

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555733	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER The Pavilion at Sunny Hills		STREET ADDRESS, CITY, STATE, ZIP CODE 2222 N. Harbor Blvd. Fullerton, CA 92835	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the informed consent for the psychotropic medications and treatments were complete for five of 34 final sampled residents (Residents 3, 6, 9, 69, and 231). * The facility failed to ensure Resident 3's informed consent for the sertraline hydrochloride (antidepressant medication), mirtazapine (antidepressant medication), Ativan (anxiety medication), and Ativan-Benadryl-Haldol (ABH, antipsychotic medication) medications included the behavioral manifestation related to the use of the medications per physician's orders. In addition, the facility failed to ensure the informed consent for Resident 3's Ativan (anxiety) medication included the duration for the use of the medication per physician's order. * The facility failed to ensure Resident 6's informed consent for the bupropion hydrochloride (antidepressant medication), hydroxyzine hydrochloride (antidepressant medication) and sertraline hydrochloride (antidepressant medication) medications included the behavioral manifestation related to the use of the medications per physician's orders. * The facility failed to ensure Resident 9's informed consent for the olanzapine (antipsychotic medication) medication included the behavioral manifestation related to the use of the medication as per the physician's order. * The facility failed to ensure Resident 69 informed consent for the alprazolam (anxiety medication) medication included the behavioral manifestation related to the use of the medications per the physician's orders. * The facility failed to ensure Resident 231's informed consent for the fluoxetine hydrochloride (antidepressant medication) medication included the behavioral manifestation related to the use of the medications per the physician's orders. These failures posed the risk for the residents and their responsible parties to not have complete information and make informed decisions related to the use of psychotropic medications. Findings: Review of the facility's P&P titled Informed Consent revised 1/2026 showed the following: - The facility provides with all information that is material to an individual patient's decision concerning whether to accept or refuse any proposed treatment or procedure including the disclosure of material information for administration of psychotherapeutic drugs or physical restraints or the prolonged use of a device that may lead to the inability to regain use of a normal bodily function; - Each resident has the right to participate in their healthcare planning and decision making including the request, refusal, and/or discontinue treatment, and the right to receive written disclosure in a language they understand; and (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The facility shall verify the written informed consent, obtained by the prescribing physician/LHP, is present in the medical record and specifies the disclosure of material information for proper informed consent for a prescription for psychotherapeutic drugs prior to administration, which includes: a. the reason for the treatment and the nature and seriousness of the patient's illness; and b. the nature of the procedures to be used in the proposed treatment including their probable frequency and duration. Review of the AFL 25-38.1 titled Notice of Release of Psychotherapeutic Drug Informed Consent Form dated 2/3/26, showed the facilities may use the CDPH (California Department of Public Health) Psychotherapeutic Drug Informed Consent Form or use their own in-house form as long as the in-house form contains all the data elements on the CDPH form. The form must be in use by January 1, 2026, for new residents, residents being prescribed a new psychotherapeutic drug, and residents having a psychotherapeutic drug dosage change. Review of the CDPH 9168 document titled Psychotherapeutic Drug Informed Consent Form dated 12/2025 showed to include the following psychotherapeutic drug information: drug category, drug name, dosage prescribed, frequency, duration, administration method, caution and warning summary, reason for use of the psychotherapeutic drug and benefits, the probable side effects and significant risks associated with the use of the psychotherapeutic drug, and the reasonable alternative mode(s) of treatment or possible non-pharmacological approaches that could address the resident's needs. 1. Medical record review for Resident 3 was initiated on 7/1/26. Resident 3 was readmitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 2/13/26, showed Resident 3 had no capacity to understand and make decisions. Review of Resident 3's Order Summary Report showed the following physician's orders: - dated 11/13/23, to administer sertraline hydrochloride (antidepressant medication) 75 mg one tablet by mouth one time a day for depression as manifested by verbalization of sadness; - dated 10/16/25, to administer mirtazapine (antidepressant medication) 15 mg 0.5 tablet by mouth at bedtime for depression as manifested by poor intake, less than 50%; - dated 6/14/26, to administer Ativan (anxiety medication) 0.5 mg one tablet by mouth one tablet every eight hours as needed for anxiety as manifested by verbalization of anxious for 30 days; and - dated 6/19/26, to administer Ativan-Benadryl-Haldol (ABH, antipsychotic medication) apply one ml to inner wrist in the afternoon for psychosis as manifested by disorganized thinking. a. Review of Resident 3's Antidepressant Drug Informed Consent Form dated 5/26/26, for the sertraline medication under the Reason for Use of Antidepressant Drug and Benefits section, showed (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 6/8 to 6/12/26 at 2000 hours; - 6/13/26 at 1520 hours; - 6/14 to 6/17/26 at 2000 hours; - 6/22 to 6/23/26 at 2000 hours; - 6/25/26 at 2030 hours; - 6/26 to 6/28/26 at 2000 hours; and - 6/29/26 at 2007 hours 4. Medical record review for Resident 231 was initiated on 7/1/26. Resident 231 was admitted to the facility on [DATE]. Review of Resident 231's MDS assessment dated [DATE], showed Resident 231 was cognitively intact. Review of Resident 231's Order Summary Report showed a physician's order dated 6/24/26, to administer fluoxetine hydrochloride (antidepressant medication) 20 mg one capsule by mouth one time a day for depression as manifested by tearfulness. Review of Resident 231's Antidepressant Drug Informed Consent Form dated 6/24/26, for the fluoxetine medication under the Reason for Use of Antidepressant Drug and Benefits section, showed the form did not include the behavior manifestation related to the use of fluoxetine medication. Review of Resident 231's MAR for June and July 2026 showed Resident 231 was administered with the fluoxetine medication on 6/25 to 6/29/26 at 0900 hours, and 7/1/26 at 0900 hours. On 7/2/26 at 1000 hours, an interview and concurrent medical record review for Residents 3, 6, 69, and 231 was conducted with the ADON. The ADON verified the above findings for Residents 3, 6, 69, and 231. The ADON stated the informed consent for the psychotropic medication should include the indications, frequency, and the duration for the use of the medication as per the physician's order. On 7/2/26 at 1339 hours, an interview was conducted with the DON. The DON stated the informed consent for the psychotropic medication should show the complete indications for the prescribed medication as per the physician's order. The DON was informed and acknowledged the above findings for Residents 3, 6, 69, and 231. 5. Medical record review for Resident 9 was initiated on 6/29/26. Resident 9 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 9's MDS assessment dated [DATE], showed Resident 9 had severely impaired (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognition. Review of Resident 9's Order Summary Report dated 7/1/26, showed a physician's order dated 8/28/25, to administer olanzapine (antipsychotic medication) 2.5 mg one tablet by mouth at bedtime for psychotic disorder (severe mental illnesses characterized by disruptions in thought and perception that cause individuals to lose touch with reality) manifested by disorganized thinking. Review of Resident 9's Psychotherapeutic Drug Informed Consent Form dated 3/26/26, for the olanzapine medication under the Reason for Use of Psychotherapeutic Drug and Benefits section, showed Psychosis was selected. The form did not include the specific behavior manifestation of disorganized thinking related to the use of the olanzapine medication. On 7/1/26 at 1119 hours, an interview and concurrent medical record review for Resident 9 was conducted with LVN 7. LVN 7 verified Resident 9's informed consent form for the olanzapine medication did not show the behavior manifestation related to the use of the olanzapine medication. On 7/2/26 at 0955 hours, an interview was conducted with the DON. The DON stated the informed consent for the use of psychotropic medication should include: the psychotropic medication, class, ordered dose, route, frequency, duration, and the indication of use. When asked if the specific manifested behavior should be included in the informed consent for each resident, the DON stated the consent did not show to document the manifested behavior. When asked if the manifested behavior should be included in the informed consent as part of the indications, or reason for the use of the psychotropic medication, the DON did not answer. On 7/2/26 at 1420 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the necessary services on the formulation of an advance directive was provided for four of seven final sampled residents (Residents 41, 225, 231, and 232) reviewed for advance directive. * The facility failed to follow up the advance directive status after providing the educational materials to Residents 41, 231, and 232 and/or the residents' representative. In addition, the facility failed to ensure assistance in the formulation of an advance directive was offered to Residents 41, 231, and 232. * The facility failed to provide Resident 225's representative with the written information regarding the rights to formulate an advance directive. These failures posed a risk for not providing the care and services based on the residents wishes. Findings: Review of the facility's P&P titled Advance Directive revised on 1/2026 showed the residents have the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. The facility informs residents in writing of their right to formulate an advanced directive and the facility's policies on advance directives. 1. Medical record review for Resident 41 was initiated on 6/29/26. Resident 41 was admitted to the facility on [DATE]. Review of Resident 41's POLST dated 6/15/26, showed Resident 41 had no advanced directive. Review of Resident 41's Social Services Evaluation & Initial dated 6/16/26, showed the advanced directive was not offered. Review of Resident 41's MDS assessment dated [DATE], showed Resident 41's BIMS score was 9, indicating the resident's cognition was moderately impaired. Review of Resident 41's Progress Note dated 6/26/26, showed Resident 4 had fluctuating capacity to understand and make decision. On 6/30/26 at 1431 hours, an interview and concurrent medical record review for Residents 41 was conducted with Social Services Coordinator 3. Social Services Coordinator 3 verified the above findings and was unable to show documentation indicating the assistance was offered in formulating an advanced directive to the resident's representative. Social Services Coordinator 3 further stated he provided the educational materials; however, he was not able to follow up as to whether Resident 41 had accepted or declined. On 7/2/26 at 1019 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 231 was initiated on 6/29/26. Resident 231 was admitted to the facility on [DATE]. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the residents were free from unnecessary psychotropic drugs for one of 34 final sampled residents (Resident 226) and four of five residents (Residents 3, 6, 9, and 69) reviewed for unnecessary medications. * The facility failed to ensure nonpharmacological interventions were provided prior to the use of Ativan (antianxiety), mirtazapine (antidepressant), and sertraline (antidepressant) medications for Resident 3. The facility failed to ensure Resident 3 was monitored for side effects related to the use of the mirtazapine medication. In addition, the facility failed to ensure the behavior related to the use of the sertraline medication was monitored for Resident 3. * The facility failed to ensure nonpharmacological interventions were provided prior to the use bupropion (antidepressant), hydroxyzine (antidepressant), and sertraline (antidepressant) medications for Resident 6. * The facility failed to ensure Resident 9's orthostatic blood pressure were accurately monitored as ordered by the physician for the use olanzapine (antipsychotic) medication. * The facility failed to ensure nonpharmacological interventions were provided prior to the use of alprazolam (antianxiety) medication for Resident 69. * The facility failed to ensure Resident 226's orthostatic blood pressure was accurately monitored as ordered by the physician for the use of the olanzapine (antipsychotic) medication. These failures had the potential for the residents to experience adverse effects from the psychotropic medications, not providing the correct data to the prescriber to adjust the dosage of the medications and to negatively impact the residents' well-being. Findings: Review of the facility's P&P titled Dignity and Respect Psychoactive Medications dated 1/2025 showed the following: - The resident has a right to be treated with respect and dignity including the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms; - The practitioner shall determine that the medication(s) is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication(s) is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s); - The facility staff shall monitor for, and address, symptoms consistent with prolonged sedation from the use of psychotropic medications (e.g., excessive sleeping, drowsiness, withdrawal, decreased participation in activities); - Facility staff will monitor for adverse side effects associated with the use of psychotropic medications, including but not limited to, sedation, such as sleeping during hours that he/she would not ordinarily sleep; withdrawal from activities and socializing; loss of autonomy and dignity; confusion, cognitive decline, and depression; weight loss, decline in skin integrity, or continence level; and/or decline in physical functioning including an increased dependence in activities of daily living; (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER The Pavilion at Sunny Hills		STREET ADDRESS, CITY, STATE, ZIP CODE 2222 N. Harbor Blvd. Fullerton, CA 92835	
