minimum Data Set ([MDS], a resident assessment tool), dated 4/28/2024, the MDS indicated Resident 10's cognitive skills (ability to think and reason) for daily decision making were severely impaired. The MDS indicated Resident 10 required set up or clean up assistance (helper sets up or cleans up) for eating, toileting, oral hygiene, and dressing, and when performing personal hygiene. During a review of Resident 10's Seizure Care Plan, dated 9/20/2024, the care interventions indicated the facility was to monitor and report any subtherapeutic (a drug level too low to produce the intended medical effect) or toxic (poisonous or harmful to the body) results to the physician. During a review of Resident 10's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Note, dated 2/11/2025, the SBAR Note indicated on 2/11/2025, Resident 10 exhibited a seizure in his room. The SBAR Note indicated Resident 10 exhibited stiff jerking movements and was difficult to arouse. The SBAR Note indicated seizure precautions were initiated, and oxygen was applied via a non-rebreather mask (a device that delivers oxygen to patients who need more than what they can get on their own) with 15 liters ([L]- a unit of measurement) per minute of oxygen. The SBAR Note indicated 911 was called. The SBAR Note indicated Resident 10 suffered two seizures, two minutes apart, the first seizure lasted for three minutes and the second seizure lasted two minutes. During a review of Resident 10's Order Summary, dated 2/13/2025, the Order Summary indicated Resident 10 was ordered phenobarbital tablet 32.4 milligrams ([mg]- a unit of measurement) one tablet three times a day related to epilepsy. The Order Summary also indicated Resident 10 was to have his phenobarbital level drawn every three months. (continued on next page)

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	555732	A. Building B. Wing	02/13/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/12/2025 at 2:53 p.m. with Registered Nurse (RN) 1, Resident 10's Phenobarbital Laboratory Results, dated 10/11/2024, and Nursing Progress Notes, dated 10/2024, were reviewed. The Laboratory Results indicated Resident 10 had a lowered blood level concentration reading of eight (8) micrograms per milliliter ([ug/mL]- a unit of measurement) (normal range of 14-40 ug/mL) for phenobarbital. The Nursing Progress Notes did not indicate Resident 10's physician was made aware of Resident 10's low blood level concentration of phenobarbital. RN 1 stated Resident 10's blood level concentration of phenobarbital was abnormally low. RN 1 stated the low blood level concentration of phenobarbital indicated Resident 10 was more likely to exhibit a seizure. RN 1 stated RN 1 usually reviewed all laboratory results, and Resident 10's laboratory results may have been missed. RN 1 stated Resident 10's physician should have been made aware of Resident 10's low blood level concentration of phenobarbital on 10/11/2024. RN 1 stated there was a possibility that Resident 10's phenobarbital blood levels continued to remain subtherapeutic when Resident10 suffered a seizure on 2/11/2025. During an interview on 2/12/2025 at 2:20 p.m. with the Director of Nurses (DON), the DON stated the licensed nurses were expected to monitor and report any subtherapeutic laboratory results to the physician. The DON stated the physician should have been made aware of Resident 10's low blood concentration of phenobarbital (on 10/11/2024) in his system so the physician could have adjusted Resident 10's dose. The DON stated there was a possibility Resident 10 could have exhibited a seizure on 2/11/2025 due to the possibility that Resident 10's blood level concentrations of phenobarbital were low. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, revised 11/2017, the P&P indicated the facility was to promptly notify the attending physician changes in the resident's medical/mental condition and/or status.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on interview and record review, the facility failed to ensure residents were free from physical and verbal abuse for one of six sampled residents (Resident 69). This deficient practice resulted in Resident 69 being verbally and physically abused by Resident 73, and had the potential for Resident 69 to have physical and/or psychological distress. Findings: a. During a review of Resident 69's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 69 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (weakness or paralysis on one side of the body), schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 69's Minimum Data Set ([MDS] - a resident assessment tool), dated 1/23/2025, the MDS indicated Resident 69's cognitive (the ability to think and process information) skills for daily living was severely impaired. The MDS indicated Resident 69 required maximal (helper does more than half the effort) assistance form staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 69's situation, background, assessment, recommendation ([SBAR]-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 2/2/2025, the SBAR indicated Resident 69 had a room change for better roommate compatibility. During an interview on 2/10/2025 at 9:30 a.m., with Resident 69, on the patio, Resident 69 stated a few days prior (was not able to recall the date), his roommate (Resident 73) yelled at him, called him a bad (curse) word, and threw water at him. Resident 69 stated he felt scared and sad. b. During a review of Resident 73's Face Sheet, the Face Sheet indicated Resident 73 was admitted to the facility on [DATE] with diagnoses which included DM, dysphagia (difficulty swallowing), and hypertension (HTN- high blood pressure). During a review of Resident 73's MDS, dated [DATE], the MDS indicated Resident 73's cognitive skills for daily living was intact. The MDS indicated Resident 73's required moderate (helper does less than half the effort) assistance from staff for ADLs. During a review of Resident 73's History and Physical (H&P), dated 12/1/2024, the H&P indicated Resident 73 had the capacity to understand and make decisions. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/10/2025 at 10:31 a.m., with Resident 73, in Resident 73's room. Resident 73 stated on 2/2/2025 in the early evening hours (was not able to recall the time), he had a verbal, and physical altercation with his roommate (Resident 69). Resident 73 stated he was upset and angry because Resident 69 was eating his (Resident 73) snacks. Resident 73 stated he throw water at Resident 69 and called Resident 69 a Motherf---er. During a concurrent interview and record review on 2/12/2025 at 11:00 a.m., with the Director of Nursing (DON), Resident 73's SBAR dated 2/2/2025 was reviewed. The DON stated the SBAR indicated Resident 73 yelled curse words and threw a water pitcher towards his roommate (Resident 69). The DON stated the SBAR indicated Resident 73 was yelling at Resident 69, I'm going to hit him in the face because he (Resident 69) ate my snacks. The DON stated Resident 73's action toward Resident 69 was resident to resident verbal and physical abuse. The DON stated residents at the facility shall be free from verbal, and physical abuse. During a telephone interview on 2/12/2025 at 12:00 p.m., with Licensed Vocational Nurse (LVN 6), LVN 6 stated in the evening of 2/2/2025, she was at the nurses' station and heard yelling and screaming coming from Residents 69 and 73's room. LVN 6 stated she walked into the room and observed Resident 73 yelling curse words and throwing a water pitcher towards Resident 69. LVN 6 stated Resident 73 was upset and angry because Resident 69 was eating his snacks. LVN 6 stated Resident 73's action towards Resident 69 was physical and verbal abuse. During a review of the facility's policy and procedure (P&P) titled Preventing Resident Abuse, revised 12/2013, the P&P indicated the facility would not condone any form of resident abuse. The P&P indicated the facility would maintain an abuse-free environment. During a review of the facility's P&P titled Resident Rights, revised 12/2016, the P&P indicated residents at the facility shall be free from abuse.

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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** 48343 Based on interview and record review, the facility failed to report an allegation of physical and verbal abuse for one two of six sampled residents (Resident 69 and Resident 73), by failing to: 1. Ensure facility staff report no later than two hours, the alleged resident to resident physical and verbal abuse to the California Department of Public Health (CDPH). 2. Ensure the facility report the results of the investigation within five (5) working days. These deficient practices resulted in a delay of an onsite investigation by CDPH and had the potential to place all residents in the facility at risk for further abuse. Findings: a. During a review of Resident 69's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 69 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (weakness or paralysis on one side of the body), schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 69's Minimum Data Set ([MDS] - a resident assessment tool), dated 1/23/2025, the MDS indicated Resident 69's cognitive (the ability to think and process information) skills for daily living was severely impaired. The MDS indicated Resident 69 required maximal (helper does more than half the effort) assistance form staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 69's situation, background, assessment, recommendation ([SBAR]-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 2/2/2025, the SBAR indicated Resident 69 had a room change for better roommate compatibility. During an interview on 2/10/2025 at 9:30 a.m., with Resident 69, on the facility's patio, Resident 69 stated a few days prior (was not able to recall the date), his roommate (Resident 73) yelled at him, called him a bad (curse) word and threw water at him. Resident 69 stated he felt scared and sad. b. During a review of Resident 73's Face Sheet, the Face Sheet indicated Resident 73 was admitted to the facility on [DATE] with diagnoses which included DM, dysphagia (difficulty swallowing), and hypertension (HTN- high blood pressure). During a review of Resident 73's MDS, dated [DATE], the MDS indicated Resident 73's cognitive skills for daily living was intact. The MDS indicated Resident 73's required moderate (helper does less than half the effort) assistance from staff for ADLs. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 73's History and Physical (H&P), dated 12/1/2024, the H&P indicated Resident 73 had the capacity to understand and make decisions. During an interview on 2/10/2025 at 10:31 a.m., with Resident 73, in Resident 73's room, Resident 73 stated on 2/2/2025 in the early evening hours (was not able to recall the time), he had a verbal, and physical altercation with his roommate (Resident 69). Resident 73 stated he was upset and angry because Resident 69 was eating his (Resident 73) snacks. Resident 73 stated he threw water at Resident 69 and called Resident 69 a Motherf---er. During a concurrent interview and record review on 2/12/2025 at 11:00 a.m., with the Director of Nursing (DON), Resident 73's SBAR dated 2/2/2025 was reviewed. The DON stated the SBAR indicated Resident 73 curse words and threw a water pitcher towards his roommate (Resident 69). The DON stated the SBAR indicated Resident 73 was yelling at Resident 69 I'm going to hit him in the face because he (Resident 69) ate my snacks. The DON stated Resident 73's action toward Resident 69 was resident to resident verbal and physical abuse. The DON stated, the staff should have reported to her (DON) and/or Administrator (ADM). During a telephone interview on 2/12/2025 at 12:00 p.m., with Licensed Vocational Nurse (LVN 6), LVN 6 stated in the evening of 2/2/2025, she was at the nurses' station and heard yelling and screaming coming from Residents 69, and 73's room. LVN 6 stated she walked into the room and observed Resident 73 yelling curse words and throwing a water pitcher towards Resident 69. LVN 6 stated Resident 73 was upset and angry because Resident 69 was eating his snacks. LVN 6 stated Resident 73's action towards Resident 69 was a physical and verbal abuse. LVN 6 stated she did not report the resident to resident physical and verbal abuse to the DON, ADM, and/or the CDPH. LVN 6 stated it was important to report a verbal and physical abuse to the DON, ADM, and/or the CDPH immediately, to investigate the allegations, and to prevent the risk of Resident 69 and other residents in the facility from being abused. During a review of the facility's policy and procedure (P&P) titled Recognizing Signs and Symptoms of Abuse/Neglect, revised 1/2011, the P&P indicated all personnel would report any signs and symptoms of abuse to their supervisor and/or to the Director of Nursing (DON) immediately. During a review of the facility's P&P titled Abuse Investigation, revised 4/2014, the P&P indicated should an incident or suspected incident of resident abuse should be reported to the Administrator (ADM), or his/her designee. During a review of the P&P titled Abuse Reporting and Investigation, dated 11/2018, the P&P indicated: 1. The facility would report all allegations of abuse as required by law and regulations to the appropriate agencies within two (2) hours. 2. The facility would provide a written report of the results of the abuse investigation and appropriate action taken to the CDPH Licensing and Certification within five (5) working days of the reported allegation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on interview, and record review, the facility failed to implement its policy and procedure (P&P) by failing to investigate a resident-to-resident physical and verbal abuse between two of six sampled residents (Resident 69 and Resident 73). This deficient practice resulted in unidentified abuse in the facility to Resident 69 and failed to protect other residents from abuse. Findings: a. During a review of Resident 69's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 69 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (weakness or paralysis on one side of the body), schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 69's Minimum Data Set ([MDS] - a resident assessment tool), dated 1/23/2025, the MDS indicated Resident 69's cognitive (the ability to think and process information) skills for daily living was severely impaired. The MDS indicated Resident 69 required maximal (helper does more than half the effort) assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an interview on 2/10/2025 at 9:30 a.m., with Resident 69, on the facility's patio, Resident 69 stated a few days prior (was not able to recall the date), his roommate (Resident 73) yelled at him, called him a curse word, and threw water at him. Resident 69 stated he felt scared and sad. b. During a review of Resident 73's Face Sheet, the Face Sheet indicated Resident 73 was admitted to the facility on [DATE] with diagnoses which included DM, dysphagia (difficulty swallowing), and hypertension (HTN- high blood pressure). During a review of Resident 73's MDS, dated [DATE], the MDS indicated Resident 73's cognitive skills for daily living was intact. The MDS indicated Resident 73's required moderate (helper does less than half the effort) assistance from staff for ADLs. During a review of Resident 73's History and Physical (H&P), dated 12/1/2024, the H&P indicated Resident 73 had the capacity to understand and make decisions. During an interview on 2/10/2025 at 10:31 a.m., with Resident 73, in Resident 73's room, Resident 73 stated on 2/2/2025 in the early evening hours (was not able to recall the time), he had a verbal and physical altercation with his roommate (Resident 69). Resident 73 stated he was upset and angry because Resident 69 was eating his (Resident 73) snacks. Resident 73 stated he throw water at Resident 69 and called Resident 69 a Motherf---er. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/12/2025 at 11:00 a.m., with the Director of Nursing (DON), Resident 73's SBAR dated 2/2/2025 was reviewed. The DON stated the SBAR indicated Resident 73 used curse words and threw a water pitcher towards Resident 69. The DON stated the SBAR indicated Resident 73 was yelling at Resident 69 I'm going to hit him in the face because he (Resident 69) ate my snacks. The DON stated Resident 73's action toward Resident 69 was resident to resident verbal and physical abuse, and the staff should have investigated the abuse allegations immediately (no later than two hours) per the facility's policy. During a telephone interview on 2/12/2025 at 12:00 p.m., with Licensed Vocational Nurse (LVN 6), LVN 6 stated in the evening of 2/2/2025, while at the nurses' station she heard yelling and screaming coming from Residents 69, and 73's room. LVN 6 stated she walked into the room and observed Resident 73 yelling curse words and throwing a water pitcher towards Resident 69. LVN 6 stated she should have immediately reported what occurred between Resident 69 and Resident 73 to the DON so the DON could have started an investigation immediately and prevent the risk of Resident 69 and other residents in the facility from being abused. During a review of the facility's P&P titled Abuse Investigation, revised 4/2014, the P&P indicated all reports of resident abuse shall be thoroughly and promptly investigated by the facility management.