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- These effects may result in convenience for the staff, as the resident may require staff to exert less effort than previously. Even if a medication was initially administered for a medical symptom, the continued administration of a medication in the absence of such symptom, which sedates a resident or otherwise makes it easier to care for them, would be deemed a chemical restraint; - The use of non-pharmacological approaches shall be attempted, unless clinically contraindicated, to minimize the need for psychotropic medications, use the lowest possible dose, or discontinue the medications; - The facility shall ensure documentation in the resident's medical record that the facility has attempted behavioral (nonpharmacological) interventions, and that these interventions have been deemed clinically contraindicated when the resident is prescribed psychotropic medications, regardless of whether the medication is approved for the resident's condition; and - The facility's medication management process focuses on recognition or identification of the resident's problem, completion of the assessment, diagnosis, attempted root cause identification, management, and treatment through non-pharmacological interventions when possible, monitoring, and revising interventions to improve the resident's quality of life. 1. Medical record review for Resident 3 was initiated on 7/1/26. Resident 3 was readmitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 2/13/26, showed Resident 3 had no capacity to understand and make decisions. Review of Resident 3's Order Summary Report showed the following physician's orders: - dated 6/24/22, for sertraline: monitor episodes of depression as manifested by verbalization of sadness, every shift; - dated 11/13/23, to administer sertraline hydrochloride 75 mg one tablet by mouth one time a day for depression as manifested by verbalization of sadness; - dated 12/26/23, for mirtazapine: nonpharmacological approach attempted prior to administration of anti-depression: (1) Encourage to verbalize feelings(needs/concern); (2) Encourage family to participate in care; (3) Encourage to attend daily activities; (4) Provide a quiet & calm environment with diversion like listening to music/watching TV; (5) Teach resident relaxation techniques or deep breathing exercises; (6) Redirect & provide gentle reality orientation; (7) Other; every shift; - dated 12/26/23, for sertraline: Nonpharmacological approach attempted prior to administration of anti-depression: (1) Encourage to verbalize feelings(needs/concern); (2) Encourage family to participate in care; (3) Encourage to attend daily activities; (4) Provide a quiet & calm environment with diversion like listening to music/watching TV; (5) Teach resident relaxation techniques or deep breathing exercises; (6) Redirect & provide gentle reality orientation; (7) Other; every shift; (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated 10/16/25, to administer mirtazapine 15 mg 0.5 tablet by mouth at bedtime for depression as manifested by poor intake, less than 50%; - dated 11/24/25, for mirtazapine/sertraline: monitor side effects of anti-depressant agent every shift. Chart 0 for none or use first letters hdtas h= headache; d= dizziness; t= tremors; d= dry mouth; a= anorexia; d= diarrhea; s= sweating; every shift; - dated 12/19/25, for Ativan: Nonpharmacological approach attempted prior to administration of anti-anxiety medication: (1) Encourage to verbalize feelings(needs/concern); (2) Encourage family to participate in care; (3) Encourage to attend daily activities; (4) Provide a quiet & calm environment with diversion like listening to music/watching TV; (5) Teach resident relaxation techniques or deep breathing exercises; (6) Redirect & provide gentle reality orientation; (7) Other; every shift; and - dated 6/14/26, to administer Ativan 0.5 mg one tablet by mouth one tablet every eight hours as needed for anxiety as manifested by verbalization of anxious for 30 days. Review of Resident 3's MAR for June and July 2026 showed the following: a. Resident 3 was administered with the Ativan medication on the following dates and times: - 6/14/26 at 1900 hours; - 6/15/26 at 1500 hours; and - 6/16/26 at 1500 hours. Further review of Resident 3's medical records failed to show documented evidence the nonpharmacological interventions were provided prior to the administration of the Ativan medication on the dates and time above. b. Resident 3 was administered mirtazapine medication on 6/5, 6/20, 6/25, 6/26, 6/27, 6/28, and 6/30/26 at 2100 hours. Further review of Resident 3's medical records failed to show documented evidence the nonpharmacological interventions were provided prior to the administration of mirtazapine medication on the dates and times above. In addition, the resident was not monitored for the side effects of the mirtazapine medication on 6/30/26, in the evening shift. c. Resident 3 was administered with sertraline medication on 6/19, 6/20, 6/21, and 6/23 to 6/28/26 at 0900 hours, and on 7/1/26 at 0900 hours. Further review of Resident 3's medical records failed to show documented evidence the nonpharmacological interventions were provided prior to the administration of sertraline medication on the dates and times above. In addition, the resident was not monitored for the behavior related to the use of sertraline medication on 6/30/26, in the evening shift. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Medical record review for Resident 6 was initiated on 7/1/26. Resident 6 was readmitted to the facility on [DATE]. Review of Resident 6's H&P examination dated 9/24/25, showed Resident 6 had no capacity to understand and make decisions. Review of Resident 6's Order Summary Report showed the following physician's orders: - dated 3/14/26, to administer bupropion hydrochloride 100 mg one tablet by mouth three times a day for depression as manifested by verbalization of sadness; - dated 3/14/26, to administer hydroxyzine hydrochloride 25 mg one tablet by mouth two times a day for anxiety as manifested by restlessness; - dated 3/14/26, to administer sertraline hydrochloride 100 mg two tablets by mouth one time a day for depression as manifested by tearfulness; - dated 3/14/26, for sertraline/bupropion: Nonpharmacological approach attempted prior to administration of anti-depression medication: (1) Encourage to verbalize feelings(needs/concern); (2) Encourage family to participate in care; (3) Encourage to attend daily activities; (4) Provide a quiet & calm environment with diversion like listening to music/watching TV; (5) Teach resident relaxation techniques or deep breathing exercises; (6) Redirect & provide gentle reality orientation; (7) Other; every shift; and - dated 3/14/26, for hydroxyzine: Non-pharmacological approach attempted prior to administration of anti-anxiety medication: (1) Encourage to verbalize feelings(needs/concern); (2) Encourage family to participate in care; (3) Encourage to attend daily activities; (4) Provide a quiet & calm environment with diversion like listening to music/watching TV; (5) Teach resident relaxation techniques or deep breathing exercises; (6) Redirect & provide gentle reality orientation; (7) Other; every shift; Review of Resident 6's MAR for June and July 2026 showed the following: a. Resident 6 was administered with bupropion medication as ordered on the following dates and times: - 6/3, 6/5, 6/7, 6/12, 6/13, 6/14, 6/15, 6/17, 6/18, 6/19, 6/24, 6/26, and 6/29/26 at 0900 hours; - 6/3, 6/5, 6/7, 6/12, 6/13, 6/14, 6/15, 6/17, 6/18, 6/19, 6/24, 6/25, 6/26, 6/29, and 6/30/26 at 1300 hours; - 6/2, 6/3, 6/4, 6/5, 6/6, 6/7, 6/9, 6/12, 6/13, 6/14, 6/15, 6/16, 6/17, 6/18, 6/19, 6/20, 6/23, 6/24, 6/25, 6/26, 6/27, 6/29, and 6/30/26 at 1700 hours; and - 7/1/26 at 0900 hours, 1300 hours and 1700 hours. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident 6's medical records failed to show documented evidence the nonpharmacological interventions were provided prior to the administration of bupropion medication on the dates and times above. b. Resident 6 was administered with hydroxyzine medication as ordered on the following dates and time: - 6/3, 6/7, 6/12, 6/13, 6/15, 6/17, 6/18, 6/19, 6/21, 6/24, 6/26, and 6/29/26 at 0900 hours; - 6/2, 6/3, 6/7, 6/12, 6/13, 6/15, 6/17, 6/18, 6/19, 6/20, 6/23, 6/24, 6/26, 6/27, and 6/30/26 at 1700 hours; and - 7/1/26 at 0900 hours and 1700 hours. Further review of Resident 6's medical records failed to show documented evidence the nonpharmacological interventions were provided prior to the administration of hydroxyzine medication on the dates and times above. c. Resident 6 was administered with sertraline medication as ordered on the following dates and time: - 6/3, 6/5, 6/7, 6/12, 6/13, 6/14, 6/15, 6/17, 6/18, 6/19, 6/24, 6/26, and 6/29/26 at 0900 hours; and - 7/1/26 at 0900 hours. Further review of Resident 6's medical records failed to show documented evidence the nonpharmacological interventions were provided prior to the administration of sertraline medication on the dates and times above. 3. Medical record review for Resident 69 was initiated on 7/1/26. Resident 69 was readmitted to the facility on [DATE]. Review of Resident 69's H&P examination dated 6/5/25, showed Resident 69 had the capacity to make decisions. Review of Resident 69's Order Summary Report showed the following physician's orders: - dated 12/13/23, for alprazolam: Nonpharmacological approach attempted prior to administration of anti-anxiety medication: (1) Encourage to verbalize feelings(needs/concern); (2) Encourage family to participate in care; (3) Encourage to attend daily activities; (4) Provide a quiet & calm environment with diversion like listening to music/watching TV; (5) Teach resident relaxation techniques or deep breathing exercises; (6) Redirect & provide gentle reality orientation; (7) Other; every shift; and - dated 5/30/26, to administer alprazolam (antianxiety medication) 0.5 mg one tablet by mouth every eight hours as needed for anxiety as manifested by inability to relax for 90 days. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 69's MAR for June 2026 showed Resident 69 was administered with alprazolam medication on the following dates and time: - 6/2 to 6/3/26 at 2000 hours; - 6/8 to 6/11/26 at 2000 hours; - 6/14 to 6/17/26 at 2000 hours; - 6/22 to 6/23/26 at 2000 hours; - 6/25/26 at 2030 hours; - 6/26 to 6/28/26 at 2000 hours; and - 6/29/26 at 2007 hours. Further review of Resident 69's medical records failed to show documented evidence the nonpharmacological interventions were provided prior to the administration of alprazolam medication on the dates and times above. On 7/2/26 at 1000 hours, an interview and concurrent medical record review for Residents 3, 6, and 69 was conducted with the ADON. The ADON verified the above findings for Residents 3, 6, and 69. The ADON stated the manifested behaviors and side effects of the psychotropic medications ordered for the resident should be accurately documented to determine if the resident was getting better or worse and it would also assist in determining whether the medication should be continued or not. The ADON further stated providing nonpharmacological interventions prior to administration of the medications should be initiated to determine if it would help the resident and limit the use of pharmacological interventions. On 7/2/26 at 1339 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Residents 3, 6, and 69. 4. Medical record review for Resident 9 was initiated on 6/29/26. Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 9's MDS assessment dated [DATE], showed Resident 9 had severely impaired cognition. Review of Resident 9's Order Summary Report dated 7/1/26, showed the following physician's orders: - dated 8/28/25, to administer olanzapine (antipsychotic medication) 2.5 mg one tablet by mouth at bedtime for psychotic disorder manifested by disorganized thinking; (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated 6/15/26, for the use of the olanzapine medication, to monitor Resident 9 for orthostatic hypotension - blood pressure in the sitting position, every seven days, during the day shift; and - dated 6/15/26, for the use of the olanzapine medication, to monitor Resident 9 for orthostatic hypotension -blood pressure in the lying position, every seven days, during the day shift. Review of Resident 9's MAR for June 2026 showed Resident 9 was administered with olanzapine 2.5 mg medication at 2100 hours the from 6/1 to 6/30/26. Further review of Resident 9's MAR showed the following: - dated 6/22/26, the BP readings were 142/70 mmHg for the sitting and lying position; and - dated 6/29/26, the BP readings were 138/67 mmHg for the sitting and lying positions. On 7/1/26 at 1105 hours, an interview and concurrent medical record review for Resident 9 was conducted with LVN 6. LVN 6 stated the orthostatic BP was monitored weekly by obtaining the BP readings in the lying and then sitting positions. LVN 6 verified the orthostatic BP reading for the lying and sitting positions were the same for the above dates. On 7/2/26 at 0955 hours, an interview was conducted with the DON. The DON stated for the residents who were administered the antipsychotic medication, the orthostatic BP was being monitored weekly. The BP readings should be obtained in the different positions, sitting and lying and the BP readings were compared. The DON stated the BP readings for the different positions should not be the same. On 7/2/26 at 1420 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 5. Medical record review for Resident 226 was initiated on 6/30/26. Resident 226 was admitted to the facility on [DATE]. Review of Resident 9's Order Summary Report dated 7/1/26, showed the following physician's orders dated 6/25/26: - to administer olanzapine (antipsychotic medication) 0.5 mg by mouth at bedtime for psychosis manifested by disorganized thinking;- to monitor for orthostatic hypotension everyday shift, for BP in lying position for 10 days; and- to monitor for orthostatic hypotension everyday shift, for BP in sitting position for 10 days. Review of Resident 226's MARs for June 2026 showed the orthostatic blood pressures (sitting and lying) were scheduled to be monitored every day for 10 days. However, the blood pressure readings for both positions (lying and sitting) were the same as follows:- dated 6/26/26 , the blood pressure readings were 106/63 mmHg for sitting and lying positions;- dated 6/27/26, the blood pressure readings were 126/70 mmHg for sitting and lying positions; and- dated 6/28/26, the blood pressure readings were 138/70 mmHg for sitting and lying positions. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/1/26 at 1428 hours, an interview and concurrent medical record review for Resident 226 was conducted with the ADON. The ADON verified the physician's order for the use of olanzapine medication was to monitor the orthostatic hypotension for Resident 226. The ADON stated the monitoring of the orthostatic hypotension was due to the side effects of the psychotropic medication use. The ADON verified and stated the orthostatic hypotension monitoring for Resident 226 were inaccurate. On 7/2/26 at 1416 hours, an interview and concurrent medical record review for Resident 226 was conducted with the DON. The DON was informed and verified the above findings.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review the facility failed to timely notify and accurately sent the Notification of Proposed Transfer/Discharge to the Office of the State Long-Term Care (LTC) Ombudsman, notified the resident's representative in writing of the reason for transfer and/or bed hold for two of 34 final sampled residents (Residents 49 and 98) and three of three sampled residents (Residents 221, 222, and 223) reviewed for closed records.* The facility failed to ensure the notification of proposed transfer was sent to the Ombudsman for Residents 49, 221, 222, and 223.* The facility failed to ensure Resident 98's family member was notified in writing of reason of transfer to the acute care hospital and bed hold; and the copy of transfer was sent to the Ombudsman. These failures had the potential for the Ombudsman and resident's representative to not be aware of the resident's discharge and advocate for the resident's rights from inappropriate transfer and discharge. Findings: Review of facility's P&P titled Transfer and Discharge revised 1/2026 showed the facility transfers or discharges residents in a safe manner that ensure the discharge meets the resident's needs, provides needed support and resources, and meets the resident's preferences, and permits residents to return to the facility following hospitalization or therapeutic leave. The Transfer and Discharge Requirements & Facility Requirements section showed: 5. The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care ombudsman. The Documentation section showed: 9. The facility documents the resident's transfer or discharge in the medical record and communicates appropriate information to the receiving health care institution or provider when a resident is transferred from the facility; and 10. When a resident's transfer or discharge is necessary to meet the resident's welfare and the resident's needs cannot be met in the facility, the resident's physician or extender shall document: a. The basis for the resident's transfer; b. The specific needs which cannot be met; c. The facility attempts to meet the needs; and d. The services available at the receiving facility to meet the resident's needs. The Permitting Residents to Return to Facility section showed: 16. The facility permits residents to return to the facility after they are hospitalized or placed on therapeutic leave; and 17. The facility provides written notice of bed-hold rights to the resident and/or resident representative at the time of admission and prior to any transfer to a hospital or therapeutic leave. 1. Closed medical record review for Resident 49 was initiated on [DATE]. Resident 49 was (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	readmitted to the facility on [DATE], and transferred to the acute care hospital on 5/1 and [DATE]. Review of Resident 49's Order Summary Report showed the following physician's orders: - dated [DATE], may transfer resident to Acute Care Hospital 1 ER for abdominal CT scan related to abdominal distention with tenderness; and - dated [DATE], may send Resident 49 out to the acute care hospital for further evaluation. Review of Resident 49's Notice of Proposed Transfer and Discharge & 1102 & V2 dated 5/1 and [DATE], failed to show the forms were sent to the Ombudsman. Further review of the medical record did not show any documentation the Ombudsman was notified of Resident 49's transfer to the acute care hospital on 5/1 and [DATE]. On [DATE] at 0919 hours, an interview and concurrent medical record review for Resident 49 was conducted with the ADON. The ADON verified the Notification of Proposed Transfer and Discharge was not sent to the Ombudsman when Resident 49 was transferred to the acute care hospital on 5/1 and [DATE]. 2. Closed medical record review for Resident 221 was initiated on [DATE]. Resident 221 was admitted to the facility on [DATE], and transferred to the acute care hospital on [DATE]. Review of Resident 221's Order Summary Report showed a physician's order dated [DATE], ok to transfer to Acute Care Hospital 2 ED for evaluation and bed hold for seven days if admitted . Review of Resident 221's Notice of Proposed Transfer and Discharge & 1102 & V2 dated [DATE], failed to show the form was sent to the Ombudsman. Further review of the medical record did not show any documentation the Ombudsman was notified of Resident 221's transfer to the acute care hospital on [DATE]. On [DATE] at 0912 hours, an interview and concurrent medical record review for Resident 221 was conducted with the ADON. The ADON verified the Notification of Proposed Transfer and Discharge was not sent to the Ombudsman when Resident 221 was transferred to the acute care hospital on [DATE]. 3. Closed medical record review for Resident 222 was initiated on [DATE]. Resident 222 was readmitted to the facility on [DATE], and discharged due to death on [DATE]. Review of Resident 222's Order Summary Report showed a physician's order dated [DATE], may release the body to Mortuary Provider 1. Further medical record review for Resident 222 failed to show documented evidence the Ombudsman was notified of Resident 222's death on [DATE]. On [DATE] at 0827 hours, an interview and concurrent medical record review for Resident 222 was (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	conducted with the ADON. The ADON verified the Ombudsman was not notified for Resident 222's death on [DATE]. The ADON stated the Ombudsman should be notified of the resident's discharge from the facility whether it was discharge to home, acute care hospital, or other health facility, AMA, or death. 4. Closed medical record review for Resident 223 was initiated on [DATE]. Resident 223 was admitted to the facility on [DATE], and discharged on [DATE]. Review of Resident 223's Order Summary Report showed a physician's order dated [DATE], may discharge home AMA with responsible party. Further review of Resident 223 medical record failed to show documented evidence the Ombudsman was notified of Resident 223's discharge on [DATE]. On [DATE] at 0909 hours, an interview and concurrent medical record review for Resident 223 was conducted with the ADON. The ADON verified the Ombudsman was not notified for Resident 223's discharge to home AMA on [DATE]. On [DATE] at 1339 hours, an interview was conducted with the DON. The DON stated the Ombudsman should be notified of all the discharges of the residents which included discharge to home or other health facilities, AMA, and death. The DON stated the discharging nurse would fax the Notification of Proposed Transfer and Discharge to the Ombudsman and the fax transmittal receipt should be given to the medical record department for filing in the PCC. The DON further stated the expectation was for the nurses to fax it to the Ombudsman as soon as possible or before the end of their shift. The DON was informed and acknowledged the above findings for Residents 49, 221, 222, and 223. 5. Medical record review for Resident 98 was initiated on [DATE]. Resident 98 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 98's H&P examination dated [DATE], showed Resident 98 had no capacity to understand and to make decisions. Review of Resident 98's Order Summary Report showed a physician's order dated [DATE], for may transfer Resident 98 to the acute care hospital and bed hold for seven days if admitted . Further review of Resident 98's medical record failed to show if Resident 98's representative was provided with a written documentation of the reason of the transfer to the acute care hospital and the bed hold, and any documentation if the Ombudsman was notified of Resident 98's transfer to the acute care hospital. On [DATE] at 0739 hours, an interview was conducted with the MRD. The MRD stated the written notification of the transfer and bed hold was not being done since the facility had changed to electronic medical records. (continued on next page)		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555733	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER The Pavilion at Sunny Hills		STREET ADDRESS, CITY, STATE, ZIP CODE 2222 N. Harbor Blvd. Fullerton, CA 92835	
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1037 hours, an interview and concurrent record review for Resident 98 was conducted with the DON. The DON verified the resident's medical record failed to show the notification in writing regarding Resident 98's transfer and bed hold for when the resident was transferred on [DATE]. The DON stated the Ombudsman should have been notified by the licensed nurses through fax. The DON verified no documentation of notification of the Ombudsman was completed for Resident 98.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility record review, and facility P&P review, the facility failed to provide the necessary services to attain or maintain the highest practicable well-being for six of 34 final sampled residents (Residents 6, 7, 9, 201, 222, and 230). * The facility failed to ensure the insulin administration sites were rotated as ordered by the physician for Residents 6, 7, 9, and 230. This failure had the potential to result in ineffective treatment, altered medication effectiveness/absorption, and tissue damage. * The facility failed to ensure Resident 201's Lovenox (anticoagulant medication) and insulin injection sites were rotated as ordered by the physician. This failure had the potential to result in ineffective treatment, altered medication effectiveness/absorption, and tissue damage. * The facility failed to ensure Resident 222 was assessed when the resident was readmitted to the facility. This failure had the potential for the resident to not receive the necessary care and services as the assessments were not completed and may negatively affect the resident's well-being. Findings: Review of the facility's P&P titled Insulin Administration revised 1/2025 showed insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. The injection sites should be rotated to reduce the risk of damaging the skin tissue. According to Taylor's Clinical Nursing Skills, seventh edition, the various sites used for subcutaneous injections are the outer aspect of the upper arm, the abdomen (from below the costal margin to the iliac crest), the anterior aspect of the thigh, the upper back, and the upper ventral (upper front) or dorsogluteal area (buttocks). It is necessary to rotate sites or areas for injections to prevent buildup of fibrous tissue and permit complete absorption of the medication. 1. Medical record review for Resident 6 was initiated on [DATE]. Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 6's H&P examination dated [DATE], showed Resident 6 had no capacity to understand and make decisions. Review of Resident 6's Order Summary Report dated [DATE], showed the following physician's orders dated [DATE]: - to administer regular insulin (a short-acting insulin designed to manage high blood sugar levels) 100 unit/ml as per sliding scale (amount of insulin to be administered based on the blood sugar results) subcutaneously before meals and at bedtime and to rotate the site of administration, and - to administer insulin glargine (a long-acting insulin designed to manage blood sugar levels) six units subcutaneously at bedtime and to rotate the site of administration. Review of Resident 6's Location of Administration Report for [DATE] showed the insulin glargine and (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	regular insulin were administered consecutively at the same injection site on the following dates and times: - dated [DATE] at 2046 hours, insulin glargine was administered to the LLQ (left lower quadrant) of the abdomen; - dated [DATE] at 2038 hours, insulin glargine was administered to the LLQ (left lower quadrant) of the abdomen; - dated [DATE] at 2044 hours, insulin glargine was administered to the LLQ (left lower quadrant) of the abdomen; - dated [DATE] at 2109 hours, regular insulin was administered to the LLQ (left lower quadrant) of the abdomen; and at 2111 hours, insulin glargine was administered to the LLQ (left lower quadrant) of the abdomen; - dated [DATE] at 2053 hours, insulin glargine was administered to the LLQ (left lower quadrant) of the abdomen; and - dated [DATE] at 2035 hours, insulin glargine was administered to the LLQ (left lower quadrant) of the abdomen. On [DATE] at 1500 hours, an interview and concurrent medical record review for Resident 6 was conducted with LVN 4. LVN 4 verified the physician's orders for the insulin injection for the routine and sliding scale insulin coverage. LVN 4 stated prior to administering the insulin injection the licensed nurse should check the MAR to see the last administration site. LVN 4 further stated the insulin injection sites should be rotated to prevent complications of the skin from repeated injections at same site. LVN 4 reviewed Resident 6's MAR for [DATE] and verified the above findings when the insulin administration sites were not rotated. 2. Medical record review for Resident 7 was initiated on [DATE]. Resident 7 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 7's H&P examination dated [DATE], showed Resident 7 had the capacity to understand and make decisions. Review of Resident 7's Order Summary Report dated [DATE], showed a physician's order dated [DATE], to administer insulin glargine (a long-acting insulin designed to manage blood sugar levels) 22 units subcutaneously at bedtime and to rotate the site of administration. Review of Resident 7's Location of Administration Report for [DATE] showed the insulin glargine were administered consecutively at the same injection sites on the following dates and times: - dated [DATE] at 2130 hours, insulin glargine was administered to the left arm; (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated [DATE] at 2205 hours, insulin glargine was administered to the left arm; - dated [DATE] at 2201 hours, insulin glargine was administered to the left arm; - dated [DATE] at 2111 hours, insulin glargine was administered to the left arm; - dated [DATE] at 2142 hours, insulin glargine was administered to the left arm; - dated [DATE] at 2112 hours, insulin glargine was administered to the left arm; - dated [DATE] at 2114 hours, insulin glargine was administered to the left arm; - dated [DATE] at 2223 hours, insulin glargine was administered to the left arm; - dated [DATE] at 2033 hours, insulin glargine was administered to the left arm; - dated [DATE] at 2042 hours, insulin glargine was administered to the left arm; - dated [DATE] at 2118 hours, insulin glargine was administered to the left arm; - dated [DATE] at 2146 hours, insulin glargine was administered to the left arm; - dated [DATE] at 2150 hours, insulin glargine was administered to the left arm; and - dated [DATE] at 2135 hours, insulin glargine was administered to the left arm. On [DATE] at 1033 hours, an interview and concurrent medical record review for Resident 7 was conducted with LVN 4. LVN 4 verified the physician's orders for the insulin injection for the routine glargine insulin. LVN 4 reviewed Resident 7's s MAR for [DATE] and verified the above findings when the insulin administration sites were not rotated. LVN 4 stated the insulin injection sites should be rotated as per the physician's order. 3. Medical record review for Resident 9 was initiated on [DATE]. Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 9's MDS assessment dated [DATE], showed Resident 9 had severely impaired cognition. Review of Resident 9's Order Summary Report dated [DATE], showed a physician's order dated [DATE], to administer Humulin R insulin (a short-acting insulin designed to manage high blood sugar levels) 100 unit/ml as per sliding scale (amount of insulin to be administered based on the blood sugar results) subcutaneously before meals and at bedtime and to rotate the site of administration. Review of Resident 9's Location of Administration Report for [DATE] showed the Humulin R insulin was administered consecutively at the same injection site on the following dates and times: (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated [DATE] at 1806 and 2051 hours, Humulin R insulin was administered to the LLQ of the abdomen; - dated [DATE] at 0650 hours, Humulin R insulin was administered to the LLQ of the abdomen; - dated [DATE] at 1543 and 2045 hours, Humulin R insulin was administered to the LLQ of the abdomen; - dated [DATE] at 1547 and 2138 hours, Humulin R insulin was administered to the LLQ of the abdomen; and - dated [DATE] at 1216, 1748 and 2048 hours, Humulin R insulin was administered to the LLQ of the abdomen. On [DATE] at 1119 hours, an interview and concurrent medical record review for Resident 9 was conducted with LVN 7. LVN 7 verified the physician's orders for the Humulin R insulin as per the sliding scale. LVN 4 reviewed Resident 9's MAR for [DATE] and verified the above findings when the insulin administration sites were not rotated. LVN 4 stated the insulin injection sites should be rotated. On [DATE] at 0955 hours, an interview was conducted with the DON. The DON stated prior to the administration of the insulin injections, the licensed nurse should review the resident's MAR to see the location of the previous insulin injection site. The DON stated the insulin injection sites should be rotated to prevent skin complications due to repeated injections at the same site and it may affect the absorption of the insulin. On [DATE] at 1420 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 4. Medical record Review for Resident 230 was initiated on [DATE]. Resident was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 230's Order Summary Report dated [DATE], showed the following physician's orders: - dated [DATE], to administer Humulin regular insulin (a short-acting insulin) subcutaneously before meals and at bedtime, as per sliding scale; - dated [DATE], to inject 30 units, NPH insulin (an intermediate-acting insulin) subcutaneously at bedtime, rotate injection site of administration; and - dated [DATE], inject 55 units, NPH insulin subcutaneously in the morning, rotate injection site of administration. Review of Resident 230's Location of Administration Report for [DATE] showed the Humulin regular (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	insulin and NPH insulin was administered consecutively on the same injection sites on the following dates and times: - dated [DATE] at 1719 hours, Humulin regular insulin was administered to LLQ of the abdomen; - dated [DATE] at 2137 hours, Humulin regular insulin was administered to LLQ of the abdomen; - dated [DATE] at 1210 hours, Humulin regular insulin was administered to LUQ of the abdomen; - dated [DATE] at 2019 hours, NPH insulin was administered to LUQ of the abdomen; - dated [DATE] at 0808 hours, NPH insulin was administered to LUQ of the abdomen; - dated [DATE] at 1726 hours, Humulin regular insulin was administered to LUQ of the abdomen; - dated [DATE] at 2149 hours, NPH insulin was administered to LUQ of the abdomen; - dated [DATE] at 2148 hours, Humulin regular insulin was administered to LUQ of the abdomen; and - dated [DATE] at 1058 hours, NPH insulin was administered to LUQ of the abdomen; On [DATE] at 1358 hours, an interview and concurrent medical record review for Resident 230 was conducted with LVN 12. LVN 12 verified the above findings and stated the injection site should be rotated with each insulin administration. On [DATE] at 1014 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 5. Medical record review for Resident 201 was initiated on [DATE]. Resident 201 was admitted to the facility on [DATE]. Review of Resident 201's H&P examination dated [DATE], showed Resident 201 had the capacity to make medical decisions. Review of Resident 201's Order Summary Report dated [DATE], showed the following physician's order: -dated [DATE], to administer Lovenox injection 40 mg subcutaneously in the morning, and -dated [DATE], to administer Lispro insulin (a short-acting insulin designed to manage high blood sugar levels) as per sliding scale subcutaneously before meals and at bedtime and to rotate injection sites. Review of Resident 201's Location of Administration Report for [DATE] showed the Lovenox medication was administered consecutively on the same injection sites on the following dates and (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	times: - dated [DATE] at 0813 hours and [DATE] at 0907 hours, the Lovenox medication was administered subcutaneously in the abdomen LUQ (left upper quadrant); and - dated [DATE] at 0916 hours and [DATE] at 0925 hours, the Lovenox medication was administered subcutaneously in the abdomen LLQ (left lower quadrant). Review of Resident 201's Location of Administration Report for [DATE] showed the lispro insulin (used for diabetic) was administered consecutively on the same injection sites on the following dates and times: - dated [DATE] at 0642 hours and at 1216 hours, the lispro insulin was administered subcutaneously in the abdomen LLQ (left lower quadrant); - dated [DATE] at 2123 hours and [DATE] at 1159 hours, the lispro insulin was administered subcutaneously in the abdomen RUQ (right upper quadrant); - dated [DATE] at 2040 hours and [DATE] at 0628 hours, the lispro insulin was administered subcutaneously in the abdomen LUQ (left upper quadrant); and - dated [DATE] at 1215 hours, 1548 hours and 2035 hours, the lispro insulin was administered subcutaneously in the abdomen RLQ (right lower quadrant). On [DATE] at 0850 hours, an interview and concurrent medical record review for Resident 201 was conducted with the ADON. The ADON verified the physician's order for the administration of anticoagulant and insulin medication for Resident 201. The ADON verified and acknowledged injection sites for the anticoagulant medication and insulin were not rotated for the above dates and times. The ADON stated the injection sites should have been rotated to prevent any complication on the injection sites. On [DATE] at 1416 hours, an interview and concurrent medical record review for Resident 201 was conducted with the DON. The DON stated she expected the licensed nurses to rotate the injection sites for the administration of the injectable medications. The DON was informed and acknowledged the above findings. 6. Closed medical record review for Resident 222 was initiated on [DATE]. Resident 222 was readmitted to the facility on [DATE], and discharged due to death on [DATE]. Review of Resident 222's H&P examination dated [DATE], showed Resident 222 had no capacity to understand and make decisions. Review of Resident 222's POLST dated [DATE], showed Resident 222 was a DNR status. Review of Resident 222's Order Summary Report showed a physician's order dated [DATE], for DNR, (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	selective treatment, trial period of artificial nutrition including feeding tubes. Review of Resident 222's Progress Notes showed the following: - dated [DATE] at 1843 hours, Resident 222 came back from the acute care hospital accompanied by a family member, via stretcher ambulance. Resident 222 was awake and alert but with weakness, no signs and symptoms of pain, no shortness of breath noted. Resident 222 would be on intravenous ceftriaxone (antibiotic) medication for pneumonia; - dated [DATE] at 2145 hours, CNA notified the charge nurse Resident 222 appeared to be in distress and breathing abnormally. The charge nurse immediately assessed Resident 222. Resident 222 was noted to be unresponsive. The vital signs were attempted. The pulse rate was noted to be decreasing and unable to obtain. The RN supervisor was immediately notified and responded to bedside. Resident 222 was assessed by two licensed nurses. No pulse rate was detected and no respiration was observed. Resident 222's chart was reviewed and DNR status was confirmed. In accordance with Resident 222's DNR order, no resuscitative measures were initiated; and - dated [DATE] at 2150 hours, Resident 222 was pronounced deceased by the RN supervisor. The time of death called was at 2150 hours. The physician, family, and appropriate facility personnel were notified as per the facility's protocol. Postmortem care initiated as per the facility's policy. Further review of Resident 222 medical record failed to show documented evidence of the assessment and vital signs readings when Resident 222 was admitted to the facility, three hours prior to the change of condition. On [DATE] at 0827 hours, an interview and concurrent medical record review for Resident 222 was conducted with the ADON. The ADON stated upon the resident's admission the licensed nurse would use the Admit/Readmit Evaluation which included the demographics/orientation, neurological, respiratory, cardiovascular, sleep, skin integrity and additional information as basis for the complete assessment and should take the initial vital signs as soon as possible. Review of Resident 222's Weight and Vitals Summary showed the last recorded vital signs was on [DATE] at 1352 hours. The ADON verified Resident 222's vital signs were not assessed and the completed assessment was not performed when Resident 222 was readmitted on [DATE]. When asked if the Admit/Readmit Evaluation should have been completed for Resident 222 upon admission on [DATE], the ADON stated she was not sure if the Admit/Readmit Evaluation assessment should have been done. The ADON further stated Resident 222 was in and out of the acute care hospital and there was a plan for the resident to be placed in either hospice or palliative care. On [DATE] at 1339 hours, an interview and concurrent medical record review for Resident 222 was conducted with the DON. The DON stated no matter what the resident type was, either skilled or long-term resident and initial or readmission, the licensed nurse should do a thorough assessment of the resident and utilize the Admit/Readmit Evaluation in the PCC for the assessment of the resident. The DON stated either the CNA or licensed nurse should check or get the initial vital signs upon admission of the resident as soon as possible. The DON was informed and acknowledged the above findings for Resident 222.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and P&P review, the facility failed to provide the necessary care and services related to GT enteral feeding for four of 34 final sampled residents (Residents 12, 49, 117, and 148) reviewed for tube feedings. * The facility failed to ensure the GT enteral feeding formula was labeled with the start time for Resident 12. * The facility failed to ensure Resident 49 was administered with the complete dose of the GT enteral feeding as per the physician's order. In addition, the facility failed to label Resident 49's enteral feeding formula with the start time. * The facility failed to ensure Resident 117 was administered with the complete dose of the GT enteral feeding as per the physician's order. * The facility failed to ensure Resident 148's enteral feed syringe was changed daily. These failures had the potential for the residents to have complications related to the use of GT and/or to put the residents risk for weight loss and/or dehydration. Findings: Review of the facility's P&P titled Enteral Feeding- Safety Precautions revised 1/2025 showed enteral formulas shall be administered at full strength or in accordance with the physician order. The nurse shall verify the enteral nutrition label against the order before administration. To ensure: a. Resident name, ID and room number; b. Type of formula; c. Date and time formula were prepared; d. Route of delivery; e. Access site; f. Method (pump, gravity, syringe); g. Rate of administration (mL/hour); and h. The formula label contains the initials, date and time the formula was hung/administered. 1. Medical record review for Resident 12 was initiated on 6/29/26. Resident 12 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 12's H&P examination dated 4/22/26, showed Resident 12 had no capacity to understand and make decisions. Review of Resident 12's Order Summary Report for June 2026 showed a physician's order dated 4/20/26, to administer Glucerna 1.2 (enteral feeding formula) or equivalent at 45 ml/hr for 20 hours, (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to provide 900 ml (1080 calories) and to start the infusion at 1200 hours and continue for 20 hours or until the total volume is complete. On 6/29/26 at 1454 hours, an observation was conducted for Resident 12. Resident 12 was observed lying in bed with the GT feeding of Glucerna 1.2 running at 45 ml/hr via the GT. The enteral feeding formula bottle was not observed labeled with the start time. On 6/29/26 at 1502 hours, an interview and concurrent observation was conducted with LVN 4. LVN 4 stated when hanging a new enteral feeding formula, the bottle should be labeled with the resident's name, ordered rate, and date and time the feeding was started. LVN 4 stated the enteral feeding formulas should be discarded after 24 hours. LVN 4 further stated the start time should be labeled, to determine when the enteral feeding formula should be discarded. LVN 4 verified the above findings. LVN 4 stated she should have labeled the feeding formula bottle so the next shift would know when it should be discarded. 