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set ([MDS] - a resident assessment tool), for one of eight sampled residents (Resident 48) was accurately coded to reflect Resident 48's oral and/or dental status. This deficient practice resulted in incorrect data transmitted to the Centers for Medicare and Medicaid Services (CMS) regarding Resident 48's dentures (oral appliances that replace missing teeth) and had the potential to negatively affect Resident 48's care plan and delivery of necessary care and services. Findings: During a review of Resident 48's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 48 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease ([COPD]- a chronic lung disease causing difficulty in breathing), diabetes mellitus ([DM]- a disorder characterized by difficulty in blood sugar control and poor wound healing), depression (loss of interest in activities), and anxiety (feeling of fear). During a review of Resident 48's Minimum Data Set ([MDS]- a resident assessment tool), dated 11/29/2024, the MDS indicated Resident 48's cognitive (the ability to think and process information) skills for daily decision making was intact. The MDS indicated Resident 48 required moderate (helper does less than half the effort) assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 48 was assessed as not having any oral and/or dental issues. During a concurrent observation and interview on 2/11/2025 at 3:35 p.m., in Resident 48's room, with Minimum Data Set Nurse (MDSN 1), Resident 48 was observed sitting on the bed. MDSN 1 stated Resident 48 did not have her upper and bottom teeth. MDSN 1 stated Resident 48's dentures were placed on the top of Resident 48's bedside table. During a concurrent interview and record review on 2/11/2025 at 4:00 p.m., with MDSN 1, Resident 48's MDS, dated [DATE] section L was reviewed. MDSN 1 stated Resident 48's MDS section L (oral/dental status) was coded incorrectly as it did not reflect the resident's actual oral and/or dental status. MDSN 1 stated because of Resident 48's use of dentures, the MDS should have been coded. MDSN 1 stated accuracy of the MDS assessment was important for, quality measures tools that help quality and measure healthcare process, outcomes, and resident perceptions, and care for the resident. MDSN 1 stated inaccuracy of the MDS assessment had the potential to result in not meeting the resident's care needs and services. During a review of the facility's policy and procedure (P&P) titled Certifying Accuracy of the Resident Assessment, revised 11/2019, the P&P indicated qualified professionals who have completed the MDS resident assessment are to certify the accuracy of the section they have completed.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on interview and record review, the facility failed to accurately complete the Preadmission Screening and Resident Review ([PASARR] - a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) Level I screening by omitting a diagnoses of depression (a mental health condition characterized by loss of interest in activities that interfere with daily functioning) and anxiety (feeling of fear) for one of six sampled residents (Resident 80). This deficient practice had the potential for Resident 80 to not receive the necessary and appropriate care, treatment and services, and increased risk for a decline in the resident's health and well-being. Findings: During a review of Resident 80's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 80 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included depression, anxiety, hypertension (HTN-high blood pressure), dementia (a progressive state of decline in mental abilities), and diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 80's Minimum Data Set ([MDS] - a resident assessment tool), dated 1/8/2025, the MDS indicated Resident 80's cognitive (the ability to think and process information) skills for daily decision making was intact. The MDS indicated Resident 80 required setup or clean up (helper sets up or cleans up; resident completes activity) assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated anxiety and depression were currently Resident 80's active diagnoses. During a concurrent interview and record review on 2/11/2025 at 2:30 p.m., with the Director of Nursing (DON), Resident 80's PASARR Level I, dated 4/1/2024 was reviewed. The DON stated Resident 80's PASARR Level I, dated 4/1/2024, indicated Resident 80 did not have a serious mental illness (such as depression, and anxiety). The DON stated the facility failed to accurately complete the PASARR Level I screening for Resident 80. The DON stated Resident 80 currently had depression and anxiety diagnoses which were indicated in the clinical records. The DON stated an accurate PASARR was important to identify whether the resident needed special services based on mental illness. The DON stated Resident 80's inaccurate PASARR Level I increased the risk the resident would not receive needed specialized care and services based on the diagnoses and potentially lead to a decline in health and well-being. During a review of the facility's policy and procedure (P&P) titled Pre-Admission Screening Resident Review, undated, the P&P indicated the facility would coordinate assessments and the pre-admission screening and resident review (PASARR). The P&P indicated the facility would refer residents with serious mental disorder for Level II resident review upon assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview, and record review, the facility failed to develop and implement the care plan for three of 18 sampled residents (Residents 48, 10, and 242) by failing to: 1. Develop and implement a comprehensive care plan for Resident 48's use of dentures (oral appliances that replace missing teeth). 2. Ensure Resident 10's care plan for seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) was implemented when the facility failed to notify Resident 10's physician of Resident 10's low blood level concentration of Phenobarbital (a medication used to control seizures). 3. Develop and implement a comprehensive, person-centered care plan for Resident 242's oxygen administration. These deficient practices had the potential to negatively affect Residents 48, 10, and 242's physical well-being, increased Resident 10's risk for a seizure which could lead to bodily injury, and delay necessary monitoring and safety interventions related to Resident 242's oxygen administration. Findings: a. During a review of Resident 48's Admission Record, the Admission Record indicated Resident 48 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease ([COPD]- a chronic lung disease causing difficulty in breathing) and depression (loss of interest in activities). During a review of Resident 48's Minimum Data Set ([MDS]- a resident assessment tool), dated 11/29/2024, the MDS indicated Resident 48's cognitive (the ability to think and process information) skills for daily decision making was intact. The MDS indicated Resident 48 required moderate (helper does less than half the effort) assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 48 was assessed as not having any oral and/or dental issues. During a concurrent observation and interview on 2/11/2025 at 3:35 p.m., in Resident 48's room, with Minimum Data Set Nurse (MDSN 1), observed Resident 48 seated on the bed. MDSN 1 stated Resident 48 did not have her upper and bottom teeth. MDSN 1 stated Resident 48's dentures placed on the top of Resident 48's bedside table. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/11/2025 at 4:00 p.m., with MDSN 1, Resident 48's electronic medical record (eMAR), was reviewed. MDSN 1 was not able to locate a care plan for Resident 48's use of dentures. MDSN 1 stated there was no care plan for the use of dentures and there should have been a care plan initiated upon Resident 48's admission to the facility. MDSN 1 stated care planning served as a communication tool among facility staff who provided care to the residents. MDSN 1 stated if there was no care plan, the facility staff would not be able to provide quality of care to residents. 47858 b. During a review of Resident 10's Admission Record, the Admission Record indicated Resident 10 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 10's diagnoses included epilepsy (a chronic brain disorder characterized by recurrent seizures), status epilepticus (a life-threatening medical emergency that can occur in people with epilepsy), history of falling, schizophrenia (a mental illness that is characterized by disturbances in thought), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), and abnormalities of gait and mobility. During a review of Resident 10's MDS, dated [DATE], the MDS indicated Resident 10's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 10 required set up or clean up assistance (helper sets up or cleans up) for eating, toileting, oral hygiene, and dressing, and when performing personal hygiene. During a review of Resident 10's Seizure Care Plan, dated 9/20/2024, the interventions indicated the facility was to monitor and report any subtherapeutic (a drug level too low to produce the intended medical effect) or toxic (poisonous or harmful to the body) results to the physician. During a review of Resident 10's Phenobarbital Laboratory Results, dated 10/11/2025, the Phenobarbital Laboratory Results indicated Resident 10 had a lowered blood level phenobarbital reading of eight (8) micrograms per milliliter ([ug/mL]- a unit of measurement) (normal range of 14-40 ug/mL). During a review of Resident 10's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 2/11/2025, the SBAR indicated on 2/11/2025, Resident 10 exhibited a seizure in his room. The SBAR Note indicated Resident 10 exhibited stiff jerking movements and was difficult to arouse. The SBAR note indicated seizure precautions were initiated, and oxygen was applied via a non-rebreather mask (a device that delivers oxygen to patients who need more than what they can get on their own) with 15 liters ([L]- a unit of measurement) of oxygen per minute. The SBAR note indicated 911 was called. The SBAR note indicated Resident 10 suffered two seizures, two minutes apart. The SBAR note indicated the first seizure lasted for three minutes and the second seizure lasted two minutes. During a review of Resident 10's Order Summary, dated 2/13/2025, the Order Summary indicated Resident 10 was ordered Phenobarbital Tablet 32.4 milligrams ([mg]- a unit of measurement) one tablet three times a day related to epilepsy. The Order Summary also indicated Resident 10 was to have his phenobarbital level drawn every three months (February, May, August and November). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview on 2/12/2025 at 2:53 p.m. with Registered Nurse (RN) 1, Resident 10's Phenobarbital Laboratory Results, dated 10/11/2024, and Nursing Progress Notes, dated 10/2024, were reviewed. The Laboratory Results indicated Resident 10 had a phenobarbital blood level reading of 8 ug/mL. The Nursing Progress Notes did not indicate Resident 10's physician was made aware of Resident 10's low blood level of phenobarbital. RN 1 stated Resident 10's blood level of phenobarbital was abnormally low. RN 1 stated the low blood level concentration of phenobarbital indicated Resident 10 was more likely to exhibit a seizure. RN 1 stated RN 1 usually reviewed all laboratory results, and Resident 10's laboratory results may have been missed. RN 1 stated Resident 10's physician should have been made aware of Resident 10's low blood levels of phenobarbital. RN 1 stated there was a possibility that Resident 10's phenobarbital blood levels continued to remain subtherapeutic when Resident 10 suffered a seizure on 2/11/2025. During a concurrent record review and interview on 2/13/2025 at 11:25 a.m., with Quality Assurance Nurse (QA 1), Resident 10's Seizure Care Plan interventions, dated, 9/20/2024, was reviewed. The Seizure Care Plan interventions indicated the facility was to monitor and report any subtherapeutic or toxic results to the physician. QA 1 stated the licensed nurses did not follow Resident 10's seizure care plan and there was a lack of documentation to indicate the physician was made aware. QA 1 stated the physician would have been able to adjust Resident 10's dose of phenobarbital if the physician was made aware. QA 1 stated the lack of physician notification increased the likelihood of Resident 10 to exhibit a seizure or a fall due to a seizure. 48131 c. During a review of Resident 242's Admission Record, the Admission Record indicated Resident 242 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The admission record indicated the following diagnoses which included COPD, respiratory failure (a serious lung condition that makes it difficult to breathe on your own), dependence on supplemental oxygen, type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and chronic kidney disease (CKD - a longstanding disease in which the kidneys are damaged and cannot filter blood as well as they should). During a review of Resident 242's H&P, dated 2/5/2025, the H&P indicated Resident 242 had the capacity to understand and make decisions. During a review of Resident 242's MDS, dated [DATE], the MDS indicated Resident 242's cognition was moderately impaired. The MDS indicated Resident 242 required set-up and clean up assistance (helper sets up or cleans up) for eating and was dependent (helper does all of the effort) with bathing and toileting. During a review of Resident 242's Order Summary Report dated 2/5/2025, the order summary report indicated Resident 242 had an active order on 1/8/2025 for oxygen at 2 liters per minute (LPM) via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) every day as needed to keep oxygen above 93 percent (%) related to aspiration (when food, drink or objects enter the lungs) precautions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/10/2025 at 4:07 p.m., observed Resident 242 lying in bed receiving oxygen at 2 LPM via nasal cannula. During a concurrent interview and record review on 2/12/2025 at 12:37 p.m., with Licensed Vocational Nurse (LVN) 4, LVN 4 reviewed Resident 242's care plans. LVN 4 stated Resident 242 did not have an oxygen care plan. LVN 4 stated Resident 242 should have had an oxygen care plan because the resident was receiving oxygen. LVN 4 stated an oxygen care plan was important in order to follow interventions regarding Resident 242's oxygen parameters and oxygen safety. During an interview on 2/13/2025 at 9:47 a.m., with the Director of Nursing (DON), the DON stated all residents receiving oxygen should have a care plan. The DON stated the MDS Coordinator or any licensed nurse care assigned to the resident was responsible for initiating a care plan once a resident was placed on oxygen. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive [NAME]-Centered, revised March 2022, the P&P indicated a comprehensive, person-centered care plan would includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs would be developed and implemented for each resident. The P&P indicated the comprehensive, person-centered care plan would be developed within seven days of the completion of the MDS assessment and no more than 21 days after admission.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview, and record review, the facility failed to provide care and services to maintain good grooming and personal hygiene for one of eight sampled residents (Residents 86) by failing to keep Resident 86's fingernails clean and neat. This failure had the potential to result in a negative impact on Resident 86's quality of life and self-esteem and had the potential for the development of an infection. Findings: During a concurrent observation and interview on 2/10/2025 at 8:57 a.m., with Resident 86, in Resident 86's room, observed Resident 86's fingernails long with black substance underneath her fingernails. Resident 86 stated she did not remember the last time her fingernails were cleaned or cut. Resident 86 stated her fingernails looked long and that she would like to have her fingernails cut and cleaned. During a review of Resident 86's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 86 was admitted to the facility on [DATE] with diagnoses which included dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), muscle wasting (weakening, shrinking, and loss of muscle), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 86's Minimum Data Set ([MDS] - a resident assessment tool), dated 1/8/2025, the MDS indicated Resident 86's cognitive (the ability to think and process information) skills for daily living was severely impaired. The MDS indicated Resident 86 required maximal (helper does more than half the effort) assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 86's care plan with a focus of Resident has an ADL self-care deficit related to impaired cognitive skills, date initiated 1/4/2025, the care plan interventions indicated the facility would assist Resident 86 with ADLs as needed. During an observation on 2/10/2025 at 2:00 p.m., in Resident 86's room, Resident 86 had long fingernails and black substance underneath her fingernails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/11/2025 at 2:50 p.m., with Certified Nursing Assistant (CNA 2), in Resident 86's room, Resident 86 was observed with long fingernails with black substance underneath. CNA 2 stated Resident 86's fingernails were long and dirty. CNA 2 stated CNAs were responsible for cleaning the residents' fingernails daily and trimming as needed. CNA 2 stated it was important to keep Resident 86's fingernails clean and trimmed to prevent the growth of bacteria (infection). CNA 2 stated long, dirty fingernails had the potential for the resident to scratch her skin and if Resident 86 scratched herself hard enough, it could create an open wound and increased risk of infection. CNA 2 stated having dirty fingernails was not sanitary because the resident will use her hands to hold utensils when eating and any bacteria could transfer into the body. During an interview on 2/13/2025 at 10:43 a.m., with the Director of Staff Development (DSD), the DSD stated it was the CNAs' responsibility to make sure the residents' fingernails were cleaned daily and trimmed as needed. The DSD stated residents should be provided with care and services necessary to maintain good personal hygiene. During a review of the facility's policy and procedure (P&P) titled Fingernails/Toenails, Care, revised 2/2018, the P&P indicated the facility would clean residents' fingernails daily to prevent infections. The P&P indicated the facility would trim resident's fingernails regularly to prevent the resident from scratching and injuring his or her skin. During a review of the facility's P&P titled Job Description Certified Nursing Assistant (CNA), undated, the P&P indicated the CNAs would assist residents with nails care (i.e., clipping, trimming, and cleaning the fingernails).