2. Medical record review for Resident 49 was initiated on 6/29/26. Resident 49 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 49's H&P examination dated 6/12/25, showed Resident 49 had no capacity to make decisions. a. Review of Resident 49's Order Summary Report for June 2026 showed a physician's order dated 6/25/26, to administer Glucerna 1.5 (enteral feeding formula) at 90 ml/hr for 12 hours, to provide 1080 ml and to start the infusion at 1800 hours and off at 0600 hours, or until the dose is met. On 6/29/26 at 1013 hours, during the initial tour of the facility, Resident 49 was observed lying in bed with the GT enteral feeding of Glucerna 1.5 running at 90 ml/hr via the GT. The enteral formula bottle was not observed labeled with the start time. On 6/29/26 at 1033 hours, an observation for Resident 49 and concurrent interview was conducted with LVN 6. LVN 6 stated when hanging the GT enteral feeding formula, the bottle should be labeled with the resident's name, date and time the feeding started, the ordered rate and volume. LVN 6 verified Resident 49's enteral formula bottle was not labeled with the start time b. Review of Resident 49's Order Summary Report for June 2026, showed a physician's orders dated 6/30/26, to administer Glucerna 1.5 at 75 ml/hr for 15 hours, to provide 1125 ml and to start the infusion at 1800 hours and off at 0900 hours, or until the dose is met. On 7/1/26 at 0819 hours, an observation was conducted for Resident 49. Resident 49 was observed lying in bed. The GT enteral feeding was not connected. However, the GT enteral feeding bottle of Glucerna 1.5 was hanging on the pole and was labeled with the date of 7/1/26 at 0530 hours and the rate showed 90 ml/hr for 12 hours. On 7/1/26 at 1413 hours, an observation for Resident 49 and concurrent interview and record review was conducted with LVN 7. LVN 7 stated Resident 49 was currently receiving the GT enteral feeding (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Glucerna 1.5 at 90 ml/hr for 12 hours. LVN 7 further stated during the shift change in morning, Resident 49 was connected to the GT at the rate of 90 ml/hr. LVN 7 was asked to check Resident 49's feeding pump. The GT feeding pump history showed the current enteral feeding formula rate was 90 ml/hr and 1080 ml fed. LVN 7 reviewed Resident 49's medical records and verified the new physician's order dated 6/30/26, for the GT enteral feeding rate of 75 ml/hr for 15 hours, for a total volume of 1125 ml. LVN 7 stated the new rate and duration of the enteral feedings should have been changed yesterday. c. On 7/2/26 at 0830 hours, a follow-up observation was conducted for Resident 49. Resident 49 was observed lying in bed with the GT feeding of Glucerna 1.5 running at 75 ml/hr via the GT. The enteral feeding formula bottle was not observed labeled with the start time. On 7/2/26 at 0851 hours, an observation for Resident 49 and concurrent interview was conducted with LVN 7. LVN 7 verified the enteral feeding formula bottle was not labeled with the start time. On 7/2/26 at 0955 hours, an interview was conducted with the DON. The DON stated the enteral feeding formula should be administered as per the physician's order and the enteral feeding bottles should be labeled with the resident's name, date and time the formula was started, and the rate and duration. The DON stated the enteral feeding formulas were good for 24 hours, and the labeling of the time would let the licensed nurses know when the enteral feeding formula should be discarded. The DON further stated if the resident did not receive the enteral feedings at the ordered rate and duration, there may be a protentional for weight loss. On 7/2/26 at 1420 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 3. Medical record review for Resident 117 was initiated on 6/29/26. Resident 117 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 117's H&P examination dated 6/22/26, showed Resident 117 did not have decision-making capacity. Review of Resident 117's MDS 5-day PPS assessment dated [DATE], showed Resident 117 had a feeding tube and had a medical diagnosis of dysphagia (difficulty swallowing). Review of Resident 117's Order Summary Report showed a physician's order dated 6/22/26, to administer Glucerna 1.2 at 65 ml/hr for 20 hours (on at 1200 hours, off at 0800 hours or when dose met) to provide 1300 ml/1560 kcal. On 6/29/26 at 1113 hours, an observation for Resident 117 and concurrent interview was conducted with LVN 2. Resident 117 was observed in bed with no GT enteral feeding hanging. LVN 2 verified Resident 117 was not connected with GT enteral feeding. When LVN 2 was asked to check Resident 117's GT feeding pump, the feeding pump showed feeding incomplete. The GT feeding pump history showed 104 ml left. LVN 2 verified Resident 117 did not receive the prescribed dose of 1300 ml of enteral feeding. (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/2/26 at 0825 hours, a follow-up observation for Resident 117 and concurrent interview was conducted for Resident 117 with the ADON. Resident 117 was observed lying in bed with no GT enteral feeding hanging. When ADON was asked to check Resident 117's GT feeding pump, the feeding pump showed feeding incomplete. The GT feeding pump history showed 275 ml left. The ADON verified Resident 117 did not receive the prescribed dose of 1300ml of enteral feeding. 4. Review of the facility's P&P titled Enteral Feeding - Syringe revised 3/2023 showed the purpose of this procedure is to guide the proper sanitizing of reusable enteral feeding syringes. Enteral feeding syringes are replaced every 24 hours. Medical record review for Resident 148 was initiated on 6/29/26. Resident 148 was admitted to the facility on [DATE]. Review of Resident 148's H&P examination dated 5/14/26, showed Resident 148 had limited decision making capacity. Review of Resident 148's MDS 5 day PPS assessment dated [DATE], showed Resident 148 had a feeding tube and had a medical diagnosis of dysphagia (difficulty swallowing). Review of Resident 148's Order Summary Report showed the following physician's order dated 5/14/26, to change the enteral feed syringe every day shift daily. On 6/29/26 at 1043 hours, an observation for Resident 148 and concurrent interview was conducted with LVN 2. Resident 148 was observed lying in bed. Resident 148 was observed with enteral feeding syringe at bedside labeled 6/26/26. LVN 2 verified the findings. LVN 2 stated the enteral feeding syringe were changed every day. On 7/2/26 at 0837 hours, an interview was conducted with the DON. The DON stated the residents who were on GT enteral feeding need to have new enteral feeding syringes every day for infection prevention. The DON further stated the licensed nurses were expected to make sure the residents who were on the GT enteral feeding will receive the full amount of the enteral feeding as prescribed by the physician. On 7/2/26 at 1416 hours, an interview was conducted with the Administrator and Assistant Administrator. The Administrator and Assistant Administrator were informed and acknowledged the above findings.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary respiratory care and services were provided for 10 of 34 final sampled residents (Residents 3, 5, 10, 68, 106, 164, 224, 225, 227, and 231) and one nonsampled resident (Resident 236). * The facility failed to ensure Resident 3's oxygen tubing and storage bag were changed every seven days. * The facility failed to ensure Resident 5's oxygen tubing and nebulizer tubing were changed every seven days. In addition, the facility failed to ensure the nebulizer tubing was inside a storage bag when not in use. * The facility failed to ensure Resident 10 was administered with the oxygen therapy as ordered by the physician. * The facility failed to ensure Resident 68 was administered with the oxygen therapy as ordered by the physician. In addition, the facility failed to ensure Resident 68's nasal cannula tubing was dated and labeled. * The facility failed to obtain a physician's order for Resident 106's CPAP machine settings. In addition, the facility failed to follow the care and maintenance of Resident 106's CPAP machine as per the manufacturer's guidelines. * The facility failed to ensure Resident 164's oxygen tubing and storage bag were changed every seven days. * The facility failed to ensure a physician's order was obtained for Resident 224's use of oxygen therapy. In addition, the facility failed to ensure the oxygen tubing was dated and labeled and inside a storage bag when not in use. * The facility failed to ensure a physician's order was obtained for Resident 225's use of oxygen therapy. In addition, the facility failed to ensure Resident 225's oxygen tubing was not touching the floor, the humidifier was dated and labeled and a sign to show oxygen in use was posted outside Resident 225's room. * The facility failed to ensure Resident 227's oxygen tubing was inside a storage bag when not in use. * The facility failed to ensure Resident 231's oxygen humidifier, nasal canula and storage bag were dated and labeled. * The facility failed to ensure Resident 236's oxygen humidifier was dated and labeled. These failures had the potential for the residents to not receive the appropriate respiratory care and services and may negatively impact the residents' medical conditions. Findings: Review of the facility's P&P titled Storage Maintenance and Handling of Oxygen revised 1/2026 showed the following oxygen safety guidelines have been established to provide safety to staff and residents. Use plugs, caps and plastic bags to protect equipment not in use from dust and dirt. Review of the facility's P&P titled Respiratory/Tracheostomy Care and Suctioning revised 1/2026 showed a physician's order shall be maintained in the medical record including parameters of oxygen administration and indication for use. 1. On 6/29/26 at 0812 hours, during the initial tour of the facility, an observation was conducted for Resident 224. Resident 224 was observed lying in bed. An oxygen concentrator was observed at bedside with oxygen tubing attached. The oxygen tubing was hanging on the IV pole with no date and label and was not inside a storage bag. Medical record review for Resident 224 was initiated on 6/29/26. Resident 224 was admitted to the facility on [DATE]. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 224's H&P examination dated 6/25/26, showed Resident 224 had limited decision-making capacity. Review of Resident 224's Order Summary Report failed to show a physician's order for Resident 224's use of oxygen. On 6/29/26 at 0828 hours, an observation for Resident 224 and concurrent interview was conducted with the DSD. The DSD verified the oxygen tubing was hanging on the IV pole, had no date and label, and was not inside a storage bag. The DSD stated the nasal cannula should have been changed every seven days, for infection control. The DSD further stated when the oxygen was not in use, the oxygen tubing needed to be inside a storage bag for sanitary purposes. On 6/29/26 at 1518 hours, a follow-up observation, interview, and concurrent medical record review for Resident 224 was conducted with LVN 1. Resident 224 was observed lying in bed with oxygen at a rate of two liters per minute via nasal cannula. LVN 1 verified Resident 224 was receiving oxygen at two liters per minute and stated there was no order for Resident 224's oxygen use. 2. On 6/29/26 at 0831 hours, during the initial tour of the facility, Resident 3 was observed lying in bed receiving oxygen therapy at a rate of three liters per minute via nasal cannula. A nasal cannula dated 6/21/26, was connected to the oxygen concentrator and a nebulizer tubing was observed inside a storage bag with label dated 6/21/26. Medial record review for Resident 3 was initiated on 6/29/26. Resident 3 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 3's H&P examination dated 4/12/26, showed Resident 3 had no capacity to understand and make decisions. Review of Resident 3's Order Summary Report dated 7/1/26, showed the following physician's orders: - dated 6/13/25, to administer oxygen at three liters per minute via nasal cannula, as needed for low oxygen saturation. - dated 6/18/25, to administer ipratropium- albuterol (bronchodilator used to control and prevent breathing difficulties) solution 3 ml via nebulizer every six hours as needed for wheezing or shortness of breath. On 6/29/26 at 0835 hours, an observation for Resident 3 and concurrent interview was conducted with LVN 3. LVN 3 verified the oxygen and nebulizer tubing was dated 6/21/26. LVN 3 stated the oxygen and nebulizer tubing need to be changed every week for infection and sanitary purposes. 3. On 6/29/26 at 0841 hours, an observation was conducted for Resident 5. Resident 5 was observed sitting in bed and receiving oxygen at a rate of two liters per minute via nasal cannula. Resident 5 nebulizer tubing was observed on top of the bedside table dated 6/21/26, and was not inside the (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	storage bag. Medical record review for Resident 5 was initiated on 6/29/26. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 5's H&P examination dated 6/1/26, showed Resident 5 had the capacity to understand and make decisions. Review of Resident 5's Order Summary Report dated 7/1/26, showed the following physician's orders: - dated 5/31/26, to administer oxygen at a rate of one-two liters per minute via nasal cannula, as needed for acute hypoxic respiratory failure, - dated 6/11/26, to administer ipratropium- albuterol solution 3 ml via nebulizer every six hours as needed for wheezing or shortness of breath, and - dated 6/11/26, to administer ipratropium- albuterol solution 3 ml via nebulizer three times a day for wheezing or shortness of breath. On 6/29/26 at 0853 hours, an observation for Resident 5 and concurrent interview was conducted with LVN 3. LVN 3 verified the above findings. LVN 3 stated the nasal cannula, and nebulizer tubing should have been changed every week, and the nebulizer tubing should have been inside a storage bag when not in use for infection control. 4. On 6/29/26 at 0929 hours, an observation was conducted for Resident 164. Resident 164 was observed lying in bed receiving oxygen at a rate of five liters per minute via nasal cannula. The oxygen tubing and storage bag was dated 6/21/26. Medical record review for Resident 164 was initiated on 6/29/26. Resident 164 was admitted to the facility on [DATE]. Review of Resident 164's H&P examination dated 3/21/26, showed Resident 164 had the capacity to understand and make decisions. Review of Resident 164's Order Summary Report showed a physician's order dated 3/20/25, to administer oxygen at a rate of five liters per minute via nasal cannula as needed for low oxygen saturation. On 6/29/26 at 0944 hours, an observation for Resident 164 and concurrent interview was conducted with LVN 3. LVN 3 verified the above findings and stated the nasal cannula tubing need to be changed every week, for infection control. 5. On 6/29/26 at 1029 hours, during the initial tour of the facility, an observation was conducted for Resident 227. Resident 227 was observed lying in bed and receiving oxygen at a rate of three liters (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	per minute via nasal cannula. Medical record review for Resident 227 was initiated on 6/29/26. Resident 227 was admitted to the facility on [DATE]. Review of Resident 227's H&P examination dated 6/29/26, showed Resident 227 had a decision-making capacity. Review of Resident 227's Order Summary Report showed a physician's order dated 6/27/26, to administer oxygen at a rate of three liters per minute via nasal cannula as needed for acute respiratory failure. On 6/29/26 at 1157 hours, a follow-up observation for Resident 227 and concurrent interview was conducted with LVN 1. An oxygen tubing was observed attached to the oxygen cylinder tank in the wheelchair was coiled and was not inside a storage bag. LVN 1 verified the findings. LVN 1 stated the oxygen tubing if not in use needed to be inside a storage bag for infection control. On 7/2/26 at 0837 hours, an interview was conducted with the DON. The DON was asked about the process when a resident was on oxygen therapy. The DON stated an order needs to be placed before starting oxygen therapy for the residents, and care plan. The licensed nurses need to label the oxygen/nebulizer tubing and storage bag with the date when it was changed. The oxygen and nebulizer tubing needs to be changed every week for infection control and sanitary purposes. The DON stated when the oxygen and nebulizer tubing was not in use, it was expected for the licensed nurses to store the tubing inside the storage bag. On 7/2/26 at 1416 hours, an interview was conducted with the Administrator and Assistant Administrator. The Administrator and Assistant Administrator were informed and acknowledged the above findings. 6. On 6/29/26 at 0936 hours, during the initial tour of the facility, Resident 68 was observed sitting in the wheelchair in her room. Resident 68 was observed receiving continuous oxygen via the nasal cannula at a rate of three liters per minute. Resident 68's nasal cannula was not observed labeled with the date and the storage bag hanging on the oxygen cannister behind Resident 68's wheelchair, was labeled with the date of 6/7/26. When asked, Resident 68 stated she was receiving four liters per minute of oxygen. Medical record review for Resident 68 was initiated on 6/29/26. Resident 68 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 68's H&P examination dated 5/7/26, showed Resident 68 had the capacity to understand and make decisions. Review of Resident 68's Order Summary Report for June 2026 showed a physician's order dated 6/27/26, to administer oxygen at a rate of four liters per minute via nasal cannula as needed or continuous for the diagnosis of chronic obstructive pulmonary disease (COPD, a progressive, (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inflammatory lung disease that blocks airflow and causes severe breathing difficulty). On 6/29/26 at 0952 hours, an observation for Resident 68 and concurrent interview and medical record review was conducted with LVN 5. LVN 5 stated the oxygen tubing should be changed weekly. LVN 5 stated both the oxygen tubing as well as the set-up bag should be labeled and dated. LVN 5 verified Resident 68 was receiving oxygen at a rate of three liter per minute. LVN 5 stated the oxygen therapy should be administered as ordered at a rate of four liters per minute. 7. On 6/29/26 at 1017 hours, during the initial tour of the facility, Resident 10 was observed sleeping in bed with the nasal cannula on the bed. The nasal canula was connected to the oxygen concentrator and set at a rate of three liters per minute. Medical record review for Resident 10 was initiated on 6/29/26. Resident 10 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 10's H&P examination dated 9/12/25, showed Resident 10 had the capacity to understand and make decisions. Review of Resident 10's Order Summary Report for June 2026 showed a physician's order dated 4/10/26, to administer oxygen therapy at a rate of two liters per minute via nasal cannula as needed for comfort and management of shortness of breath. On 6/29/26 at 1038 hours, an observation for Resident 10, and concurrent interview and medical record review was conducted with LVN 6. LVN 6 verified Resident 10 was receiving oxygen therapy at a rate of three liters per minute. However, review of the physician's order for oxygen administration showed to administer oxygen therapy at a rate of two liters per minute via nasal cannula. LVN 6 stated the oxygen therapy should be administered as per the physician's order. On 7/2/26 at 0955 hours, an interview was conducted with the DON. The DON stated continuous oxygen therapy should be administered as per the physician's order and should be checked by the licensed nurses. The DON stated the tubing should be kept in the bag when not in use. The DON stated the oxygen tubing should be labeled with the date when it was changed every week. On 7/2/26 at 1420 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 8. Review of facility's P&P titled Storage Maintenance and Handling of Oxygen dated January 2026 showed the facility's general rules included the No Smoking signs shall be visible where oxygen is stored or being administered. On 6/29/26 at 0949 hours, an observation was conducted for Resident 225. Resident 225 was observed in bed receiving oxygen at a rate of 1.5 liters per minute via nasal cannula connected to the humidifier from the concentrator oxygen machine. The oxygen tubing was observed touching the floor and the humidifier was undated. In addition, there was no posted signage of No Smoking outside Resident 225's room. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident 225 was initiated on 6/29/26. Resident 225 was admitted to the facility on [DATE]. Review of Resident 225's H&P examination dated 6/29/26, showed Resident 225 had no capacity to understand and make decisions. Review of Resident 225's Order Summary Report dated 7/1/26, failed to show documented evidence a physician order was obtained for the use of oxygen therapy. On 6/29/26 at 1500 hours, an observation, concurrent interview and medical record review for Resident 225 was conducted with LVN 15. LVN 15 was asked at Resident 225's bedside. LVN 15 verified and acknowledged the oxygen tubing was touching the floor, the humidifier was undated, and there was no posted signage for no smoking outside the room of Resident 225. In addition, LVN 15 was asked about the physician's order for Resident 225's use of oxygen therapy. LVN 15 verified there was no physician's order for Resident 225's use of the oxygen. Cross reference F655. 9. Review of the facility's P&P titled BiPAP and CPAP Therapy dated January 2026 showed the facility's guidelines to review the physician's order to determine the oxygen concentration, duration, flow, and the PEEP pressure (CPAP) for the machine. Review and follow the manufacturer's instructions for the CPAP machine setup and oxygen delivery. Medical record review for Resident 106 was initiated on 6/29/26. Resident 106 was admitted to the facility on [DATE]. Review of Resident 106's H&P examination dated 6/22/26, showed Resident 106 had the capacity to understand and make decisions. On 6/29/26 at 1225 hours, an observation and concurrent interview was conducted with Resident 106. Resident 106 was observed awake in bed and the CPAP machine on top of the bedside drawer. Resident 106 stated the CPAP machine was brought from home and her husband would help her to put on the CPAP mask at night and the nurses helped her take it off in the morning. When asked if she had seen the nurses clean the mask and tubing of her CPAP mask, Resident 106 did not answer. Review of Resident 106's Order Summary Report dated 7/1/26, showed a physician's order dated 6/25/26, for CPAP settings: Hours of use: Continuous at NOC and PRN. Further review of the Order Summary Report failed to show a physician's order for the oxygen concentration, duration, flow, and the PEEP pressure (CPAP) for the machine as per the manufacturer's instruction. On 7/1/26 at 0826 hours, an interview for Resident 106 was conducted with LVN 16. LVN 16 verified Resident 106 was using the CPAP machine. LVN 16 stated the RT does the setting of the machine and the licensed nurses were responsible for turning on and off for the resident. LVN 16 stated the charge nurses were responsible for cleaning and maintaining the CPAP machine. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/1/26 at 0843 hours, an interview and concurrent medical record review for Resident 106 and 225 was conducted with the ADON. The ADON was informed of the findings and stated the oxygen humidifier should have been labeled and dated, the oxygen tubing should not be touching the floor and there should be a posted signage of No Smoking on the doorway. The ADON verified and acknowledged there was no order for Resident 225's oxygen use. The ADON verified Resident 106's CPAP machine physician's order had no specific setting order as per the manufacturer's instruction. On 7/2/26 at 1416 hours, an interview and concurrent medical record review for Resident 106 and 225 was conducted with the DON. The DON was informed and verified the above findings. Cross reference F 656, example # 2. 10. Medical record Review for Resident 231 was initiated on 6/29/26. Resident was admitted to the facility on [DATE]. Review of Resident 231's Order Summary Report dated 6/30/26 showed a physician's order dated 6/24/26, to administer oxygen at a rate of 2-3 liters per minute via nasal cannula continuously. a. On 6/29/26 at 1012 hours, during the initial tour, Resident 231's oxygen concentrator with a humidifier attached was at bedside. The humidifier was observed not labeled with a date. On 6/29/26 at 1516 hours, an observation Resident 231's oxygen concentrator and concurrent interview was conducted with LVN 12. LVN 12 verified the humidifier was observed not labeled with date. b. On 7/1/26 at 0836 hours, a follow-up observation of Resident 231 was conducted. Resident 231 was in the room, lying in bed. An oxygen with attached nasal cannula was observed on a wheelchair by the foot of Resident 231's bed. The nasal cannula and plastic bag was observed not labeled with a date. Resident 231 stated the wheelchair and the oxygen belonged to her. Resident 231 further stated she did not know when the nasal cannula was changed. On 7/1/26 at 0836 hours, an observation of Resident 231 and concurrent interview was conducted with LVN 8. LVN 8 verified Resident 231's oxygen nasal cannula was not labeled with a date. LVN 8 stated the nasal cannula should be labeled with a date. On 7/2/26 at 1023 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 11. Medical record review for Resident 236 was initiated on 6/29/26. Resident 236 was admitted to the facility on [DATE], and readmitted on [DATE]. On 6/29/26 at 1006 hours, during the initial tour of the facility, Resident 236 was observed in the resident's room with oxygen at the rate of two liters per minute via nasal cannula. The humidifier was observed not labeled with date. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/29/26 at 1518 hours, an observation of Resident 236's oxygen nasal cannula and concurrent interview was conducted with LVN 12. LVN 12 verified the resident's humidifier was observed not labeled with a date. On 7/2/26 at 1023 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the appropriate dialysis care was provided for four of 34 final sampled residents (Residents 6, 201, 227 and 228) reviewed for dialysis services. * The facility failed to ensure Resident 6's left upper arm dialysis shunt was being monitored for bruit and thrill. Additionally, the facility failed to ensure Resident 6's hemodialysis communication records were complete, and failed to ensure Resident 6's intake and output were accurately monitored. * The facility failed to ensure Resident 201 and 228's fluid restriction was accurately monitored per physician's order. * The facility failed to ensure the emergency dialysis kit was kept at Resident 227's bedside. These failures had the potential for the residents not to receive the necessary and/or immediate interventions to manage the dialysis care, access site, and prevent possible medical complications. Findings: Review of the facility's P&P titled Dialysis Management revised 3/2023 showed to provide the residents who require dialysis care, services consistent with professional standards of practice, a comprehensive person-centered care plan which meets the residents' goals and preferences. 1. Medical record review for Resident 227 was initiated on 6/29/26. Resident 227 was admitted to the facility on [DATE]. Review of Resident 227's H&P examination dated 6/29/26, showed Resident 227 had a decision-making capacity. Review of Resident 227's admission Record showed Resident 227 had a diagnosis of ESRD (End Stage Renal Disease) and was dependent on renal dialysis. Review of Resident 227's Order Summary Report showed a physician's order dated 6/27/26, for hemodialysis every Monday, Wednesday, and Friday at the dialysis center. On 6/29/26 at 1029 hours, during the initial tour of the facility, an observation and concurrent interview was conducted for Resident 227. Resident 227 was observed lying in bed. Resident 227 was observed with left upper chest perma-catheter and a left upper arm AV fistula. Resident stated that she went to dialysis every Monday, Wednesday, and Friday. No emergency dialysis kit was observed at bedside. On 6/29/26 at 1157 hours, an observation and concurrent interview for Resident 227 was conducted with LVN 1. LVN 1 verified there was no emergency dialysis kit at Resident 227's bedside. LVN 1 stated the residents who received dialysis needed to have an emergency dialysis at bedside, and residents were at risks for bleeding. 2. Medical record review for Resident 228 was initiated on 6/29/26. Resident 228 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 228's H&P examination dated 6/23/26, showed Resident 228 had a decision-making capacity. Review of Resident 228's admission Record showed Resident 228 had a diagnosis of ESRD and was dependent on renal dialysis. Review of Resident 228's Order Summary Report dated 7/1/26, showed the following physician's orders: - dated 6/22/26, for hemodialysis every Monday, Wednesday, and Friday at the dialysis facility; - dated 6/22/26, for 1500 ml fluid restriction (nursing-780 ml, and dietary-720 ml); and - dated 6/22/26, to monitor intake and output every shift. Review of Resident 228's MAR for the month of 6/2026 showed 1500 ml fluid restriction monitoring by the licensed nurses. Resident 228's monitoring of fluid restrictions on each shift by the licensed nurses showed a check mark on each entry. There was no specific amount of fluid consumed on each shift every day. On 6/30/26 at 1015 hours, an observation was conducted for Resident 228. Resident 228 was observed sitting in a wheelchair with 500 ml water pitcher at the bedside table. On 7/1/26 at 0936 hours, an interview and concurrent medical record review for Resident 228 was conducted with the ADON. The ADON verified the above findings. The ADON stated the monitoring of the fluid restriction was inaccurate when the licensed nurses placed only check marks on each shift in the MAR. On 7/2/26 at 0837 hours, an interview was conducted with DON. The DON was informed and verified the above findings. On 7/2/26 at 1416 hours, an interview was conducted with the Administrator and Assistant Administrator. The Administrator and Assistant Administrator were informed and acknowledged the above findings. 