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on observation, interview, and record review, the facility failed to ensure a resident, with severe, painful bilateral (pertaining to both sides) hand contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) was provided the application of hand splints (used to support and position the hand and wrist to help reduce pain and swelling, and to prevent further contractures) for four to five hours, as ordered by the physician, for one out of six sampled residents (Resident 3). This failure had the potential for Resident 3 to develop worsening pain, experience more frequent episodes of bleeding on Resident 3's inner palm (where his ring finger met the face of his palm), and worsen the condition of Resident 3's bilateral hand contractures. Findings: During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included dysphagia (difficulty swallowing), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 3's Minimum Data Set ([MDS], a resident assessment tool), dated 11/22/2024, the MDS indicated Resident 3's cognitive skills (ability to think and reason) for daily decision making was intact. The MDS indicated Resident 3 required substantial or maximal assistance (helper provides more than half of the effort) for eating, toileting, oral hygiene, and dressing, and when performing personal hygiene. The MDS indicated Resident 3 had functional limitations in both upper extremities. During a review of Resident 3's Order Summary Report, dated 2/11/2025, the Order Summary Report indicated Resident 3 was ordered the application of bilateral hand rolls (splints) for four to five hours every day five days a week. During a concurrent observation and interview on 2/10/2025 at 12:45 p.m., with Resident 3, in Resident 3's room, Resident 3's hands were observed. Resident 3's hands were tightly curled into a fist, and Resident 3's inner palm had redness and a deep indentation where his ring fingernail met his palm. Resident 3 stated his inner palm (where his ring finger met his palm) would bleed on occasion. Resident 3 stated his contractures caused him pain, and he did not receive services to splint his hands or exercises to improve his range of motion in his arms or his legs. During observations made on 2/11/2025 at 7:45 a.m., 9:51 a.m., 11:28 a.m., 12:15 p.m., 1:04 p.m., 2:16 p.m. , and 3:05 p.m., Resident 3 did not have hand splints applied. During an interview on 2/12/25 at 9:58 a.m., with Resident 3, Resident 3 stated the Restorative Nurse Aids (RNAs) did not apply hand splints on him for the entire day yesterday (2/11/2025). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/12/2025 at 10:35 a.m. with RNA 1, Resident 3's RNA Flow Sheet, dated 2/2025, and RNA 1's timecard, dated 2/11/22025, were reviewed. The RNA Flow Sheet indicated Resident 3 received 240 minutes of the application of bilateral hand splints on 2/11/2025. The timecard indicated RNA 1 worked on 2/11/2025, from 7:17 a.m. to 3:35 p.m. RNA 1 stated she was the assigned RNA for Resident 3. RNA 1 stated she did not apply Resident 3's bilateral hand splints because she did not have enough time to complete the task, and she did not chart accurately in Resident 3's RNA Flow Sheet. RNA 1 stated RNAs were only scheduled to work on weekdays, and if Resident 3 did not get his splinting done on 2/11/2025, then Resident 3 did not receive services to splint his hands for the entire five days, as ordered. RNA 1 stated there was a possibility for Resident 3's bilateral hand contractures to worsen if his bilateral hand splints were not applied for four to five hours as ordered. During an interview on 2/12/2025 at 11:30 a.m. with Certified Occupational Therapy Assistant (COTA) 1, COTA 1 stated the application of hand splints were beneficial for residents with hand contractures to ease the pain associated with hand contractures and to prevent gradual worsening of the hand contractures. COTA 1 stated there was a potential for decline or the worsening of hand contractures if the resident did not receive the application of the hand splints as ordered. During a review of the facility's Policy and Procedure (P&P), titled, Restorative Nursing Services, revised 7/2017, the P&P indicated the facility was to ensure residents will receive restorative nursing care as needed to help promote optimal safety and independence. During a review of the facility's P&P, titled, Health Information Record Manual, revised 1/2025, the P&P indicated the facility was to ensure charting for RNA programs must agree with the physician orders or the nursing plan of care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to ensure residents' environment remains as free of accident hazards as possible for three out of 15 sampled residents (Residents 72, 80, and 3), by failing to: 1. Ensure nursing staff followed the facility's policy and procedure (P&P) on fall prevention for Resident 72 by ensuring a footpath free of obstacles and the call light device was within reach at all times. 2. Ensure the leaking bathroom sink and drainpipe was repaired in Resident 80's bathroom. 3. Certified Nursing Assistant (CNA 3) did not watch television on her personal cellular phone device with earphones in each ear while she fed Resident 3 his meal. These deficient practices increased Residents 72 and 80's risk for falls and leading to injury, and had the potential for Resident 3 to exhibit an unwitnessed episode of choking (when a person cannot speak, cough, or breath because something is blocking the airway) or undetected signs and symptoms of choking while being fed. Findings: a. During a review of Resident 72's Admission Record, the admission record indicated Resident 72 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses which included type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic kidney disease (CKD - a longstanding disease in which the kidneys are damaged and cannot filter blood as well as they should), muscle wasting (weakening, shrinking, and loss of muscle), and difficulty walking. During a review of Resident 72's History and Physical (H&P), dated 12/5/2024, the H&P indicated Resident 72 had a fluctuating capacity to understand and make decisions. During a review of Resident 72's Minimum Data Set (MDS - a resident assessment tool), dated 1/30/2025, the MDS indicated Resident 72's cognition (ability to think, remember, and reason) was moderately impaired. The MDS indicated Resident 72 required moderate assistance (helper does less than half the effort) with bathing, toileting and personal hygiene. The MDS indicated Resident 72 required moderate assistance to walk 10 feet and utilized a wheelchair or walker to assist with mobility (the ability to move freely). During a review of Resident 72's Fall Risk Evaluation, dated 1/20/2025, the fall risk evaluation indicated Resident 72 was at high risk for falls. The fall risk evaluation indicated Resident 72 had decreased muscular coordination, balance problems while walking and standing, and required the use of assistive devices. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 72's Care Plan titled Risk for Falls, initiated on 7/23/2024, the care plan indicated Resident 72's fall risk was related to an abnormal gait (walk), mobility, and cognitive impairment. The care plan indicated Resident 72's goal was to be free of falls. The care plan interventions indicated to evaluate Resident 72's environment to identify factors known to increase the risk of falls. The care plan interventions also indicated if Resident 72 was a fall risk, to initiate fall risk precautions, ensure Resident 72's call light was available, and utilize devices as appropriate to ensure Resident 72's safety. During a review of Resident 72's Care Plan titled Resident at Risk for Falls, initiated on 10/28/2024, the care plan indicated Resident 72's fall risk was related to psychoactive (affects how the brain works) drug use, weakness, and fatigue (tiredness and lack of energy). The care plan goals indicated Resident 72 would be free of falls and not sustain serious injury for 90 days. The care plan interventions indicated Resident 72 needed a safe environment with even floors that were free from spills and clutter, a working and reachable call light, and a bed in low position. The care plan interventions also indicated Resident 72 required prompt responses to all requests for assistance. During an observation on 2/10/2025 at 10:55 a.m., in Resident 72's room, observed Resident 72 lying in bed with her call light device not within reach hanging from the drawer handle of her nightstand table. Resident 72 wore a yellow Fall Precaution bracelet on her left wrist. Resident 72 had cords and wires along with several pairs of shoes on the floor next to her bed. During an observation on 2/11/2025 at 2:15 p.m., in Resident 72's room, observed Resident 72 in bed. Observed Resident 72's call light device not within reach hanging from the drawer of her nightstand. Wires and shoes were observed on the floor next to Resident 72's bed. During a concurrent observation and interview on 2/11/2025 at 2:20 p.m. with Certified Nursing Assistant (CNA) 1, in Resident 72's room, Resident 72 was observed lying in bed with the call light device hanging from the nightstand drawer along with wires, cords and shoes on the floor next to the bed. CNA 1 stated the call light should not be on the nightstand because Resident 72 could not reach it, and the resident could fall if she attempted to retrieve the call light hanging from the nightstand. CNA 1 stated the call light should be on the bed next to Resident 72. CNA 1 stated the wires, cords and shoes on the floor could cause Resident 72 to fall if she (Resident 72) attempted to get out of bed. CNA 1 stated the wires and cords should be removed from the floor and Resident 72's shoes belonged inside of the cabinet and not on the floor next to the bed. During an interview on 2/11/2025 at 2:28 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Resident 72's call light device should have been within reach. LVN 3 stated the call light device needed to be within reach in order for Resident 72 to call out for assistance and to prevent falls. LVN 3 stated the shoes and wires around the bed should not have been there. LVN 3 stated everything should be in place in Resident 72's room to prevent the resident from falling. LVN 3 stated Resident 72 should not have had items in the area where she had to walk. During an interview on 2/13/2025 at 9:40 a.m., with the Director of Nursing (DON), the DON stated the nursing staff must ensure the call lights are within reach for the residents at all times. The DON stated cords and shoes on the floor was a tripping hazard for the resident and should not have been there. 48343 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. During an observation on 2/10/2025 at 9:45 a.m., in Resident 80's bathroom, observed leaking from the bathroom sink and drainpipe. Water was observed on the bathroom floor. A plastic container was placed under the sink drainpipe. During a review of Resident 80's Admission Record, the admission record indicated Resident 80 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included depression (a mental health condition characterized by loss of interest in activities that interfere with daily functioning), anxiety (feeling of fear), hypertension (HTN- high blood pressure), dementia (a progressive state of decline in mental abilities), and DM. During a review of Resident 80's MDS, dated [DATE], the MDS indicated Resident 80's cognitive skills for daily decision making was intact. The MDS indicated Resident 80 required setup or clean up (helper sets up or cleans up; resident completes activity) assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 80 required a walker (a device used to help with balance while walking) for mobility. During a review of Resident 80's Fall Risk Evaluation (a standardized tool used to evaluate a resident's risk of fall), dated 1/8/2025, the Fall Risk Evaluation indicated Resident 80 was at high-risk for falls, related to gait (walking) and/or balance (to be steady) problem while walking and required the use of a assistive device (walker). During a review of Resident 80's care plan with a focus of Resident had impaired cognitive function and had the potential for fall, date initiated 9/19/2024, the care plan indicated the interventions included to provide Resident 80 with a safe environment. During an observation on 2/11/2025 at 9:10 a.m., in Resident 80's bathroom, observed leaking water from the bathroom sink and drainpipe. Observed water on the bathroom floor. During a concurrent observation and interview on 2/11/2025 at 2:10 p.m., in Resident 80's bathroom, with Resident 80, observed Resident 80 standing by the bathroom sink. Resident 80's bathroom sink was leaking. Water was observed on the floor under the bathroom sink with a plastic container placed under the leaking sink drainpipe. Resident 80 stated the sink and the drainpipe had been leaking for one week. Resident 80 stated he notified the nurse (unidentified) of the leaking sink and drainpipe a few days prior. Resident 80 stated the staff did not come to check and/or fix the leak. Resident 80 stated he was worried he would slip and fall because the water was all over the bathroom floor. Resident 80 stated he placed the plastic container under the sink to prevent the water from leaking onto the bathroom floor. During a concurrent observation and interview on 2/11/2025 at 2:30 p.m., with CNA 2, in Resident 80's bathroom, observed the leaking water from the sink and drainpipe. Water was observed on the floor. CNA 2 stated water on the bathroom floor created an unsafe environment for the resident and had the potential to place Resident 80 at risk for fall and injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/11/2025 at 3:05 p.m., with the Maintenance Supervisor (MS), in Resident 80's bathroom, observed water on the bathroom floor. A plastic container with water was observed under the leaking bathroom sink drainpipe. The MS stated the leaking sink and drainpipe and water on the floor was unsafe and dangerous for Resident 80. The MS stated Resident 80 could slip on the wet floor and fall. The MS stated the plastic container under the sink's drainpipe should not be on the floor and/or in the resident's bathroom because Resident 80 could trip and/or try to use the water which was unsafe and unsanitary. 47858 c. During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was admitted to the facility on [DATE]. Resident 3's diagnoses included dysphagia (difficulty swallowing), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 3's MSD, dated 11/22/2024, the MDS indicated Resident 3's cognitive skills for daily decision making was intact. The MDS indicated Resident 3 required substantial or maximal assistance (helper provides more than half of the effort) for eating, toileting, oral hygiene, and dressing, and when performing personal hygiene. During a review of Resident 3's Physician Orders, dated 7/2024, the Physician Orders indicated Resident 3 was ordered a pureed (food that has been ground, pressed, blended or served to the consistency of paste or liquid) diet. During an observation on 2/11/2/2025 at 1:04 p.m. in Resident 3's room, observed Certified Nursing Assistant (CNA) 3 seated in a chair with her back facing away from the entrance of the room. Resident 3's bed side table was positioned in front of CNA 3. CNA 3's personal cellular phone device and Resident 3's meal tray was positioned on top of Resident 3's bed side table. CNA 3 had both earphones in each ear. CNA 3 proceeded to scoop the contents of Resident 3's meal plate onto a spoon and feed it into Resident 3's mouth while she continued to watch her personal cellular phone device. CNA 3 continued to watch her personal cellular phone device with earphones in both ears until CNA 3 heard the State Agency Surveyor call CNA 3's attention on the third attempt. During an interview on 2/11/2025 at 2:06 p.m. with CNA 3, CNA 3 stated she watched Tik Tok on her personal cellular phone and had both earphones in her ears while feeding Resident 3. CNA 3 stated it was not an acceptable practice because she would not have been able to see or hear if Resident 3 choked as it was not a safe way to feed any resident. During a review of the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents, revised July 2017, the P&P indicated, Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The P&P indicated employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accidents hazards and try to prevent avoidable accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Falls and Fall Risk, Managing, revised March 2018, the P&P indicated the staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. The P&P indicated obstacles in the footpath as a fall risk factor. The P&P indicated the staff would monitor and document each resident's response to intervention intended to reduce falling or the risks of falling. During a review of the facility's P&P titled, Answering the Call Light, revised August 2022, the P&P indicated when a resident is in the bed or confined to a chair, the call light must be within easy reach of the resident.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to place oxygen signage at the doorway indicating oxygen was in use for one of eight sampled residents (Resident 242) receiving oxygen therapy. This deficient practice had the potential to place all residents' and staff's safety at risk. Findings: During a review of Resident 242's Admission Record, dated 2/13/2024, the admission record indicated Resident 242 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The admission record indicated the following diagnoses which included, chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), respiratory failure (a serious lung condition that makes it difficult to breathe on your own), dependence on supplemental oxygen, type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and chronic kidney disease (CKD - a longstanding disease in which the kidneys are damaged and cannot filter blood as well as they should). During a review of Resident 242's History and Physical (H&P), dated 2/5/2025, the H&P indicated Resident 242 had the capacity to understand and make decisions. During a review of Resident 242's Minimum Data Set (MDS - a resident assessment tool), dated 2/10/2025, the MDS indicated Resident 242's cognition (ability to think, remember, and reason) was moderately impaired. The MDS indicated Resident 242 required set-up and clean up assistance (helper sets up or cleans up) for eating and was dependent (helper does all of the effort) with bathing and toileting. During a review of Resident 242's Order Summary Report dated 2/5/2025, the order summary report indicated Resident 242 had an active order on 1/8/2025 for oxygen at two liters (unit of volume) per minute (LPM) via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) every day as needed to keep oxygen saturation (O2 sat - a measurement of how much oxygen the blood is carrying as a percentage) above 93 percent (%) (normal O2 sat - 95% to 100%) related to aspiration (when food, drink or objects enter the lungs) precautions. During an observation on 2/10/2025 at 4:07 p.m., observed Resident 242 lying in bed receiving oxygen at two LPM via nasal cannula. Observed Resident 242 did not have oxygen signage placed outside of the doorway or in the room. During a concurrent observation and interview on 2/11/2025 at 2:40 a.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 observed Resident 242 lying in bed on two LPM oxygen via nasal cannula. LVN 3 stated Resident 242 did not have oxygen signage placed outside of the door. LVN 3 stated there should be an oxygen sign on Resident 242's door because the resident was receiving oxygen. LVN 3 stated it was important to have oxygen signage on the door of residents receiving oxygen in case of a fire or other safety precautions. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/23/2025 at 9:47 a.m., with the Director of Nursing (DON), the DON stated as soon as the nursing staff were aware Resident 242 was receiving oxygen, the oxygen signage should have gone up. The DON stated the nursing staff do not have to wait on the environmental services department to place the oxygen signage on the door but should place the oxygen signage on the door as soon as the resident was placed on oxygen. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, revised on October 2010, the P&P indicated the following guidelines for safe oxygen administration: 1. Place an Oxygen in Use sign on the outside of the room entrance door and place an Oxygen in Use sign in a designated place on or over the resident's bed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130 Based on observation, interview, and record review, the facility failed to: 1. Administer medications as per physician's orders and/or manufacturer specifications for two of eight sampled residents (Resident 50 and Resident 69) by failing to: a. Ensure Resident 50's Aspirin (a medication used to prevent heart attack [flow of blood and oxygen is blocked] and stroke [loss of blood flow to a part of the brain]) chewable tablet was administered as chewable during medication administration. b. Ensure Resident 69's Quetiapine (a medication used to treat schizophrenia [a mental illness that is characterized by disturbances in thought] and major depressive disorder (depression) with bipolar disorder [sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs]) order was entered with accurate scheduled administration times and clarified with the physician before it was administered, when physician order indicating Quetiapine 25 milligrams (mg - a unit of measurement for mass), give 1 tablet orally three times a day related to schizophrenia, order date 12/30/2024, and medication card / bubble pack indicating Quetiapine 25 mg, take one-half (0.5) tablet by mouth (12.5mg) every 8 hours for agitation, did not match. 2. Clarify Resident 30's order for Polyethylene Glycol (a medication used to treat constipation) 3350 oral powder 17 gram (gm - a unit of measurement for mass) per scoop, give 17 gm orally as needed for constipation mix 17 gm with 8 ounce (oz - a unit of measurement for volume) of water or juice and take by mouth, order date 2/18/2024, start date 7/1/2024, to ensure the order had a frequency of administration. These failures of not administering medications to Residents 30, 50 and 69 in accordance with the physician orders or professional standards of practice had the potential to result in hospitalization due to adverse effects such as heart attack, stroke, diarrhea and behavioral disturbances. Findings: 1a. During a review of Resident 50's Admission Record (a document containing demographic and diagnostic information), dated 2/10/2025, the admission record indicated, Resident 50 was originally admitted to facility on 3/2/2018 and readmitted on [DATE] with diagnoses including but not limited to atherosclerosis (a medical condition with buildup of fat and calcium) of aorta (the main blood vessel through which oxygen and nutrients travel from the heart to organs throughout the body), and Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high blood glucose level) and hyperlipidemia (a condition with high levels of fat particles [lipids] in the blood). During a review of Resident 50's History and Physical (H&P), dated 1/14/2025, the document indicated, Resident 50 did not have the capacity to understand and make decisions. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 50's Minimum Data Set (MDS - a resident assessment tool), dated 12/23/2024, the MDS indicated, Resident 50's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was moderately impaired. The MDS indicated Resident 50 required supervision level assistance from the facility staff in performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, upper and lower body dressing, putting on/taking off footwear, and moderate assistance for oral hygiene, toileting and showering. During an observation on 2/10/2025 between 9:27 a.m. and 9:43 a.m., Licensed Vocational Nurse (LVN) 3 prepared and administered ten medications for Resident 50 that included one tablet of aspirin 81 mg chewable tablet from a manufacturer's bottle. LVN 3 failed to instruct Resident 50 to chew the aspirin tablet. Resident 50 was observed swallowing all medications including the aspirin 81 mg chewable tablet. During a review of Resident 50's Order Summary Report (a document containing a summary of all active physician orders), dated 2/10/2025 and 1/19/2025, the order summary report indicated but not limited to the following physician order: Aspirin tab delayed release 81 mg, give 1 tablet orally in the morning for cerebrovascular accident ([CVA] - loss of blood flow to part of the brain, which damages brain tissue) prophylaxis (PPX - prevention), order date 4/22/2024, start date 7/1/2024. During an interview on 2/10/2025 at 12:32 p.m. with LVN 3, LVN 3 stated aspirin 81 mg for Resident 50 was a chewable tablet and was supposed to be chewed before swallowing. LVN 3 stated Resident 50 did not chew the tablet per manufacturer specifications, which would increase the possibility that aspirin could be ineffective and could increase the resident's potential risk for stroke, heart attack or hospitalization . 1b. During a review of Resident 69's admission record, dated 2/11/2025, the admission record indicated, Resident 69 was admitted to facility on 10/18/2021 with diagnoses including but not limited to schizophrenia and major depressive disorder, recurrent and severe with psychotic symptoms. During a review of Resident 69's history and physical (H&P), dated 10/24/2024, the H&P indicated Resident 69 had fluctuating capacity to understand and make decisions. During a review of Resident 69's MDS, dated [DATE], the MDS indicated Resident 69 had severe cognitive impairment. The MDS indicated Resident 69 required supervision level assistance from the facility staff for ADLs such as eating, moderate assistance for oral hygiene, and maximal assistance for toileting, showering, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During an observation of a medication administration on 2/11/2025 at 1:22 p.m., LVN 1 prepared and administered one-half (0.5) tablet (12.5 mg) of quetiapine fumarate 25 mg to Resident 69 from medication card / bubble pack. During a medication reconciliation review on 2/11/2025 at 2:20 p.m. Resident 69's order summary report and observed administered medication details were reviewed. The order summary report, dated 2/12/2025 indicated, but not limited to the following physician orders: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Quetiapine fumarate tab 25 mg, give 1 tablet orally three times a day related to schizophrenia, unspecified, manifested by (m/b) constantly trying to throw/slide himself out of bed. Informed consent obtained by MD after explanation of risks and benefits to the resident, order date 12/30/2024, start date 12/30/2024. Quetiapine fumarate oral tablet, give 12.5 mg by mouth three times a day for schizophrenia, unspecified, m/b constantly trying to throw/slide himself out of bed. Informed consent obtained by MD after explanation of risks and benefits to the resident, order date 2/11/2025, start date 2/11/2025. Quetiapine fumarate oral tablet, give 12.5 mg by mouth three times a day for schizophrenia, unspecified m/b constantly trying to throw/slide himself out of bed. Informed consent obtained by MD after explanation of risks and benefits to the resident, order date 2/11/2025, start date 2/11/2025. The order summary report, dated 1/19/2025 indicated, but not limited to the following physician order: Quetiapine fumarate tab 25 mg, give 1 tablet orally three times a day related to schizophrenia, unspecified, manifested by (m/b) constantly trying to throw/slide himself out of bed. Informed consent obtained by MD after explanation of risks and benefits to the resident, order date 12/30/2024, start date 12/30/2024. During a review of Resident 69's electronic medication administration record (eMAR) order details, dated 2/11/2025, for quetiapine 25 mg, order date 12/30/2024, the order details indicated facility time code was entered as 9:00 a.m., 1:00 p.m. and 5:00 p.m., and specific times were shown as 9:00 a.m., 2:00 p.m. and 9:00 p.m. During a review of Resident 69's Medication Administration Record ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 12/30/2024 to 12/31/2024, 1/1/2025 to 1/31/2025 and 2/1/2025 to 2/11/2025, the MAR indicated quetiapine 25 mg was administered for a total of 129 times as give 1 tablet orally three times a day related to schizophrenia with start date 12/30/2024. During a concurrent interview and record review on 2/11/2025 at 3:02 p.m. with LVN 1, Resident 69's administered order of quetiapine during medication pass observation on 2/11/2025, medication card / bubble pack dated 1/14/2025 and eMAR for quetiapine fumarate tab 25 mg dated 2/13/2025, were reviewed. LVN 1 stated the medication card / bubble pack indicated, quetiapine fum 25 mg, take 0.5 tablet by mouth (12.5 mg) every 8 hours for agitation, whereas the eMAR indicated, quetiapine fumarate tab 25 mg, give 1 tablet orally three times a day related to schizophrenia, order date: 12/30/2024, order status: active. LVN 1 stated the medication card for Resident 69's quetiapine did not match with eMAR order details for quetiapine. LVN 1 stated Resident 69 did not receive quetiapine as ordered by physician and she would call physician to clarify quetiapine order. LVN 1 stated Resident 69 did not receive appropriate dose of quetiapine which possibly failed to manage symptoms and increased risk for behavioral disturbances and hospitalization . 2. During a review of Resident 30's admission record, dated 2/11/2025, the admission record indicated Resident 30 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including but not limited to chronic pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 30's H&P dated 2/19/2024, the H&P indicated Resident 30 had fluctuating capacity to understand and make decisions. During a review of Resident 30's MDS, dated [DATE], the MDS indicated Resident 30's cognition was moderately impaired. The MDS indicated Resident 30 needed supervision level assistance from the facility staff for ADLs such as eating, moderate assistance for oral hygiene, and maximal assistance for toileting, showering, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During a medication reconciliation review on 2/11/2025 at 2:05 p.m. following medication administration observation on 2/11/2025 at 12:05 p.m. with LVN 1, Resident 30's order summary report dated 2/12/2025 and 1/19/2025 were reviewed. The order summary report dated 2/12/2025 indicated, but not limited to the following physician orders: Polyethylene Glycol 3350 oral powder 17 gm/scoop, give 17 grams orally as needed for constipation, mix 17 g with 8 oz of water and juice and take by mouth (PO), order date 2/18/2024, start date 7/1/2024. Polyethylene Glycol 3350 oral powder 17 gm/scoop, give 17 grams orally every 24 hours as needed for constipation, mix 17 g with 8 oz of water or juice and take PO, order date 2/11/2025, start date 2/11/2025. The order summary report dated 1/19/2025 indicated, but not limited to the following physician order: Polyethylene Glycol 3350 oral powder 17 gm/scoop, give 17 grams orally as needed for constipation, mix 17 g with 8 oz of water and juice and take by mouth (PO), order date 2/18/2024, start date 7/1/2024. During a concurrent interview and record review on 2/11/2025 at 4:49 p.m. with LVN 1, Resident 30's eMAR for polyethylene glycol 3350 oral powder dated 2/13/2025 was reviewed. LVN 1 stated polyethylene glycol order did not have a frequency of administration and needed to be clarified with physician. LVN 1 stated polyethylene glycol was last administered to Resident 30 on 10/7/2024 at 6:48 p.m. LVN 1 stated there was a risk of causing diarrhea, fluid loss and dehydration if polyethylene glycol was given in excess than what Resident 30 needed. LVN 1 stated it was not safe or effective to have a medication order without a clear dosing frequency. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/2025 at 3:50 p.m. with the Director of Nursing (DON), the DON stated Resident 50's chewable aspirin 81 mg should have been administered as a chewable tablet per manufacturer specifications to prevent stroke and clotting. The DON stated if the chewable aspirin was swallowed without chewing, it might not get absorbed completely or timely which could increase the risk for thrombosis (a medical term used when blood clots block blood vessels obstructing blood blow). The DON stated the aspirin 81 mg order should have been clarified with the physician because it was entered in eMAR as a capsule but given as a chewable aspirin tablet where the LVN did not instruct resident to chew the tablet. The DON stated medication orders should have a dosing frequency. The DON stated polyethylene glycol order with only as needed without a frequency could have caused Resident 30 to receive more or lesser amount of medication than needed, increasing resident's risk for diarrhea, dehydration and depending on how the resident reacted to the medication it could cause more harm. The DON stated regarding Resident 69's quetiapine order, during recap, there was an error with quetiapine order, and physician and pharmacy were called for clarification. The DON stated facility should have compared eMAR, the chart and medication card to ensure there were no discrepancies in the orders. The DON stated, resident was doing very well on quetiapine 12.5 mg dose, otherwise there could have been a medication error. The DON stated the nurse who entered the order no longer worked at the facility, but orders should have been entered accurately for the scheduled times of administration according to physician orders. During a review of the facility's policy and procedure (P&P) titled, Medication Orders, dated 11/2014, the P&P indicated, 1. Medication Orders - When recording orders for medication, specify the type, route, dosage, frequency and strength of the medication ordered .example: Dilantin .per day. 2. PRN Medication Orders - When recording PRN medication orders, specify the type, route, dosage, frequency, strength and the reason for administration. Example Tylenol 101F. During a review of the facility's P&P titled, Administering Medications, dated 4/2019, the P&P indicated, Medications are administered in a safe and timely manner and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. The P&P indicated, If a dosage is believed to be inappropriate or excessive for a resident .the person preparing or administering the medication will contact the prescriber, the resident's Attending Physician or the facility's Medical Director to discuss the concerns. The P&P indicated, The individual administering the medication checks the label three (3) times to verify the right resident .right dosage .right method (route) of administration before giving the medication.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130 Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5 percent (%) during medication pass for two of eight sampled residents (Residents 50 and 69) by failing to: a. Ensure Resident 50's Aspirin (a medication used to prevent heart attack [flow of blood and oxygen is blocked] and stroke [loss of blood flow to a part of the brain]) chewable tablet was administered as chewable during medication administration. b. Ensure Resident 69's Quetiapine (a medication used to treat schizophrenia [a mental illness that is characterized by disturbances in thought] and major depressive disorder (depression) with bipolar disorder [sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs]) order was clarified with physician before it was administered, when physician order indicating Quetiapine 25 milligrams (mg - a unit of measurement for mass), give 1 tablet orally three times a day related to schizophrenia, order date 12/30/2024, and medication card / bubble pack indicating Quetiapine 25 mg, take one-half (0.5) tablet by mouth (12.5mg) every 8 hours for agitation, did not match. These deficient practices of medication administration error rate of 8 percent (%) exceeded the five (5) percent (%) threshold. Findings: a. During a review of Resident 50's Admission Record (a document containing demographic and diagnostic information), dated 2/10/2025, the admission record indicated, Resident 50 was originally admitted to facility on 3/2/2018 and readmitted on [DATE] with diagnoses including but not limited to atherosclerosis (a medical condition with buildup of fat and calcium) of aorta (the main blood vessel through which oxygen and nutrients travel from the heart to organs throughout the body), and Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high blood glucose level) and hyperlipidemia (a condition with high levels of fat particles [lipids] in the blood). During a review of Resident 50's History and Physical (H&P), dated 1/14/2025, the document indicated, Resident 50 did not have the capacity to understand and make decisions. During a review of Resident 50's Minimum Data Set (MDS - a resident assessment tool), dated 12/23/2024, the MDS indicated Resident 50's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was moderately impaired. The MDS indicated Resident 50 required supervision level assistance from the facility staff in performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, upper and lower body dressing, putting on/taking off footwear and moderate assistance for oral hygiene, toileting and showering. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/10/2025 between 9:27 a.m. and 9:43 a.m., Licensed Vocational Nurse (LVN) 3 prepared and administered the following ten medications for Resident 50 that included one tablet of aspirin 81 mg chewable tablet from a manufacturer's bottle. LVN 3 failed to instruct Resident 50 to chew the aspirin tablet. Resident 50 was observed swallowing all of the following medications including aspirin 81 mg chewable tablet: 1. One tablet of amlodipine (a medication used to treat high blood pressure) 5 mg. 2. One tablet of chewable aspirin 81 mg. 3. One tablet of buspirone (a medication used to treat anxiety) 5 mg. 4. One tablet of divalproex (a medication used to treat seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] and manic episodes related to bipolar disorder) sodium delayed release 500 mg. 5. One tablet of glyburide (a medication used to treat high blood glucose level) 2.5 mg. 6. One tablet of lisinopril (a medication used to treat high blood pressure) 10 mg. 7. One tablet of megestrol (a medication used to stimulate appetite) 40 mg. 8. One tablet of multivitamin with minerals. 9. One tablet of risperidone (a medication used to treat schizophrenia) 2 mg. 10. One tablet of metformin (a medication used to treat high blood glucose level) 500 mg. During a review of Resident 50's Order Summary Report (a document containing a summary of all active physician orders), dated 1/19/2025 and 2/10/2025, the order summary report indicated but not limited to the following physician order: Aspirin tab delayed release 81 mg, give 1 tablet orally in the morning for cerebrovascular accident ([CVA] - loss of blood flow to part of the brain, which damages brain tissue) prophylaxis (PPX - prevention), order date 4/22/2024, start date 7/1/2024. During an interview on 2/10/2025 at 12:32 p.m. with LVN 3, LVN 3 stated aspirin 81 mg for Resident 50 was a chewable tablet and was supposed to be chewed before swallowing. LVN 3 stated Resident 50 did not chew the tablet per manufacturer specifications, which would increase the possibility that aspirin could be ineffective and could increase resident's potential risk for stroke, heart attack or hospitalization . b. During a review of Resident 69's admission record, dated 2/11/2025, the admission record indicated, Resident 69 was admitted to facility on 10/18/2021 with diagnoses including but not limited to schizophrenia and major depressive disorder, recurrent and severe with psychotic symptoms. During a review of Resident 69's H&P, dated 10/24/2024, the H&P indicated Resident 69 had fluctuating capacity to understand and make decisions. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 69's MDS, dated [DATE], the MDS indicated Resident 69 had severe cognitive impairment. The MDS indicated Resident 69 required supervision level assistance from the facility staff for ADLs such as eating, moderate assistance for oral hygiene, and maximal assistance for toileting, showering, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During an observation of a medication administration on 2/11/2025 at 1:22 p.m., LVN 1 prepared and administered one-half (0.5) tablet (12.5 mg) of quetiapine fumarate 25 mg to Resident 69 from medication card / bubble pack. During a medication reconciliation review on 2/11/2025 at 2:20 p.m. Resident 69's order summary report and observed administered medication details were reviewed. The order summary report, dated 2/12/2025 indicated, but not limited to the following physician orders: Quetiapine fumarate tab 25 mg, give 1 tablet orally three times a day related to schizophrenia, unspecified, manifested by (m/b) constantly trying to throw/slide himself out of bed. Informed consent obtained by MD after explanation of risks and benefits to the resident, order date 12/30/2024, start date 12/30/2024. Quetiapine fumarate oral tablet, give 12.5 mg by mouth three times a day for schizophrenia, unspecified, m/b constantly trying to throw/slide himself out of bed. Informed consent obtained by MD after explanation of risks and benefits to the resident, order date 2/11/2025, start date 2/11/2025. Quetiapine fumarate oral tablet, give 12.5 mg by mouth three times a day for schizophrenia, unspecified m/b constantly trying to throw/slide himself out of bed. Informed consent obtained by MD after explanation of risks and benefits to the resident, order date 2/11/2025, start date 2/11/2025. The order summary report, dated 1/19/2025 indicated, but not limited to the following physician order: Quetiapine fumarate tab 25 mg, give 1 tablet orally three times a day related to schizophrenia, unspecified, manifested by (m/b) constantly trying to throw/slide himself out of bed. Informed consent obtained by MD after explanation of risks and benefits to the resident, order date 12/30/2024, start date 12/30/2024. During a review of Resident 69's electronic medication administration record (eMAR) order details, dated 2/11/2025, for quetiapine 25 mg, order date 12/30/2024, the order details indicated facility time code was entered as 9:00 a.m., 1:00 p.m. and 5:00 p.m., and specific times were shown as 9:00 a.m., 2:00 p.m. and 9:00 p.m. During a review of Resident 69's Medication Administration Record ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 12/30/2024 to 12/31/2024, 1/1/2025 to 1/31/2025 and 2/1/2025 to 2/11/2025, the MAR indicated quetiapine 25 mg was administered for a total of 129 times as give 1 tablet orally three times a day related to schizophrenia with start date 12/30/2024. During a concurrent interview and record review on 2/11/2025 at 3:02 p.m. with LVN 1, (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 69's administered order of quetiapine during medication pass observation on 2/11/2025, medication card / bubble pack dated 1/14/2025 and eMAR for quetiapine fumarate tab 25 mg dated 2/13/2025, were reviewed. LVN 1 stated the medication card / bubble pack indicated, quetiapine fum 25 mg, take 0.5 tablet by mouth (12.5 mg) every 8 hours for agitation, whereas the eMAR indicated, quetiapine fumarate tab 25 mg, give 1 tablet orally three times a day related to schizophrenia, order date: 12/30/2024, order status: active. LVN 1 stated the medication card for Resident 69's quetiapine did not match with eMAR order details for quetiapine. LVN 1 stated Resident 69 did not receive quetiapine as ordered by physician and she would call physician to clarify quetiapine order. LVN 1 stated Resident 69 did not receive appropriate dose of quetiapine which possibly failed to manage symptoms and increased risk for behavioral disturbances and hospitalization . During an interview on 2/12/2025 at 3:50 p.m. with the Director of Nursing (DON), the DON stated Resident 50's chewable aspirin 81 mg should have been administered as a chewable tablet per manufacturer specifications to prevent stroke and clotting. The DON stated if the chewable aspirin was swallowed without chewing, it might not get absorbed completely or timely which could increase the risk for thrombosis (a medical term used when blood clots block blood vessels obstructing blood blow). The DON stated the aspirin 81 mg order should have been clarified with the physician because it was entered in eMAR as a capsule but given as a chewable aspirin tablet where the LVN did not instruct resident to chew the tablet. The DON stated regarding Resident 69's quetiapine order, during recap, there was an error with quetiapine order, and physician and pharmacy were called for clarification. The DON stated facility should have compared eMAR, the chart and medication card to ensure there were no discrepancies in the orders. The DON stated, resident was doing very well on quetiapine 12.5 mg dose, otherwise there could have been a medication error. The DON stated the nurse who entered the order no longer worked at the facility, but orders should have been entered accurately for the scheduled times of administration according to physician orders. During a review of the facility's policy and procedure (P&P) titled, Medication Orders, dated 11/2014, the P&P indicated, 1. Medication Orders - When recording orders for medication, specify the type, route, dosage, frequency and strength of the medication ordered .example: Dilantin .per day. 2. PRN Medication Orders - When recording PRN medication orders, specify the type, route, dosage, frequency, strength and the reason for administration. Example Tylenol 101F. During a review of the facility's P&P titled, Administering Medications, dated 4/2019, the P&P indicated, Medications are administered in a safe and timely manner and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. The P&P indicated, If a dosage is believed to be inappropriate or excessive for a resident .the person preparing or administering the medication will contact the prescriber, the resident's Attending Physician or the facility's Medical Director to discuss the concerns. The P&P indicated, The individual administering the medication checks the label three (3) times to verify the right resident .right dosage .right method (route) of administration before giving the medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130 Based on observation, interview, and record review, the facility failed to: 1. Ensure medications were stored separately from food items (Sriracha [a brand of spicy sauce] bottle) in one of one inspected medication room (Station A Medication Room). 2. Ensure removal of expired niacin (a vitamin B supplement to treat low level of vitamin B) tablets from one of one inspected medication room (Station A Medication Room). 3. Ensure medication storage area did not have an unidentified and/or unapproved container noted to be utilized during medication administration to measure water volume for G-tube flushes in one of two inspected medication carts (Medication Cart B). 4. Ensure storage, labeling and/or removal of expired and/or discontinued medications that included vitamin B12 (a vitamin supplement to treat low level of vitamin B12) tablets, latanoprost ophthalmic solution (a medication in form of eye drops used to treat high pressure in the eyes), insulin glargine (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) prefilled pen, metoclopramide (a medication used to treat heartburn, stomach discomfort and increase gastrointestinal motility) oral solution, cranberry tablets and vitamin D3 (a vitamin supplement to treat low level of vitamin D3) tablets, in accordance with manufacturer requirements, affecting three residents (Residents 58, 83, 36) in two of two inspected medication carts (Medication Cart B, Middle Medication Cart 2). 5. Ensure 15 controlled medications (medications that the use and possession of are controlled by the federal government) that were for discharged residents and/or discontinued orders, were removed from medication cart, and the physical inventory for 15 controlled medications was documented daily in controlled medication accountability record, affecting nine residents (Residents 342, 26, 343, 19, 90, 344, 78 and 29) in one of two inspected medication carts (Medication Cart B). The medications included one or more medication cards (bubble packs) of clonazepam (a medication used to treat panic disorder and seizure [a medical term used to describe sudden, uncontrolled burst of electrical activity in the brain]), lorazepam (a medication used to treat anxiety and insomnia [trouble falling asleep or staying asleep]), temazepam (a medication used to treat insomnia), hydrocodone-acetaminophen (a combination medication used to treat pain), zolpidem (a medication used to treat sleep disorder), tramadol (a medication used to treat pain) and diphenoxylate-atropine (a combination medication used to treat diarrhea). These failures increased the risk that Residents 58, 83, 36, 342, 26, 343, 19, 90, 344, 78, 29 and other facility residents could have received medications that had become ineffective or toxic due to improper storage, labeling and/or expiration, possibly leading to abnormal blood glucose levels, other health complications, hospitalization , and increased risk for inadvertent medication administration, medication errors, misuse, drug loss, diversion, and accidental exposure to controlled substances to residents and staff. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Findings: 1. During a concurrent inspection and interview on 2/10/2025 at 1:45 p.m. with Licensed Vocational Nurse (LVN) 3 of the Station A Medication Room, there was a bottle of Sriracha sauce (food item) placed on shelf along with medications. LVN 3 stated Sriracha bottle should not have been there along with medications because that posed a risk for cross contamination. During an interview on 2/12/2025 at 2:55 p.m. with the Director of Nursing (DON), the DON stated facility staff should not be storing food items or water or a bottle of Sriracha sauce next to medications because that increased the risk for contamination. 2. During a concurrent inspection and interview on 2/10/2025 at 1:45 p.m. with LVN 3 of the Station A Medication Room, the following product was expired: a. One sealed bottle of niacin 100 milligram (mg - a unit of measurement for mass), quantity of 100 tablets, with an expiration date of 8/2024. LVN 3 stated the expired niacin bottle was expired and should have been removed from medication stock. LVN 3 stated the expired product would not be safe or effective to administer and could cause the residents to have side effects or reactions if administered. During an interview on 2/12/2025 at 2:55 p.m. with the DON, the DON stated expired medications would have a different chemical breakdown and would not be effective or safe to be administered to residents. 3. During a concurrent inspection and interview on 2/10/2025 at 2:20 p.m. with LVN 4 of the Medication Cart B, there was an empty, white container with some measurements on the outside with a blue lid in the medication cart. The container label was not in English language except the words, Drink Saver 800ml. The container indicated handwritten words Gtube (gastrostomy, [G-tube] a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) flushes in black ink on the lid and on the side. LVN 4 stated she would not take the container with her inside resident's room, but she used the container to measure water whenever she had to perform a G-tube administration and would use same container to measure water volume for G-tube flushes. During an interview on 2/12/2025 at 02:55 p.m. with the DON, the DON stated there should not have been a random bottle or container in medication cart to measure water volume for any purposes. The DON stated the container was not approved by facility to be used and all facility staff should follow a standard process to measure volume of water for G-tube administration to prevent medication errors. 4a. During a concurrent inspection and interview on 2/10/2025 at 2:20 p.m. with LVN 4 of the Medication Cart B, the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications: 1. One open bottle of vitamin B12 100 microgram (mcg - a unit of measurement for mass) with an expiration date of 12/2024. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. One bottle of sealed latanoprost ophthalmic solution 0.005 percent (%) for Resident 58 with no opened date. According to the manufacturer's product labeling, unopened bottle(s) should be stored under refrigeration at 2-to-8 degree Celsius [(C) is a unit of temperature] (36-to-46 degree Fahrenheit [(F) is a unit of temperature]) and open or in-use bottle should be stored at room temperature up to 25 C (77 F) for six weeks. LVN 4 stated the latanoprost eye drops would help Resident 58 to treat glaucoma so if it was not properly stored according to manufacturer specifications, the medication should not be administered because it would not be safe or effective and could have side effects. LVN 4 stated, I don't know what those side effects would be. 3. One prefilled pen of insulin glargine-yfgn 100 units (a unit of measurement for insulin) / milliliters ([mL] - a unit of measurement for volume) for Resident 83 with no opened date. According to the manufacturer's product labeling, in-use (opened) pen and not in-use (unopened) pen if stored at room temperature (up to 30 C [86 F]) should be used within 28 days or be discarded. LVN 4 stated insulin glargine for Resident 83 did not have an opened date and placed the resident at risk for side effects if administered. 4. In-use bottle of metoclopramide oral solution 5 mg/5 mL for Resident 36 with the pharmacy label that indicated, Take 1 mL by mouth (1 mg) three times daily for antiemetic (to treat nausea) for 3 days (therapy ends 12/10/24). LVN 4 stated she would need to clarify with pharmacy because the order was not matching in the computer system. LVN 4 stated the pharmacy label indicated the medication administration should have ended on 12/10/2024. LVN 4 stated the physician order in electronic medication administration record (eMAR) and the pharmacy label were contradicting and could cause a medication error due to inadvertent administration of a discontinued order. LVN 4 stated metoclopramide for Resident 36 was for peptic ulcer disease, so if medication was not properly given, it would not protect resident's stomach lining and could cause ulcer (a small open sore or wound generally found in the stomach or on the skin) and lead to hospitalization . 4b. During a concurrent inspection and interview on 2/11/2025 at 3:56 p.m. with LVN 5 of the Middle Medication Cart 2, the following medications were found expired: 1. One opened bottle of cranberry 450 mg with an expiration date of 12/2023. 2. One opened bottle of vitamin D3 25 mcg with an expiration date of 4/2023. LVN 5 stated it would be unsafe to give expired meds to residents because they could have a bad reaction. LVN 5 stated cranberry was a supplement and if given to residents as expired, it could cause adverse reactions such as nausea and vomiting and would not be a proper dose either. LVN 5 stated the expired vitamin D would not treat deficiency and could be harmful if administered. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During a concurrent inspection and interview on 2/10/2025 at 2:20 p.m. with LVN 4 of the Medication Cart B, the following 15 controlled medications were found in the locked section. The pharmacy medication card / bubble pack and drug accountability record indicated the following medications and remaining quantities: 1. Temazepam 15 mg for Resident 342, quantity of 15 capsules, date on medication card 12/10/2024. 2. Clonazepam 1 mg for Resident 342, quantity of 11 tablets, date on medication card 1/2/2025, last dispensed date on controlled drug record 1/14/2025. 3. Temazepam 15 mg for Resident 342, quantity of 15 capsules, date on medication card 1/9/2025. 4. Temazepam 15 mg for Resident 342, quantity of four capsules, date on medication card 11/13/2024, last dispensed date on controlled drug record 1/13/2025. 5. Hydrocodone-Acetaminophen 5-325 mg for Resident 26, quantity of 22 tablets, date on medication card 11/27/2024, last dispensed date on controlled drug record 1/26/2025. 6. Zolpidem 5 mg for Resident 343, quantity of 13 tablets, date on medication card 1/11/2025, last dispensed date on controlled drug record 1/17/2025. 7. Clonazepam 0.5 mg for Resident 343, quantity of nine tablets, date on medication card 12/16/2024, last dispensed date on controlled drug record 1/11/2025. 8. Clonazepam 0.5 mg for Resident 343, quantity of 16 tablets, date on medication card 1/11/2025, last dispensed date on controlled drug record 1/18/2025. 9. Lorazepam 0.5 mg for Resident 19, quantity of 28 tablets, date on medication card 12/23/2024, last dispensed date on controlled drug record 1/15/2025. 10. Tramadol 50 mg for Resident 19, quantity of 30 tablets, date on medication card 12/23/2024. 11. Temazepam 15 mg for Resident 90, quantity of one capsule, date on medication card 10/10/2024, last dispensed date on controlled drug record 11/1/2024. 12. Diphenoxylate-Atropine 2.5 mg-0.025 mg for Resident 344, quantity of 18 tablets (two tablets in each bubble pack for nine bubbles), date on medication card 12/21/2024. 13. Lorazepam 0.5 mg for Resident 78, quantity of 21 tablets, date on medication card 11/4/2024, last dispensed date on controlled drug record 11/25/2024. 14. Clonazepam 0.5 mg for Resident 29, quantity of one-half 29 tablets, date on medication card 12/6/2024, last dispensed date on controlled drug record 12/11/2024. 15. Lorazepam 1 mg for Resident 29, quantity of 18 tablets, date on medication card 12/6/2024, last dispensed date on controlled drug record 1/8/2025. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 4 stated these controlled medications medication cards were stored separately in locked cabinet of medication cart because they were discontinued orders or for discharged residents. LVN 4 stated discontinued controlled medications or for discharged residents should have been given to the DON as soon as possible but she did not have a chance to do so. LVN 4 stated there was a risk of medication diversion or misuse but they were locked in medication cart. LVN 4 stated she did not know the policy on when the controlled medications should be given to the DON after they were discontinued. During a review of Resident 342's Admission Record (a document containing demographic and diagnostic information), dated 2/12/2025, the admission record indicated, Resident 342 was originally admitted to the facility on [DATE], readmitted on [DATE] and discharged on [DATE]. During a review of Resident 343's admission record, dated 2/13/2025, the admission record indicated, Resident 342 was admitted to the facility on [DATE] and discharged on [DATE]. During a review of Resident 19's admission record, dated 2/12/2025, the admission record indicated Resident 19 was originally admitted to the facility on [DATE], readmitted on [DATE] and discharged on [DATE]. During a review of Resident 90's admission record, dated 2/12/2025, the admission record indicated Resident 90 was admitted to the facility on [DATE] and discharged on [DATE]. During a review of Resident 344's admission record, dated 2/11/2025, Resident 344 was admitted to the facility on [DATE] and discharged on [DATE]. During a review of Resident 78's clinical physician orders, dated 2/13/2025, the Ativan (generic name - lorazepam) 0.5 mg order indicated end date to be 11/18/2024. During an interview on 2/12/2025 at 02:55 p.m. with the DON, the DON stated the facility nurse should bring controlled medications to the DON as soon as the medication was discontinued, changed or when the residents were discharged or deceased . The DON stated nurse should have brought medication as soon as they could, but it would not always happen. The DON stated she was not sure of the specific timeframe when the facility nurse should have brought the controlled medications to her after being discontinued. The DON stated the facility nurses should bring discontinued controlled medications to the DON in timely manner for their accountability because of their risk for addiction and misuse. The DON stated, But all the quantities matched right? there was no diversion! During an interview on 2/12/2025 at 02:55 p.m. with the DON, the DON stated the facility staff should be checking medication carts and medication rooms to ensure removal of expired and soon to be expiring medications. The DON stated the expired medications would not be effective or safe to be given to residents. The DON stated resident could have an adverse reaction or would not be effective if the latanoprost eye drops were not stored in refrigerator or not labeled with opened date. The DON stated the insulin with no opened date could have been used beyond the expiration rate and would not be effective in controlling blood glucose. The DON stated there would be a risk for hyperglycemia (high blood glucose), hypoglycemia (low blood glucose), ketoacidosis (extremely high serum and urine concentrations of ketones) or even hospitalization . The DON stated metoclopramide oral solution pharmacy label indicated it ended on 12/10/2024 and should have been removed from medication cart. The DON stated metoclopramide could have been expired and would not be effective to treat resident's nausea or infection. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Alliance Pharmacy Pharmaceutical Services Policy and Procedure Manual - Discontinued Medications - Disposal, dated 2/2019, the P&P indicated, Medications shall be removed from the medication cart immediately upon receipt of an order to discontinue in order to avoid inadvertent administration. Medications shall then be sequestered in a secure place within the facility, mutually acceptable .Pharmacy, Inc. During a review of the facility's P&P titled, Alliance Pharmacy Pharmaceutical Services Policy and Procedure Manual - Controlled Medications - Disposal, dated 2/2019, the P&P indicated, Schedule II, III, IV, and V medications remaining in the facility after a resident has been discharged , or the order discontinued, are disposed of in the facility by the director of nursing and consultant pharmacist jointly, by returning .as directed by state laws, regulations, and/or the DEA. During a review of the facility's P&P titled, Alliance Pharmacy Pharmaceutical Services Policy and Procedure Manual - Storage of Medications, dated 11/2020, the P&P indicated, Medications and biologicals hall be stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The P&P indicated, Medications requiring refrigeration or temperatures between 2 C (36 F) and 8 C (46 F) shall be kept in a refrigerator with a thermometer .monitoring. The P&P indicated, Unopened refrigerated items such as multi-dose insulin vials may be stored in refrigerator up to the expiration date on the pharmacy label or manufacturer expiration date whichever is earlier. If the refrigerated .expiration date. Once a refrigerated item such as multi-dose insulin vials are opened, the nurses will write down the open date and it must be discarded after 30 days from the date open. If the refrigerated item is a unit dose . from the date opened. The P&P indicated, outdated, contaminated, or deteriorated medications . shall be immediately removed from stock medication disposal. The P&P indicated, Medication storage areas shall be kept clean, well-lit and free of clutter temperatures. During a review of the facility's P&P titled, Storage of Medications, dated 11/2020, the P&P indicated, The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. The P&P indicated, Medications are stored separately from food and are labeled accordingly. During a review of the facility's P&P titled, Alliance Pharmacy Pharmaceutical Services Policy and Procedure Manual - Controlled Medication Storage, dated 11/2020, the P&P indicated, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and record keeping in the facility in accordance with federal, state and other applicable laws and regulations. The P&P indicated, At each shift change, a physical inventory of all controlled medications shall be conducted by two licensed nurses and is documented on the controlled substances accountability record.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 47441 Based on observation, interview, and record review, the facility failed to ensure kitchen staff were routinely trained and evaluated for competency skills when staff were: a. Unable to verbalize the acceptable temperature for low temperature dishmachine and the correct chlorine concentration range. b. Unable to verbalize the process of checking quaternary ammonium compound (QUAT, a chemical that disinfect) sanitizer concentration testing for the red buckets and three compartment sink's (sink for dishwashing that have wash, rinse and sanitize compartments) use. These failures had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 87 of 88 medically compromised residents who received food and ice from the kitchen. Findings: a. During a concurrent demonstration and interview on 2/11/2025 at 2:44 p.m. of the dishwashing machine process with Dietary Aide 1 (DA 1), DA 1 stated the temperature range for the low temperature dishmachine was 110 to 120 degrees ( ) Fahrenheit (F, measurement of temperature). DA 1 stated staff also checked the concentration of the sanitizer in the dishmachine and the acceptable range was at 50-100 parts per million ([ppm], describes the concentration of the solution). During a concurrent demonstration and interview on 2/13/2025 at 9:14 a.m. of the dishwashing process with Dietary Aide 2 (DA 2), DA 2 stated the acceptable temperature of the low temperature dishmachine was 110 to 120 F. DA 2 stated she read the low temperature dismachine poster and the acceptable temperature was at 120 F and not 110 F like she previously stated. DA 2 stated staff also check the chlorine concentration of the dishmachine using a test strip. Observed DA 2 retrieve a Hydrion test strip and dip it in the chlorine solution and counted 1.2.3.4.5. DA 2 stated the test strip was reading 100 ppm but she did not know the range for acceptable chlorine solution concentration. DA 2 stated it was important to know the acceptable range of concentration of the chlorine solution because if it is too low, it would not clean the dishes. During a review of the facility's policies and procedures (P&P) titled Dishwashing, dated 2023, the P&P indicated, POLICY: All dishes will be properly sanitized through the dishwasher. The dishwasher will be kept clean and in good working order. (8) A temperature log (a chlorine log for low-temperature machines) will be kept and maintain by the dishwashers to assure that the dishmachine is working correctly. This log will be completed each meal prior to any dishwashing. Please check for manufacturer's recommendations which should be posted on your machine and insert the temperature of the above posted on the line. Low temperature machine: If you do not have manufacturer's recommendations, use the machine at a range of 120 F to 140 F. The chlorine should read 50-100 ppm on dish surface in final rinse. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's poster titled Individual Low Temperature Dishmachine Procedure, undated, the poster indicated, Cycle machine and check for proper temperature 120 F. During a review of Food Code 2022, the Food Code 2022 indicated, 4-501.110 Mechanical Warewashing Equipment Wash Solution Temperature (B) The temperature of the wash solution in spray-type warewashers that use chemicals to sanitize may not be less than 120 F. During a review of Food Code 2022, the Food Code 2022 indicated, 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration. Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. b. During a concurrent demonstration and interview on 2/11/2025 at 3:12 p.m. of the QUAT sanitizer used to sanitize surfaces with DA 1 and the DS, observed DA 1 pull a test strip from the container and dip it in the premix QUAT sanitizer solution. DA 1 stated the acceptable range for the QUAT sanitizer concentration was 100-400 ppm. DS 1 stated staff always got 200 ppm and had to check the water temperature which should be around 75 F and above for it to have an accurate reading. DS 1 stated the current water temperature was at 71.6 F. DS 1 stated DA 1 did not follow manufacturers guidelines in checking the water temperature and following the acceptable range of 150-400 ppm for sanitizer concentration. DS 1 stated it was important to follow manufacturer's guidelines to ensure the sanitizer is sanitizing and cleaning the dishes well. DA 1 stated, they were not following the manufacturer's guidelines because their log is 70 F and not more than 75 F, the sanitizer concentration might not be accurate. DS 1 stated this could cause food borne illnesses as a potential outcome. During a concurrent demonstration and interview on 2/13/2024 at 9:14 a.m. of the QUAT sanitizer used to sanitize surfaces with DA 2, DA 2 stated staff also monitor the QUAT sanitizer solution, but she did not know the acceptable concentration of the QUAT sanitizer. DA 2 stated staff needed to monitor the temperature when testing the sanitizing solution which should be at 70 F. DA 2 stated the poster posted indicated the temperature when testing sanitizing solution was 75 F. DA 2 stated staff were doing it wrong, and the sanitizing solution might not be in their proper concentration reading. DA 2 stated unsanitized dishes would be the potential outcome for not correctly checking the concentration of the QUAT sanitizer. During a review of the facility's poster titled Individual Sanitizer Testing Procedure, undated, the poster indicated, 1. Use lukewarm water (room temperature) water, fill sink or container to proper level. 2. Wait for foam to dissipate 3. Test paper should be clean and dry. Immerse test paper for 10 seconds, do not move or shake the test paper. 3. Remove and match the color of the test paper to the chart on the test paper label. Range 150-400 ppm. During a review of the facility's test strip manufacturer's guidelines titled QAC QR test strips, undated, the guidelines indicated, 1. Immerse pad in solution and remove immediately. 2. Hold strip level for 5 seconds. Shake off excess water from pad. Compare pad to color chart above. Note: Sample must be at room temperature (above 75 F) During a review of the facility's log titled Quaternary Ammonium Log with Temperature Reading, dated 2/2025, the log indicated, solution temperature for testing is from 69-71 F, not following manufacturer's guidelines. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's job description titled Job Description: Dietary Aide dated and signed by DA 1, on 1/19/2024 the document indicated Duties and responsibilities included dishwashing. During a review of the facility's competency checklist titled Dietary Aide Competency Evaluation and Performance Satisfactory Completion, dated 1/4/2024, the checklist indicated, DA 1 was competent to operate kitchen equipment. The checklist did not indicate competency verification for dishmachine temperatures, checking chlorine and Quat sanitizer concentration. During a review of the facility's competency checklist titled Dietary Aide Competency Evaluation and Performance Satisfactory Completion, dated 1/12/2024, the checklist indicated, DA 2 was competent to operate kitchen equipment. The checklist did not indicate competency verification for dishmachine temperatures, checking chlorine and Quat sanitizer concentration. During a review of Food Code 2022, the Food Code 2022 indicated, 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration. Concentration of the sanitizing solution shall be accurately determined by using test kit or other device. During a review of Food Code 2022, the Food Code 2022 indicated, 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitation- Temperature, pH, Concentration, and Hardness. A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times specified under 4-703.11 (C) shall meet criteria specified under 7-204.11 Sanitizers, criteria shall be used in accordance with the EPA-registered label use instructions, and shall be used as follows: (C) A quaternary ammonium compound solution shall (1) Have a minimum temperature of 24 C (75 F), (2) Have a concentration as specified under 7-204.11 and as indicated by the manufacturer's use directions included in the labeling.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47441 Based on observation, interview, and record review, the facility failed to follow the menu and did not meet nutritional needs of: a. Seventy five (75) of 88 residents on regular texture diet who received 1/3 cup (c., a household measurement) instead of 1/2 c of sweet corn salad. b. Four (4) of six (6) residents on renal diet received less portion instead of 1/2 c when staff used a regular serving scoop instead of using a perforated spoodle (kitchen utensils with holes that is part spoon and part ladle used to scoop and serve precise portions of food). These failures had the potential to result in a decrease in food and nutrient intake resulting in unintended (not planned) weight loss. Findings: a. During a review of the facility's menu spreadsheet (a sheet containing kind and amount of food each diet would receive) titled Winter Menus, dated 2/10/2025, the spreadsheet indicated residents on regular texture diets would receive 1/2 c. sweet corn salad on the tray. During an observation on 12/10/2025 at 11:03 a.m., of [NAME] 2 portioning the sweet corn salad, observed [NAME] 2 use a green scoop (1/3 c.) when portioning sweet corn salad from the container to the individual Styrofoam bowl. During an interview on 12/10/2025 at 11:08 a.m. with [NAME] 2, [NAME] 2 stated she used the green scoop which was number 12 scoop when portioning the sweet corn salad for all the residents. During a concurrent interview and record review on 2/10/2025 at 2:27 p.m. with [NAME] 2 and the Dietary Supervisor (DS), the Winter Menu spreadsheet was reviewed. The Winter menu indicated, residents on regular texture diet would get 1/2 c of sweet corn salad. The DS stated green scoop is #12 scoop which is 1/3 c in portions. The DS stated [NAME] 2 should have used a grey scoop which was number 8 scoop or 1/2 c. [NAME] 2 stated she accidentally used an incorrect scoop which was small in portions because she read the spreadsheet as number 12 scoop instead of 1/2 a c. [NAME] 2 stated residents would not be getting the full nourishment that they need, and they could lose weight as a potential outcome. The DS stated giving small portions to the residents could cause them not to get the right amount of nutrients they needed. During a review of the facility's recipe titled Recipe: Sweet Corn Salad, undated, the recipe indicated portion size of sweet corn salad was 1/2 c. b. During a review of the facility's menu spreadsheet titled Winter Menus, dated 2/11/2025, the spreadsheet indicated residents on renal diet (diet that includes food low in salt, potassium [mineral found in banana, potatoes and tomatoes] and phosphorus [mineral found in milk, lentils, and nuts) would receive 1/2 c wheat pasta with margarine on the tray. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/11/2025 at 12:14 p.m., of the trayline (an area where foods were assembled from the steamtable to the resident's tray), observed [NAME] 1 was using a regular perforated serving spoon instead of a spoodle. During a concurrent observation and interview on 2/11/2025 at 12:24 p.m. of [NAME] 1 portioning the wheat pasta with the DS, observed [NAME] 1 using a regular spoon. The DS stated [NAME] 1 should be using 1/2 cup or number 8 scoop for the wheat pasta for renal diets. The DS stated she needed to get the correct utensils for [NAME] 1. During an interview on 2/11/2025 at 12:30 p.m. with the DS, the DS stated using a regular serving spoon would not give enough pasta to residents on renal diet hence the residents would get lesser calories. The DS stated residents on renal diet could lose weight loss and their nutritional status would go down for getting lesser calories. During an interview on 2/12/2025 at 2:01 p.m. with the Registered Dietitian (RD), the RD stated scoop number 8 was a bigger portion than scoop number 12 and it was important to use the correct scoops and utensils to ensure staff were giving the correct portion sizes to prevent potential weight loss for the residents. During a review of the facility's recipe titled Recipe: Parsley & Herb Penne, undated, the recipe indicated portion size of parsley & penne was 1/2 c. During a review of the facility's policy and procedure (P&P) titled Portion Control, dated 2023, the P&P indicated, POLICY: To provide specific portion control information. Procedure: To be sure portions served equal portion sizes listed on the menu, portion control equipment must be used. A variety of portion control equipment should be available and utilized by employees portioning food. The P&P further indicated, (1) Scoops are sized by number (the number of scoopfuls needed to equal one quart). The smaller the number, the larger the size. Scoop numbers and amounts are listed within the menus, recipe [NAME] and menu spreadsheet. (2) Ladles are sized according to their capacity. During a review of the facility's P&P titled Menus Planning, dated 2024, the P&P indicated, (4) Menus are planned to meet nutritional needs of residents in accordance with established national guidelines, physician's orders and, to the extent medically possible, in accordance with the most recent recommended dietary allowances of the Food and Nutrition Board of the National Research Council National Academy of Sciences. Menus are to be approved by the facility Registered Dietitian prior to the beginning of each quarterly menu cycle. 47858

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47441 Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved flavor, appearance, and appetizing temperature when: a. Sweet corn salad was at 62 degrees Fahrenheit (F, a scale of temperature) and the lettuce was wilted. b. Broccoli did not have seasoning and flavor and was overcooked and mushy. These failures had a potential to result in 75 of 88 residents on regular texture (no restriction) on 2/10/2025 and 89 of 89 residents on 2/11/2025 facility residents getting food from the kitchen, including Resident 70 and 34 at risk of unplanned weight loss, a consequence of poor food intake. Findings: During a review of Resident 34's Admission Record, the Admission Record indicated the facility initially admitted Resident 34 on 1/23/2020 and readmitted on [DATE] with diagnoses including polyneuropathy (malfunction of peripheral nerves throughout the body), chronic obstructive pulmonary disease (COPD, a condition caused by damage to the airways or other parts of the lung), unspecified protein-calorie malnutrition (a disorder caused by lack of proper nutrition or inability to absorb nutrients from food) and chronic kidney disease (when kidney becomes damaged overtime and have a hard time doing its function). During a review of Resident 34's Minimum Data Set (MDS- a resident assessment tool), dated 1/22/2025, the MDS indicated Resident 34 usually made self understood and usually understand others. The MDS further indicated Resident 34 required no assistance when eating while a resident of the facility and within the last seven days. During a review of Resident 34's Order Summary Report, dated 7/1/2024, the Order Summary Report indicated a physician's order for regular, thin consistency diet. During an interview on 2/10/2025 at 10:10 a.m. with Resident 34, Resident 34 stated the food absolutely sucks and did not taste good. Resident 34 stated nothing tastes good and the food did not even look good. During a review of Resident 70's Admission Record, the Admission Record indicated the facility initially admitted Resident 70 on 8/17/2021 and readmitted on [DATE] with diagnoses including acute pyelonephritis (a bacterial infection causing inflammation of the kidneys), unspecified protein-calorie malnutrition, and COPD. During a review of Resident 70's MDS, dated [DATE], the MDS indicated Resident 70 made self understood and understand others. The MDS further indicated Resident 70 required set up and clean up assistance with eating while a resident of the facility and within the last seven days. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 70's Order Summary Report, dated 7/7/2024, the Order Summary Report indicated a physician's order for regular, thin consistency, fortified diet (food with extra nutrients added to it). During an interview on 2/10/2025 at 2:22 p.m. with Resident 70, Resident 70 stated the food sucks, tastes bad and looks bad. a. During a review of the facility's menu spreadsheet (a list food of what would each diet get including the amount) titled Winter Menus, dated 2/10/2025, the spreadsheet indicated residents on regular diet texture would include the following foods in the tray: 1. Fish fillet with tarragon sauce 3 ounces (oz, a unit of measurement) / 1 oz. 2. Tartar sauce 1 tablespoon (Tbsp, a household measurement). 3. Cajun County Rice number 12 scoop (1/3 cup [c, a household measurement). 4. Creamed spinach 1/2 c. 5. Parsley garnish. 6. Sweet corn salad 1/2 c. 7. Fruit Bavarian cream 1 pc (3x2 1/2 inches). 8. Milk 4 oz. During an observation on 2/10/2025 at 11:03 a.m., observed [NAME] 2 dish up (to put food into a dish) the sweet corn salad in a Styrofoam bowl. During an observation on 2/10/2025 at 11:40 a.m., observed staff dishing out bowls of corn salad from the refrigerator to the resident's tray inside the carts. During an observation on 2/10/2025 at 12:22 p.m. of the corn salad temperature, observed corn salad temperature was at 62.1 F. During a concurrent observation and interview on 2/10/2025 at 1:06 p.m. with the Dietary Supervisor (DS), observed corn salad temperature was at 15 F coming out from the refrigerator. The DS stated there was not a reason why staff plated the salad from the refrigerator to the trays at 11:40 a.m. The DS stated the corn salad would be warm, not fresh, and it was at 62 F. The DS stated the residents would not eat it as the salad leaves were wilted because it was initially frozen and did not look appetizing. The DS stated this would result to resident's decline of meal intake leading to weight changes and weight loss as a potential outcome. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/12/2025 at 2:12 p.m. with the Registered Dietitian (RD), the RD stated the corn salad was plated in a Styrofoam and would not hold temperature. The RD stated salad at 15 F would freeze and if it would sit out for an hour, the temperature would be warm. The RD stated the acceptability and the quality of the salad would go down. The RD stated residents would not eat the salad which could potentially cause weight loss. During a review of the facility's policies and procedure (P&P) titled Meal Service, dated 2023, the P&P indicated, The food will be served on trayline at the recommended temperatures indicated below and recorded on the daily therapeutic menu in the temperature column of the regular food and next to the food item under the therapeutic diet column of each food served. The temperature of the foods should be periodically monitored throughout the meal service to ensure proper hot or cold holding temperature. Milk, puddings, salads and juice service temperature at 41 F or less. (4) Cold food items will be placed on the trays as close to the serving time as possible to assure the temperature is below 41 F. To accomplish this, all cold foods will be pre-poured and kept in the refrigerator or freezer and pulled out in small quantities at a time. (7) Temperature of the food when the resident receives it is based on palatability. The goal is to serve cold food cold and hot food hot. See table below for suggested temperatures. Cold entree less than or equal to 50 F, salads less than or equal to 45 F. b. During a review of the facility's menu spreadsheet titled Winter Menus, dated 2/11/2025, the spreadsheet indicated residents on regular diet texture would include the following foods in the tray: 1. Italian Lasagna (3x3 1/3= 1 square). 2. Seasoned broccoli 1/2 c. 3. Parsley garnish. 4. Garlic bread 1 slice. 5. Peanut Butter cup pudding number 12 scoop (1/3 c). 6. Milk 4 oz. During an observation on 2/11/2025 at 12:07 a.m., of the trayline (an area where foods are assembled from the steamtable to the resident's plate), observed the broccoli mushy and olive green, brown in color. During a concurrent observation and interview on 2/11/2025 at 12:38 p.m. of the broccoli with the DS, the DS stated the broccoli was a little mushy as it was overcooked. The DS stated when vegetables are overcooked, it loses its nutritional content. The DS stated the broccoli did not taste like it had any seasoning. The DS stated overcooked vegetables influence flavor and presentation, and residents would not eat the food causing them to lose weight as a potential outcome. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/12/2025 at 2:15 p.m., with the RD, the RD stated overcooked vegetables would lose their vitamins and would breakdown its fiber content. The RD stated vitamin deficiency and constipation would be the potential outcome for residents for overcooking the vegetables. The RD stated overcooked vegetables would not be an acceptable presentation and residents would not eat it because of the way it looked. The RD stated broccoli with no flavor could cause dissatisfaction for residents as it would not match the menu and residents' food intake would be low as a potential outcome. During a review of the facility's recipe titled Recipe: Seasoned Broccoli, dated 2024, the recipe indicated, ingredients: broccoli fresh or frozen broccoli, margarine, salt. During a review of the facility's P&P titled Food Preparation, dated 2023, the P&P indicated, Policy: Food shall be prepared by methods that conserve nutritive value, flavor and appearance. (3) Prepared foods will be sampled. The Food and Nutrition Services employee who prepares the food will sample it to be sure the food has a satisfactory flavor and consistency. Use a clean spoon or put a small portion of the food in a dish and taste from the dish. (4) Poorly prepared food will not be served- such food is to either be improved, prepared again, or replaced with an appropriate substitution. (6). Process raw and uncooked foods in batches. Remove from refrigeration only the amount of product that can be processed within a 30-minute period. Preparation of vegetables: 1. [NAME] vegetables in small amount of water for a short of time. 2. Add variety of seasonings to vegetables to arity their taste and appeal. 3. Serve vegetables promptly. Do not hold on the steamtable for long periods of time. 47858

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 47441 Based on observation, interview, and record review, the facility failed to prepare foods in a form designed to meet individual needs when puree Cajun country rice was sticky, did not pass the spoon tilt test (a test used to determine the stickiness of the food and the ability of the food to hold together), and did not hold its shape on the plate for residents on puree diet (foods that are smooth with pudding like consistency) /International Dysphagia Diet Initiative ([IDDSI] a framework for categorizing food textures and drink thickness) level four (4). These failures had the potential to result in difficulty in swallowing, chewing, decreased in food intake and nutrient intake to 8 of 88 residents on puree diet, resulting to unintended (not planned) weight loss and choking (when food gets stuck in your airway, blocking the flow of air to your lungs). Findings: During a review of the facility's menu spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled Winter Menus, dated 2/10/2025, the spreadsheet indicated residents on pureed IDDSI level 4 diet would include the following foods on the tray: 1. Pureed fish fillet number 8 scoop (1/2 cup, [c] a household measurement). 2. Puree tartar sauce 1 tablespoon (Tbsp, a household measurement). 3. Puree Cajun country rice 1/3 c. 4. Puree creamed spinach 1/3 c . 5. Parsley flakes. 6. Puree sweet corn salad 1/3 c. 7. Puree fruit Bavarian cream 1/3 c. During an observation on 2/10/2025 at 12:25 p.m. of the trayline (an area where foods were assembled from the steamtable to resident's plate), observed that the puree Cajun country rice did not hold its shape on the plate. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview of the test tray (a process of tasting, temping, and evaluating the quality of food) of the puree diet on 2/10/2025 at 12:30 p.m. with the Dietary Supervisor (DS), the DS stated the puree diet had to be a pudding-like consistency, no chunks, smooth in consistency and able to hold its shape. The DS stated the puree Cajun country rice did not hold its shape on the plate. The DS stated puree diet was used for residents who had swallowing and chewing difficulties. The DS stated the winter menus started on 12/2/2024 with the IDDSI menu and the facility was in the process of training staff and did not have a diet manual definition for IDDSI. The DS stated she was not familiar with the spoon tilt test. During a concurrent interview and IDDSI website review on 2/10/2025 at 12:45 p.m. with the DS, the IDDSI website titled IDDSI dated 7/2019 was reviewed. The website indicated, Level 4 Pureed is usually eaten with spoon, falls off spoon in a single spoonful when tilted and continues to hold shape on the plate, no lumps, not sticky, and liquid must not separate from solid. Food testing method: Spoon tilt test and Fork drip test. (IDDSI, July 2019, The IDDSI Framework section). The DS stated the puree Cajun country rice did not fall off during the spoon tilt test. During a concurrent interview and record review on 2/10/2025 at 1:01 p.m., with the DS, the facility's recipe titled, Recipe: Pureed (IDDSI Level 4) Starch (Rice, Pasta, Polenta, Potatoes), dated 2024 was reviewed. The recipe indicated, (5) The finished puree item should be smooth and free of lumps, hold its shape, while not being too firm or sticky, or should not weep. The finished puree item must pass IDDSI level 4 testing requirements (i.e. the fork drip, fork pressure and spoon tilt test). The DS stated the Cajun county rice did not fall off the spoon tilt test and residents could have a hard time swallowing the food. During an interview on 2/12/2025 at 2:08 p.m. with the Registered Dietitian (RD), the RD stated the IDDSI diets were not implemented. The RD stated the DS was told to attend the training, but the DS did not go. The RD stated if the staff did not get the training about IDDSI diets the food would not be at the right consistency and residents could choke and aspirate (when something enters your airway or lungs) as a potential outcome. The RD stated she provided an IDDSI training 2/10/2025. During a review of the facility's policies and procedures (P&P) titled Food Preparation, dated 2023, the P&P indicated, PROCEDURE: The facility will use approved recipes, standardized to meet the resident census. This count is to be kept so that an accurate amount of food is prepared. Recipes are specific as to portion yield, method of preparation, amounts of ingredients, and time and temperature guide. During a review of the facility's P&P titled Nutritional Care Management, dated 2023, the P&P indicated, POLICY: The facility will have an approved diet manual in the Food and Nutrition Services Department and at each Nurses' station. This is the primary source of therapeutic diet information. Its contents should be frequently reviewed by all Food and Nutrition Services personnel, especially FNS Director and Cooks. During a review of the facility's diet manual titled Regular Pureed Diet/IDDSI Level 4, dated 2024, the P&P indicated, Description: The pureed diet is a regular diet that has been designed for residents who have difficulty chewing and/or swallowing. The texture of the prepared puree food items included on this diet should be smooth, free of lumps, hold their shape, while not being too firm or sticky and should not weep.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47441 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1. Kitchen equipment and kitchen areas were not cleaned and sanitized: a. Reach in freezer vents had dust buildup by the exit door. b. Reach in freezer bottom shelves had dirt debris. c. Three kitchen vents had dust buildup. d. Kitchen hood had dust and dirt buildup. e. Ice machine had brown and white dirt buildup. 2. Pans were stacked wet at the storage area. 3. Two (2) dented cans were stored with non-dented cans. 4. Staff did not perform handwashing: a. Staff touched the trash lid then held sandwiches without washing her hands. b. Staff [NAME] a plastic lid on the floor then proceeded handling clean coffee mugs on the resident's tray without washing hands. c. Staff did not wash hands when touching the dirty trays then touched the clean domes. 5. Dirty potholder touching the lip of the pans with food. 6. Equipment and utensils were not smooth and easy to clean: a. Can opener blade had chips and metal was coming off. b. Two storage racks had paint coming off and had cracks. c. Ten (10) cracked resident's tray. d. Scoop storage was rusted. 7. Freezer temperature was not monitored and checked. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. Resident's refrigerator temperature range was not in an acceptable temperature of below 41 degrees Fahrenheit ([F], a scale of temperature). 9. Emergency water storage floor had a lot of trash (gloves, empty soda cans, dirty and paper) and it was not six (6) inches elevated from the floor. These failures had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 87 of 88 medically compromised residents who received food and ice from the kitchen. Findings: 1a. During an observation on 2/10/2025 at 9:12 a.m., of the reach in freezer by the exit door, observed four (4) vents had dust build up. b. During an observation on 2/10/2025 at 9:16 a.m., of the reach-in freezer, observed dirt debris at the bottom shelves. During a concurrent observation and interview on 2/10/2025 at 9:25 a.m. with the Dietary Supervisor (DS), the DS stated staff cleaned the freezer on 2/3/2025 and 2/7/2025 but there was dust buildup on the vents and debris from the boxes on the bottom shelves. The DS stated it was important to keep the freezer clean to prevent bacterial growth as residents could get sick, throw up, develop diarrhea from the food, and cross-contamination. During a review of the facility's policies and procedures (P&P) titled Refrigerator and Freezer, dated 2023, the P&P indicated, Maintaining a clean refrigerator and freezer can improve the safety and quality of your foods. 1. For the best cleaning results, always refer to your owner's manual. 2. Remove all items and clean shelves. Wipe with sanitizer. During a review of the facility's P&P titled Sanitation, dated 2023, the P&P indicated, Vents must be free of dust and dirt. c. During an observation on 2/10/2025 at 9:21 a.m. of the vents in the trayline area (an area where foods are assembled from the steamtable to the resident's plate), observed three (3) vents had dust buildup. d. During an observation on 2/10/2025 at 9:23 a.m. of the kitchen hood, where Cooks prepare and cook foods under, observed the kitchen hood had dust buildup. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 2/10/2025 at 9:31 a.m. of the kitchen vents and hoods with the DS, the DS stated the maintenance staff cleans the vents, and an outside vendor cleans the kitchen hood. The DS stated the hood was last cleaned on 9/2024 and she did not know as to when the maintenance staff cleaned the vent. The DS stated there was a dust buildup on the vents and hood where dirt could fall directly into the spinach that was being cooked under it. The DS stated dust going to the food could cause food poisoning to the residents. During a review of the facility's P&P titled Hoods, Filters and Vents, dated 2023, the P&P indicated, Hoods must be cleaned every two weeks and must be free from dust. e. During a concurrent observation and interview on 2/11/2025 at 10:48 a.m. of the ice machine with the DS, observed a dirt build up in the ice machine. The DS stated the maintenance staff cleaned the ice machine on 2/5/2025 but the brown, white, and yellowish buildup was from the hardness of the water. During an interview on 2/11/2025 at 10:56 a.m. with the DS, the DS stated it was not acceptable for the ice machine to have dirt buildup though it was not touching the ice, the particles could drop in the ice residents consume. The DS stated the dirt would contaminate the ice resulting to food borne illness as a potential outcome for the residents. During an interview on 2/11/2025 at 2:39 p.m. with the Maintenance Director (MD) and the DS, the MD stated they cleaned the ice machine 2-3 weeks prior to make sure there was no corrosion. The MD stated the pipes and the vents were cleaned so residents would not get sick from the corrosion. The MD stated the dirt from the ice machine was corrosion. The DS stated the dirt in the ice machine was from the metals from the filter and calcium build up and it was not okay due to cross-contamination. During a review of the facility's P&P titled Ice Machine Cleaning Procedures dated 2023, the P&P indicated, The ice machine needs to be cleaned and sanitized monthly. The internal components cleaned monthly or per manufacturer's recommendations, and the date recorded when cleaned. The maintenance supervisor can keep this record, or it can be posted on the ice machine. (3) Clean inside of ice machine with a sanitizing agent per the manufacturer's instructions. Add instructions to your policies or use manufacturer's procedures to clean and sanitize the machine. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-601.11 (A) Equipment Food Contact Surfaces and utensils shall be cleaned: (1) Except as specified in (B) of this section, before use with a different type of raw animal food such as beef, fish, lamb, pork or poultry; (2) Each time there is a change from working with raw foods to working with ready-to-eat food; (3) Between uses with raw fruits and vegetables and with time/temperature control for safety food. (4) Before using or storing a food temperature measuring device, and (5) At the time during the operation when contamination may have occurred. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated,4-602.13 Nonfood-Contact Surfaces. Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-602.12 Cooking and Baking Equipment. (A) The food contact surfaces of cooking and baking equipment shall be cleaned at least every 24 hours. This section does not apply to hot oil cooking and filtering equipment if it is cleaned as specified subparagraph 4-602.11 (D)(6). 2. During an initial kitchen tour observation on 2/10/2025 at 9:15 a.m. in the pots and pans storage area, observed pans were stacked wet. During a concurrent observation and interview on 2/10/2025 at 9:36 a.m. with the DS, the DS stated all the pots and pans went through the dishmachine and staff air-dried it in the clean area then store it by the preparation area. The DS stated the pans were not dry all the way and it was supposed to be dry before storing. The DS stated she needed to look up the reason why the pans could not be stored and stacked wet. During an interview on 2/11/2025 at 8:52 a.m. with the DS, the DS stated they could not stack wet pans because it could grow bacteria that could cause cross-contamination to food. During a review of the facility's P&P titled Three Compartment Procedure for Manual Dishwashing, dated 2023, the P&P indicated, Step 6: All items are air-dried, which means no water droplets are present. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-901.11 Equipment and Utensils, air-drying required. After cleaning and sanitizing equipment and utensils: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food and; (B) May not be cloth dried except that utensils that have been air-dried may be polished with cloths that are maintained clean and dry. 3. During a concurrent observation and interview on 2/10/2025 at 9:41 a.m., in the dry storage area with the DS, observed one (1) dented can and 1 bulging can stored with the non-dented cans. The DS stated kitchen staff always separated dented cans because they do not use dented cans. The DS stated residents could get sick as the metal particles could go in the food which was not good. During a review of the facility's P&P titled Food Storage-Dented Cans, dated 2023, the P&P indicated, Policy: Food in unlabeled, rusty, leaking, broken containers or cans with side seam dents, rim dents, or swells shall not be retained or used by the facility. Procedure: All dented cans (defined as side seam or rim dents) and rusty cans are to be separated from remaining stock and placed in a specified labeled area for return to purveyor for refund. All leaking cans are to be disposed of immediately. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-101.11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under 3-601. 12, honestly presented. 