3. Review of the facility's P&P titled Dialysis Management revised 3/2023 showed the licensed nurses assess, manage, and report changes in bruit or thrill, bleeding, infections, hypertension or hypotension, hyperkalemia, etc. Medical record review for Resident 6 was initiated on 6/29/26. Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE]. (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 6's H&P examination dated 9/24/25, showed Resident 6 had no capacity to understand and make decisions. Review of Resident 6's Order Summary Report dated 6/30/26, showed a physician's order dated 3/14/26, for Resident 6's hemodialysis schedule three times a week, every Tuesday, Thursday, and Saturdays with Dialysis Center A. The pick-up time was 0850 hours. a. Review of Resident 6's Dialysis Communication Record showed the following incomplete documentation: - dated 6/18/26, the type of access was AV shunt/AV fistula; however, the location of the access site was blank, - dated 6/25/26, the type of access was AV shunt/AV fistula; however, the location of the access site was blank, - dated 6/27/26, the type of access was AV shunt/AV fistula; however, the location of the access site was blank, and - dated 6/30/26, the type of access was AV shunt/AV fistula; however, the location of the access site was blank. b. Review of Resident 6's Order Summary Report dated 6/30/26, showed the following physician's orders: - dated 3/14/26, to monitor Resident 6's hemodialysis site for redness, swelling, drainage and pain, every shift. - dated 4/22/26, no BP, IV and blood draw to Resident 6's left arm. - dated 5/29/26, okay to use needles on Resident 6's left arm fistula as tolerated. Further review of the Resident 6's Order Summary Report dated 6/30/26, failed to show a physician's order for the monitoring of Resident 6's left upper arm hemodialysis access for bruit and thrill. Review of Resident 6's medical record failed to show the licensed nurses' documentation for the monitoring of Resident 6's hemodialysis access site for bruit and thrill on the days Resident 6 did not have the hemodialysis treatments. On 6/30/26 at 1430 hours, an interview and concurrent medical record review for Resident 6 was conducted with LVN 4. LVN 4 stated Resident 6 received hemodialysis treatments on Tuesdays, Thursday, and Saturdays. LVN 4 stated Resident 6's hemodialysis access was in the left upper arm and the licensed nurses were responsible for checking the resident's hemodialysis access site for bruit and thrill, and documented the assessments in the pre- and post- dialysis communication record. LVN 4 stated the dialysis communication record was used as a form of communication between the (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility and the dialysis center and all the sections on the form should be completed. LVN 4 reviewed the dialysis communication records for the above dates and verified the above findings. When asked about the monitoring of Resident 6's left arm hemodialysis access for bruit and thrill on the days Resident 6 did not have hemodialysis treatments, LVN 4 reviewed Resident 6's medical record and stated Resident 6 did not have a physician's order for the monitoring of bruit and thrill. LVN 4 verified there was no documentation of the assessment and monitoring of Resident 6's hemodialysis access site for bruit and thrill on the days Resident 6 did not have the hemodialysis treatments. c. Review of Resident 6's Order Summary Report dated 6/30/26, showed the following physician's orders dated 3/14/26: - to monitor Resident 6's daily intake and output, every shift. - to monitor Resident 6's daily intake in 24 hours, every evening shift. Review of Resident 6's MAR for 6/2026 showed inconsistent monitoring of Resident 6's intake. For example: For the monitoring of Resident 6's intake every shift, the licensed nurses documented: - on 6/1/26: 500 ml for the day shift, 250 ml for the evening shift, and 80 ml for the night shift; - on 6/2/26: 200 ml for the day shift, 240 ml for the evening shift, and 80 ml for the night shift; - on 6/3/26: 240 ml for the day shift, 240 ml for the evening shift, and 80 ml for the night shift; - on 6/4/26: 100 ml for the day shift, 300 ml for the evening shift, and 80 ml for the night shift; - on 6/5/26: 200 ml for the day shift, 300 ml for the evening shift, and 80 ml for the night shift; - on 6/6/26: 100 ml for the day shift, 240 ml for the evening shift, and 80 ml for the night shift; and - on 6/10/26, 200 ml for the day shift, 320 ml for the evening shift, and 80 ml for the night shift. However, further review of Resident 6's MAR for 6/2026 showed for the monitoring of Resident 6's 24-hour intake, the licensed nurses documented the following: - on 6/1: x2 (times two), - on 6/2: x2, - on 6/3: x2, - on 6/4: 300 ml, (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- on 6/5: 300 ml, - on 6/6: 420 ml, and - on 6/10/26: x6. On 6/30/26 at 1450 hours, an interview and concurrent medical record review for Resident 6 was conducted with LVN 6. LVN 6 stated Resident 6 was not on fluid restrictions; however, there was a physician's order to monitor the resident's intake and output every shift, and daily. LVN 6 stated the licensed nurses were responsible for the monitoring of intake and output, and documented the amount in the MAR. LVN 6 reviewed Resident 6's MAR for 6/2026 and verified the above findings. On 7/2/26 at 0948 hours, an interview and concurrent medical record review for Resident 6 was conducted with the DON. The DON stated the licensed nurses were responsible for the monitoring of the resident's hemodialysis access and assessing for bruit and thrill, every shift, to ensure the hemodialysis access site was working properly. The DON stated the licensed nurses were responsible for completing the pre- and post- dialysis assessments and the licensed nurses should document the dialysis type and location in the dialysis communication record. The DON stated for the residents with monitoring of the intake and output, the intake should be documented by the licensed nurses in the MAR, and the documentation should be accurate. The DON reviewed Resident 6's MAR for the monitoring of intake and output and verified the above findings. On 7/2/26 at 1420 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 4. Review of the facility's P&P titled Dialysis-Care Planning dated December 2025 showed the comprehensive care plan will be developed for residents receiving dialysis includes the monitoring of vital signs, weights, nutritional and fluid needs, or any restrictions. Fluid restrictions and interventions when indicated. Medical record review for Resident 201 was initiated on 6/29/26. Resident 201 was admitted to the facility on [DATE], with diagnosis of acute kidney failure and chronic kidney disease. Review of Resident 201's H&P examination dated 5/22/26, showed Resident 201 had the capacity to make medical decisions. Review of Resident 201's Order Summary Report dated 7/1/26, showed a physician's order dated 5/25/26, for the fluid restriction of 1500 ml: Nursing - 780 ml and Dietary - 720 ml. Another physician's order dated 5/22/26, showed to monitor intake and output every shift. Review of Resident 201's Plan of Care dated 5/26/26, showed a care plan problem addressing (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 201 needed dialysis related to the diagnoses. The interventions included the fluid restriction of 1500 ml per day. Review of Resident 201's Documentation Survey Report dated 7/1/26, showed the amount of fluid intake on each meal per day. Review of Resident 201's MAR for the month of 6/2026 showed the 1500 ml fluid restriction monitoring by the licensed nurses. However, the monitoring of the fluid restriction on each shift by the licensed nurses showed a check mark on each entry. There was no documentation of the specific amount of fluid Resident 201 consumed on each shift everyday. On 6/30/26 at 1421 hours, an interview for Resident 201 was conducted with CNA 3. CNA 3 verified Resident 201 was on fluid restriction. CNA 3 stated the amount of fluids from the food tray was recorded on each meal on the fluid intake log. CNA 3 verified she recorded only the fluids taken from the resident food tray on each meal and not the fluids on the resident's water pitcher at bedside. On 7/1/26 at 0850 hours, an interview and concurrent medical record review for Resident 201 was conducted with the ADON. The ADON verified Resident 201 was on dialysis every Monday, Wednesday, and Friday morning. The ADON was asked about the fluid restriction of the resident. The ADON verified the physician's order for fluid restriction of 1500 ml per day with a breakdown of amount of fluids for nursing and dietary. The ADON was informed of the findings. The ADON verified the monitoring of the fluid restriction was inaccurate monitoring because the licensed nurses placed only check mark each shift on the MAR. On 7/2/26 at 1416 hours, an interview and concurrent medical record review for Resident 201 was conducted with the DON. The DON was informed and verified the above findings.		

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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** Based on observations, interview, facility records review, and facility P&P review, the facility failed to ensure the medications were properly stored for one of 34 final sampled residents (Resident 12), one nonsampled resident (Resident 81), and in two of two medication rooms (Medication Rooms A and B). * The facility failed to ensure the medications were stored according to the manufacturer label in Medication Rooms A and B. * The facility failed to ensure the Anasept (an antimicrobial skin and wound cleanser) was not left on top of Resident 81's television stand in Room A. * The facility failed to ensure the medicine cup containing a white color cream and packet of Calma Plex (anorectal paste - provides soothing relief and external protection for irritated, inflamed perianal skin) were not left in Resident 12's room. These failures had the potential to compromise medication's stability, potency, and effectiveness and medication access of unauthorized persons. Findings: Review of the facility's P&P titled Labeling and Storage of Drugs revised 1/2025 showed the drugs shall be stored in an orderly manner in cabinets, drawers, or carts of sufficient size to prevent crowding. Review of the facility's P&P titled Pharmaceutical Service & Labeling and Storage of Drugs revised 1/2025 showed the drugs shall be stored at appropriate temperatures. 1. Review of the facility's document titled Medication Room Temperature Log for Medication Room A for April 2026 showed the temperature was 78 degrees Fahrenheit for the following dates and shifts: - dated 4/3/26 at PM shift; - dated 4/5/26 at PM shift; - dated 4/6/26 at PM shift; - dated 4/12/26 at AM shift; - dated 4/13/26 at AM and PM shift; - dated 4/16/26 at AM and PM shift; - dated 4/21/26 at AM shift; - dated 4/24/26 at AM shift; and - dated 4/27/26 at PM shift; (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's document titled Medication Room Temperature Log for Medication Room A for May 2026 showed the temperature was 78 degrees Fahrenheit for the following dates and shifts: - dated 5/3/26 AM and PM shift; - dated 5/5/26 AM shift; - dated 5/11/26 AM shift; - dated 5/18/26 AM shift; - dated 5/23/26 AM shift; - dated 5/25/26 AM and PM shift; - dated 5/26/26 AM shift; and - dated 5/27/26 AM and PM shift; Review of the facility's document titled Medication Room Temperature Log for Medication Room A for June 2026 showed the temperature was 78 degrees Fahrenheit for the following dates and shifts: - dated 6/2/26 at AM shift; - dated 6/3/26 at AM shift; - dated 6/4/26 at AM and PM shift; - dated 6/8/26 at AM and PM shift; - dated 6/11/26 at AM and PM shift; - dated 6/14/26 at AM and PM shift; - dated 6/19/26 at AM and PM shift; - dated 6/20/26 at AM shift; - dated 6/23/26 at AM and PM shift; - dated 6/26/26 at AM shift; - dated 6/28/26 at AM and PM shift; and - dated 6/30/26 at AM shift; (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/30/26 at 1035 hours, an observation of Medication Room A and concurrent interview was conducted with the ADON. The ADON checked the thermometer in Medication Room A and stated Medication Room A temperature was 78 degrees Fahrenheit. Medication Room A was observed stored with medications and intravenous emergency kit medications. On 6/30/26 at 1429 hours, another observation of Medication Room A and concurrent interview was conducted with the ADON. The ADON stated the temperature in Medication Room A was still 78 degrees Fahrenheit. Medication Room A was observed with an intravenous emergency kit medications. The ADON opened the intravenous emergency kit. The intravenous emergency kit contained the following: - one carton of 50% injectable dextrose (immediate treatment of low blood sugar), the product label showed to store at 68 to 77 degrees Fahrenheit; and - three bags of injectable metronidazole (antibiotic), the product label showed to store at 68 to 77 degrees Fahrenheit. The ADON verified the product labeling of dextrose and metronidazole medications. On 7/1/26 at 1352 hours, a follow-up observation and concurrent interview were conducted with the ADON. Medication Room A was observed with the following medications: - three bottles of acetaminophen (pain reliever and fever reducer) 500 mg, the product label showed to store at 68 to 77 degrees Fahrenheit; - three bottles of acetaminophen 325 mg, the product label showed to store at 68 to 77 degrees Fahrenheit; and - two cartons of loperamide (antidiarrheal) caplets 2 m, the product label showed to store at 68 to 77 degrees Fahrenheit. The ADON verified the product labeling of the above medications. 