3-201.11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of S3-101.11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fail victim to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard. 4a. During an observation on 2/10/2025 at 11:17 a.m. of the food preparation, observed Dietary Aide 1 (DA 1), throw her gloves in the trashcan while holding the trash lid, and then got a sandwich without washing her hands. b. During an observation on 2/10/2025 at 11:59 a.m. in the preparation area, observed [NAME] 2 throw away a plastic lid that was on the floor while touching the trash lid, and then proceeded placing coffee mugs on the resident's trays. During an interview on 2/10/2025 at 1:15 p.m. with the DS, the DS stated the staff needed to wash their hands after they come back from break, after using the bathroom, after they touched their hair, clothes and every time they touched something dirty before going back to work. The DS stated if the staff touched something dirty like the lid of the garbage there can be cross-contamination during food preparation and could cause foodborne illness to the residents. During an review of the facility's P&P titled Sanitation, dated 2023, the P&P indicated, 17. All Food and Nutrition Services staff shall know the proper hand washing technique. The FNS Director is responsible for the proper training of this. c. During an observation on 2/11/2025 at 9:13 a.m. of the dishwashing area, observed Dietary Aide 3 (DA 3) loading the soiled dishes in the dirty area then started putting away clean dishes without washing his hands. During a concurrent observation and interview on 2/11/2025 at 9:19 a.m. of the dishwashing process with the DS, the DS stated DA 3 went from the clean area then touched the soiled dishes then went back and touched the clean dishes without washing his hands. The DS stated DA 3 only rinsed his hands and he needed to tell DA 3 to wash his hands before he touches the clean dishes. The DS stated it was important to wash hands as it could contaminate the clean dishes and could potentially cause food borne illnesses for the residents. During a review of the facility's P&P titled, Handwashing Procedure, dated 2023, the P&P indicated Hand washing is important to prevent the spread of infection. When hands need to be washed: 1. After handling soiled dishes and utensils (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled Cold Storage Temperature, dated 2023, the P&P indicated, Freezer temperature standards are 0 F or below. During a review of Food Code 2022, dated 1/18/2023, the Food Code indicated 4-204.112 Temperature Measuring Devices. (A) In a mechanically refrigerated or hot FOOD storage unit, the sensor of a TEMPERATURE MEASURING DEVICE shall be located to measure the air temperature or a simulated product temperature in the warmest part of a mechanically refrigerated unit and in the coolest part of a hot FOOD storage unit. (B) Except as specified in (C) of this section, cold or hot holding EQUIPMENT used for TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be designed to include and shall be equipped with at least one integral or permanently affixed TEMPERATURE MEASURING DEVICE that is located to allow easy viewing of the device's temperature display. 8. During a concurrent observation and interview on 2/11/2025 at 11:20 p.m. of the resident's refrigerator with the QA RN, observed the temperature log acceptable range was 36 F to 46 F. The QA RN stated the acceptable range for the refrigerator for food storage is 36 F to 46 F and there was a policy for it. The QA RN stated it was important the monitor the refrigerator with an acceptable temperature range to ensure food would not spoil and bacteria would not grow in the food. The QA RN stated she needed to check the food code for the proper refrigerator food storage acceptable temperature range. During a review of the facility's P&P titled Cold Storage Temperature Monitoring and Record Keeping, dated 2023, the P&P indicated, Policy: Food and Nutrition Services staff shall review and record temperatures of all refrigerators and freezers to ensure they are at the correct temperature for food storage and handling. (3) Refrigerator temperature standards are at least to 41 F. The goal is to keep the temperature at 34 F to 39 F. This will allow for a 2 rise in temperature when the door is opened throughout the day. This will also keep the food at less than 41 F. During a review of Food Code 2022, the Food Code 2022 indicated, 3-501.16 Time/Temperature for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as a public health control as specified under 3-501.19, and except as specified under (B) and in (C) of this section, Time/Temperature Control for safety food shall be maintained: (2) At 5 C (41 F) or less. 9. During a concurrent observation and interview on 2/11/2025 at 2:34 p.m., of the disaster water supply storage area with the MD and the DS, observed the floor with empty soda can, paper, and trash and the storage racks were not six (6) inches from the ground. The MD stated he did not know what to expect when it comes to the storage of water and food however there was a lot of trash on the floor where the emergency water supplies were stored. The MD stated it was important to keep the water storage clean to prevent the water getting dirty and to prevent residents to get diseases and infection. The MD stated the storage rack was four (4) inches from the floor after measuring it with the tape measure. The DS stated the storage racks should be 6 inches and above from the floor to provide access for them to clean and sweep under it to prevent rodents in the area. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Storeroom, dated 2024, the P&P indicated, The general cleanliness and care of the storeroom and supplies are important to ensure safe wholesome food. (1) The floor, walls, ceiling, lights, shelves, and equipment must be kept clean by setting up, maintaining, and monitoring a regular cleaning schedule. Routine inspection must be made to ensure cleanliness and high standards and sanitation. During a review of the facility's P&P titled. Storage of Food and Supplies, dated 2023, the P&P indicated, 4. All shelves and storage racks or platforms should be in accordance with state and federal regulations to facilitate air circulation and promote easy and regular cleaning. Shelves and cupboards will not be lined with shelf paper or other lines. All food and food containers are to be stored 6 inches off the floor and on clean surfaces in a manner that protects it from contamination. Store food and supplies at least 18 inches below the fire sprinkler head deflectors. During a review of Food Code 2022 dated 1/16/2024 the Food Code 2022 indicated 3-305.11 Food Storage (A) Except as specified in (B) and (C) of this section, food shall be protected from contamination by storing the food: (3) at least 15 cm (6 inches) above the floor.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 47441 Based on observation, interview, and record review the facility failed to ensure two of two staff were able to verbalize the policy regarding the use and storage of food brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This failure had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 88 of 88 medically compromised residents who store food in the resident's refrigerator. Findings: During a review of the facility's Policies and Procedures (P&P), titled Food for Residents from Outside Sources, dated 2023, the P&P indicated Policy: Food brought in from outside the facility kitchen for resident's consumption will be monitored. This is done to measure effectiveness of this intervention in residents with low food intake; to be sure the food is within the guidelines of the diet order, and to better assess nutrient intake. Nursing and/or admissions will provide the family or new admits with the information sheet, Bringing in Food for a resident (Section 6, page 6.24). Procedure: The following is to be done to ensure the above is accomplished: 1. Non-perishable foods such as cookies, cake, crackers, fruit, etc. (do not require time and temperature holding), can be stored in the resident's room or at the nurses' station with the resident's name and date of storage. If unopened, refer to the Dry Storage Guide. If opened, the food must be sealed, dated to the date opened and disposed by the best by date or 30 days, whichever comes first. 2. Prepared foods, beverages, or perishable food that requires refrigeration, can be stored for the resident in the facility kitchen, the refrigerator with the nurses' station, or in the resident's personal refrigerator. In the Food and Nutrition Services Department, the policy of food storage will apply. Otherwise, if unopened, refrigerated or frozen items will be disposed of by the expiration date on the container. If opened, the food must be sealed, dated to the date opened and disposed of in 2 days after opening. Frozen items, such as ice cream, will be disposed of in 30 days. During an interview with the Dietary Supervisor (DS) on [DATE] at 10:40 p.m., the DS stated the facility did not have a refrigerator designated for resident's food from home in the kitchen, but the facility had a little refrigerator in the utility room in Nurse Station A. During an interview with the DS on [DATE] at 10:57 a.m., in the utility room, the DS stated she did not maintain the resident's refrigerator. The DS stated housekeeping maintained the resident's refrigerator. During an interview on [DATE] at 11:09 a.m. with Licensed Vocational Nurse 1 (LVN1), LVN 1 stated she was usually assigned in Station 1. LVN 1 stated she was not familiar with the food from the outside source policy but recalled having an in-service that they could not store food in the kitchen. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 11:18 a.m. with the Director of Nursing (DON), the DON stated the refrigerator in the utility room was designated for resident's food from the outside. During an interview on [DATE] at 11:20 a.m. with the Quality Assurance Nurse (QA RN), the QA RN stated the refrigerator in the utility room in Station 1 was for resident's outside food. QA RN stated she was the one monitoring the resident's refrigerator for food safety and she checked for the labeling and dating of expired food for disposal. QA RN stated it was important that the staff know of the facility's policy on food brought from home because food could spoil, and bacteria could grow in the food and could cause stomach pain. During an interview on [DATE] at 10:59 a.m. with Licensed Vocational Nurse 2 (LVN 2), who is a treatment nurse, LVN 2 stated he was not too keen about the food storage policy; however, he was aware staff could not store food because it could spoil. LVN 2 stated the facility only had a medication refrigerator at Nurse Station 2. LVN 2 stated he went to Nurse Station 1 and checked that the refrigerator there was for residents. LVN 2 stated the facility did not store any food for more than 24 hours. LVN 2 stated it was important to know the policy on food brought from home for the resident's food safety so food would not spoil.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to ensure standard infection control practices were followed when: 1. Housekeeping personnel failed to perform hand hygiene after cleaning a resident's room. 2. Nursing staff failed to perform hand hygiene after coming in contact with a resident's body fluids. 3. Nursing staff failed to sanitize a high traffic surface area contaminated with body fluids. 4. Nursing staff failed to ensure Resident 56's nebulizer (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs), nebulizer mask (a face mask over the nose and mouth to deliver medication into the lungs), and tubing was not touching the floor, was dated, and stored properly. These deficient practices had the potential to expose Resident 56, other residents, staff, and visitors to infection. Findings: a. During an observation on 2/10/2025 at 10:24 a.m., while in the hallway, observed Housekeeper (HK) 1 inside of a resident's room collecting trash from the floor with her gloved hands and placing the trash inside of a trash bag. Observed HK 1 remove her gloves and exit the resident's room without washing or sanitizing her hands. HK 1 then proceeded down the hallway with her cart. HK 1 was then observed lifting the lid of another trash can in the hallway without gloves and without washing her hands before touching the trash can lid. During an interview on 2/10/2025 at 10:26 a.m. with HK 1, HK 1 stated she should have washed her hands when she left the resident's room. HK 1 stated she usually washes her hands, but she had forgotten on this occasion. HK 1 stated handwashing was important when entering and leaving a resident's room to prevent the spread of an infection from one resident to another resident. During an observation on 2/11/2025 at 10:28 a.m., while at the nursing station, observed an unknown resident approaching the nursing station with large amounts of mucus (a thin, slippery fluid that lines your nose, throat, and other passages) dripping from his nose. The resident's mucus dripped onto the nursing station's counter. Licensed Vocational Nurse (LVN) 3 approached the resident and placed a paper towel over the mucus on the counter. LVN 3 then picked up the paper towel from the counter and gave it to the resident to cover his nose. LVN 3 walked away from the nursing station with the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 2/11/2025 at 11:22 a.m. with LVN 3, LVN 3 stated due to infection control she should have disinfected the counter at the nursing station and washed her hands before leaving with the resident. LVN 3 stated the resident left his body fluids in an area where other people could have come into contact with the bodily fluids. LVN 3 stated other residents and visitors could have become ill after exposure to the resident's bodily fluids. During an interview on 2/11/2025 at 1:25 p.m., with the Infection Preventionist Nurse (IPN), the IPN stated the housekeeper should have washed her hands before leaving the resident's room. The IPN stated when a staff member enters a room, they must wash their hands before leaving the room. The IPN stated staff must make it a habit to wash their hands before entering and leaving a resident's room even if they do not come in contact with the resident. The IPN stated the nurse should have also wiped down the counter at the nursing station, washed her hands and called housekeeping staff to sanitize the surface area immediately after the resident left body fluids on the counter. The IPN stated the counter was contaminated and if touched could have passed an infection to staff or residents. During an interview on 2/13/2025 at 9:44 a.m., with the Director of Nursing (DON), the DON stated that all high touched areas should be cleaned frequently and immediately if bodily fluid was present. During a review of the facility's policy and procedure (P&P) titled, Cleaning and Disinfection of Environmental Surfaces, revised June 2009, the P&P indicated housekeeping surfaces such as floors and tabletops will be cleaned on a regular basis, when spills occur and when these surfaces are visibly soiled. The P&P indicated spills of blood and other potentially infectious materials will promptly be cleaned and decontaminated. During a review of the facility's P&P titled, Infection Control Guidelines for All Nursing Procedures, revised August 2012, the P&P indicated employees must wash their hands for ten to fifteen seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: 1. Before and after direct contact with residents 2. When hands are visibly dirty or soiled with blood and other body fluids 3. After contact with blood, body fluids, secretions, mucous membranes, or non-intact skin 4. After removing gloves 5. After handling items potentially contaminated with blood, body fluids or secretions. 48343 b. During an observation on 2/10/2025 at 10:17 a.m., in Resident 56's room, Resident 56's nebulizer machine and the mask (a face mask over the nose and mouth to deliver medication into the lungs) were observed on the floor behind Resident 56's bed. The tubing was undated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 56's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 56 was originally admitted to the facility on [DATE] and re admitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease ([COPD]- a chronic lung disease causing difficulty in breathing), diabetes mellitus ([DM]- a disorder characterized by difficulty in blood sugar control and poor wound healing), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 56's Minimum Data Set ([MDS] - a resident assessment tool), dated 1/17/2025, the MDS indicated Resident 56's cognitive (the ability to think and process information) skills for daily living was intact. The MDS indicated Resident 56 required moderate (helper does less than half the effort) assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 56's Order Summary Report dated 3/24/2024, the order summary report indicated Levalbuterol HCL nebulizer solution (medication used to treat wheezing [a high-pitched sound during breathing]) 0.63 milligram per (/) 3 milliliters (mg/ml- metric unit of measurement, used for medication dosage and/or amount). The order summary report indicated Resident 56 would receive Levalbuterol HCL 3 ml nebulizer solution every eight (8) hours as needed for wheezing related to COPD. During a concurrent observation and interview on 2/11/2025 at 10:28 a.m., in Resident 56's room, with LVN 1, Resident 56's nebulizer machine, mask, and tubing was observed on the floor. LVN 1 stated Resident 56's nebulizer machine was touching the floor, and it was unsanitary. LVN 1 stated the nebulizer machine should have been placed on the top of the table by Resident 56's bed. LVN 1 stated the tubing and mask were on the floor and undated. LVN 1 stated the nebulizer tubing and mask should be changed and dated every seven days and stored in the plastic bag next to the resident's bed. LVN 1 stated nebulizer tubing and mask might accumulate dirt and dust and placed Resident 56 at risk for respiratory infection. During an interview on 2/13/2025 at 11:25 a.m., with the IPN, the IPN stated the nebulizer tubing and mask should be changed every seven days, dated, and stored in the bag next to the resident's bed when resident not using it. The IPN stated it was important that the respiratory equipment was dated and labeled for staff to know when it was last changed. The IPN stated it was important to store the nebulizer tubing and mask in the bag to prevent contamination, and respiratory infection. The IPN stated the purpose of changing the nebulizer tubing and mask every seven days was for infection control and it was the facility's policy. During a review of the facility's P&P titled Administering Medications through a Small Volume (Handheld) Nebulizer, revised October 2010, the P&P indicated facility would provide aerosolized (a liquid drug that can be inhaled) safely and aseptically (free from infection). The P&P indicated facility would change nebulizer equipment every seven days. The P&P indicated facility would store nebulizer equipment in a plastic bag with the resident's name and date.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 47858 Based on observation, interview, and record review, the facility failed to provide 80 square feet ([sq. ft.]- a unit of measurement) of room space per resident for 22 rooms out of 40 rooms. This deficient practice had the potential for inadequate space for each resident's privacy and safe nursing care. Findings: During a review of the facility's Room Waiver Request letter, dated 2/11/2025, the letter indicated the following two-person rooms did not meet the 80 square feet per resident requirement: Rooms 11, 12, 14, 15, 17, 18, 21, 22,23, 24,25,26,27, 28,29, 30, 31, 32, 33, 34, 35, and 36. The letter indicated the room waiver did not adversely affect the health and safety of the residents or impede the ability of any resident from attaining his or her highest practicable well-being. During an interview on 2/12/2025 3:39 p.m. with the Administrator (ADM), the ADM stated the impact to resident care was minimal and the facility would continue to ensure patient care and safety would not be compromised or effected. The ADM stated all 22 rooms had sufficient space for Hoyer lifts (an electronically operated patient lift for the safe lifting of heavier patients), wheelchairs, and gurneys (a wheeled bed used to transport patients who need medical care) to enter the rooms. During observations made throughout the course of the survey, from 2/10/2025 to 2/13/2025, there were no adverse effects that pertained to the residents' care provided by facility staff, residents' privacy, health, and safety related to the provided living space of less than 80 sq. ft. per resident. During a review of the facility's Policy and Procedure (P&P), titled, Quality of Life- Homelike Environment, revised 4/2014, the P&P indicated the facility was to ensure residents were provided with a safe, clean, comfortable and homelike environment.