2. Review of the facility's document titled Temperature Log for Medication Room B for April 2026 showed the temperature was 78 degrees Fahrenheit during PM shift on 4/2, 4/7, 4/10, 4/11, 4/13, 4/14, and 4/23/26. The temperature log further showed the temperature range was 68 to 77 degrees Fahrenheit with instructions of any deviation outside the set temperature range must be immediately reported to the DON/Administrator and reported to the pharmacy. Review of the facility's document titled Temperature Log for Medication Room B for June 2026 showed the temperature was 78 degrees Fahrenheit during AM shift on 6/30/26. On 6/30/26 at 1054 hours, an observation of Medication Room B and concurrent interview was (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	conducted with the ADON. The ADON checked the thermometer in Medication Room B and stated Medication Room B temperature was 78 degrees Fahrenheit. The ADON further stated Medication Room B was warm. Medication Room B was observed stored with medications and intravenous emergency kit medications. On 6/30/26 at 1413 hours, another observation of Medication Room B and concurrent interview was conducted with the ADON. The ADON stated the temperature in Medication Room B was still 78 degrees Fahrenheit. Medication Room B was observed with an intravenous emergency kit medication. The ADON opened the intravenous emergency kit. The intravenous emergency kit contained the following medications: - one carton of 50% injectable dextrose, the product label showed to store at 68 to 77 degrees Fahrenheit; and - three bags of injectable metronidazole, the product label showed to store at 68 to 77 degrees Fahrenheit. The ADON verified the product labeling of dextrose and metronidazole medications. On 7/1/26 at 1403 hours, a follow-up observation and concurrent interview was conducted with the ADON. Medication Room B was observed with the following medications: - two bottles of docusate sodium sulfate (stool softener) 100 mg, the product label showed to store at 59 to 77 degrees Fahrenheit; - two cartons of bisacodyl (antidiarrheal) suppositories 10 mg, the product label showed to store below 77 degrees Fahrenheit; - one carton of acetaminophen suppositories 650 mg, the product label showed to store at 68 to 77 degrees Fahrenheit; and - one carton of hemorrhoidal suppositories, the product label showed to store at 68 to 77 degrees Fahrenheit. The ADON verified the product labeling of the medications above. On 7/2/26 at 1104 hours, an interview was conducted with the DON. The DON was informed and acknowledged the temperature in Medication Room A and Medication Room B were above 77 degrees Fahrenheit. The DON acknowledged inside Medication Rooms A and B contained drugs with product labeling to store at 68 to 77 degrees Fahrenheit. The DON stated storing the medications at a proper temperature was important to maintain the potency of the medications. 3. On 6/29/26 at 0948 hours, during initial tour of the facility, a white spray bottle of Anasept was observed on top of Resident 81's television stand. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident 81 was initiated on 6/29/26. Resident 81 was admitted to the facility on [DATE]. Review of Resident 81's Progress Note dated 6/9/26, showed Resident 81 had no capacity to make decision. On 6/29/26 at 1521 hours, an observation and concurrent interview was conducted with LVN 12. LVN 12 verified the Anasept spray bottle was left on Resident 81's television stand. LVN 12 stated the Anasept spray bottle should not have been left in the resident's room. On 6/30/26 at 0908 hours, an interview was conducted with LVN 8. LVN 8 stated the Anasept spray bottle did not belong to Resident 81. LVN 8 further stated it must have been left in Resident 81's room by mistake. On 7/2/26 at 1007 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. Review of the facility's P&P titled Labeling and Storage of Drugs revised 1/2025 showed drugs shall be stored in an orderly manner in cabinets, drawers, or carts of sufficient size to prevent crowding. 4. On 6/29/26 at 0933 hours, during the initial tour of the facility, Resident 12 was observed in bed. A medication cup containing a white cream and tongue depressor and a packet of Calma Plex was observed on Resident 12's bedside drawer. Resident 12 shared the room with two other residents. Medical record review for Resident 12 was initiated on 6/29/26. Resident 12 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 12's H&P examination dated 4/22/26, showed Resident 12 had no capacity to understand and make decisions. Review of Resident 12's Self Administration of Medication assessment dated [DATE], showed the documentation Resident 12 was not mentally or physically able to administer her own medication. On 6/29/26 at 0953 hours, an observation and concurrent interview was conducted with LVN 5. LVN 5 stated Resident 12's treatments were provided by the treatment nurses. LVN 5 stated the treatment nurse would prepare the topical creams and the remainder cream should be discarded and not left at the bedside. LVN 5 verified the above findings. LVN 5 stated the topical cream should have been discarded and the packet of Calma Plex should be kept in the treatment cart. On 7/2/26 at 0955 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON stated if the residents had no capacity, the resident should not self-administer the medication. The DON further stated for those residents had no capacity, the medications should not be left at the bedside. On 7/2/26 at 1420 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility P&P review, the facility failed to ensure the food safety and sanitation requirements were met in the kitchen. * The facility failed to ensure the proper labeling of food and beverages in the kitchen. * The facility failed to ensure the items in the refrigerator was discarded after the use-by date. * The facility failed to ensure the kitchen utensils and equipment were stored or kept in sanitary conditions. * The facility failed to ensure the kitchen utensils and equipment were in good condition. *The facility failed to properly air dry the kitchen equipment. *The facility failed to ensure the temperature monitoring of the food kept in the emergency food supply room. * The facility failed to ensure Dietary Aide 1 performed hand hygiene after wearing disposable gloves in the kitchen and before donning new disposable gloves. * The facility failed to ensure the refrigerator fans were clean. These failures had the potential for exposure to food-borne illnesses for a medical vulnerable population of 168 residents who received food prepared in the kitchen. Findings: Review of the facility's document titled Diet Roster Rollup dated 6/29/26, showed 168 of 172 residents in the facility received food prepared in the kitchen. 1. According to USDA Food Code 2022, Section 3-501.17, Ready-To-Eat, Time/Temperature Control for Safety Food, Date Marking (undated), showed date marking requirements apply to containers of processed food that have been opened and to food prepared, if held for more than 24 hours, shall be clearly marked to indicate the date or day by which the food shall be consumed on the premise, sold, or discarded. Review of the facility's P&P titled Food Receiving and Storage revised 1/2026, showed when food, food products or beverages are delivered to the nursing home, the facility staff must ensure their proper storage, keeping track of when to discard perishable foods and covering, labeling, and dating all foods stored in the refrigerator or freezer as indicated. Practices to maintain safe refrigerated storage include: c. labeling dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable) or discarded. Review of the facility's P&P titled Refrigerators and Freezers revised 1/2026, showed all foods shall be appropriately dated to ensure proper rotation by expiration dates. Use-by dates will be complete with expiration dates on all prepared food in the refrigerators. Expiration dates on unopened food will be observed and use-by dates indicated once food is opened. On 6/29/26 at 0800 hours, an initial tour of the kitchen was conducted with the DSS. The following was observed:- two opened bags of chicken breasts inside Freezer A were not labeled with the opened or use-by dates; - a box of grape juice and a box of black and white tea were connected to the juice dispenser. The juice boxes were not labeled with the opened date. The label on the juice boxes showed to use the product 45 days after connecting; and- a box of prune juice was connected to the juice dispenser. The box was labeled with the date 3/10/26. The DSS stated she did not know if that was the received or opened date. The DSS verified the above findings and stated she did not know when the above items were opened. 2. Review of the facility's P&P titled Refrigerators and Freezers revised 1/2026, showed all foods shall be appropriately dated to ensure proper rotation by expiration dates. Use-by dates will be complete with expiration dates on all prepared food in the refrigerators. Expiration dates on unopened food will be observed and use-by dates indicated once food is opened. On 6/29/26 at 0800 hours, an initial tour of the kitchen was conducted with the DSS. The following was observed:- a tray containing multiple small plastic cups of Italian dressing (inside Refrigerator C) was labeled with the use-by date of 6/27/26;- a container of jelly (inside Refrigerator D) was labeled with the use-by date of 6/27/26;- a container of ham slices (inside Refrigerator D) was labeled with the use-by date of 6/28/26; and- a bowl of yogurt and two (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bowls of pudding (inside Refrigerator C) was labeled with the use-by date of 6/28/26. The DSS verified the above findings. 3. According to the USDA Food Code 2022, Section 4-601.11, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils: (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to USDA Food Code 2022, 4-602.13, Non-Food Contact Surfaces (undated) showed the presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. Review of the facility's P&P titled Safe Food Preparation revised 1/2025, showed cross-contamination can occur when harmful substances, i.e., chemical or disease-causing microorganisms are transferred to food by hands (including gloved hands), food contact surfaces, sponges, cloth towels, or utensils that are not adequately cleaned. Examples of ways to reduce cross-contamination include but are not limited to: clean and sanitize work surfaces, including cutting boards and food-contact equipment (e.g., food processors, blenders, preparation tables, knife blades, can openers, and slicers), between uses and consistent with applicable code. Review of the facility's P&P titled Cleaning and Disinfection of Utensils revised 1/2026, showed all food-contact items and surfaces shall be maintained in a sanitary condition and good repair to protect patients from contamination and foodborne illness. Utensils, counters, shelves, and equipment shall be kept clean, disinfected/sanitized as appropriate, and in good repair. Clean and disinfected utensils shall be air-dried and stored to prevent contamination. a. On 6/29/26 at 0800 hours, an initial tour of the kitchen was conducted with the DSS. The following were observed:- multiple plastic container lids stored inside a clear plastic bin. The clear plastic bin was observed with debris and food particles at the bottom of the bin;- multiple stacked small white bowls stored inside a clear plastic bin. The clear plastic bin was observed with debris and food particles at the bottom of the bin;- a food mixer observed with a dry brown stain and multiple dry brown particles inside the bowl. A paper towel was used to wipe the mixer bowl and multiple dry particles or debris were observed on the paper towel;- a meat slicer was observed with multiple dry food residue and food particles on multiple parts of the machine;- the drawer storing the kitchen utensils was observed with one black glove, a wet-white substance, and multiple dry black-brown particles;- a pizza slicer observed with dry food particles; and- a yellow cutting board observed stained. The DSS verified the above findings. The DSS stated the bins and kitchen equipment should be clean. b. On 6/30/26 at 1005 hours, a puree preparation observation was conducted of Dietary Aide 1. Dietary Aide 1 was observed preparing the black bean puree. The blender was observed with white colored food residue. Dietary Aide 1 verified the above findings and was observed removing the blender to be washed. 4. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics (undated) showed for materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be safe, durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. Review of the facility's P&P titled Cleaning and Disinfection of Utensils revised 1/2026, showed all food-contact items and surfaces shall be maintained in a sanitary condition and good repair to protect patients from contamination and foodborne illness. Utensils, counters, shelves, and equipment shall be kept clean, disinfected/sanitized as appropriate, and in good repair. Surfaces (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shall be free from breaks, corrosion, open seams, cracks, and chipped areas which preclude cleaning and sanitizing. On 6/29/26 at 0800 hours, an initial tour of the kitchen was conducted with the DSS. The following were observed:- two chipped spatulas;- one melted green plastic container lid;- one cracked blue plastic container lid; and- one white cutting board observed stained, discolored, and heavily marred on both sides.The DSS verified the above findings. 5. According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required (undated), after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food.Review of the facility's P&P titled Cleaning and Disinfection of Utensils revised 1/2026, showed all food-contact items and surfaces shall be maintained in a sanitary condition and good repair to protect patients from contamination and foodborne illness. Clean and disinfected utensils shall be air-dried and stored to prevent contamination. Air-dry: Allow items to air-dry completely; do not towel-dry. Store in a clean, protected area. On 6/29/26 at 0800 hours, an initial tour of the kitchen was conducted with the DSS. The following were observed:- six water pitchers for the resident use, stored upside down with the lid on and visibly wet;- multiple clear plastic cups stored upside down and visibly wet;- two clear plastic bins stacked and visibly wet;- two trays of plastic bowls stored upside down and visibly wet; and- two scoopers (dishers) stored in the drawer wet.The DSS verified the above findings. The DSS stated the items should be completely dried before placing them on the rack or drawer and ready for use. 6. Review of the facility's P&P titled Food Receiving and Storage revised 1/2026, showed dry storage may be in a room or area designated for the storage of dry goods, such as single service items, canned goods, and packaged or containerized bulk food that is not Potentially Hazardous Foods. Controlling temperature, humidity, and rodent and insect infestation helps prevent deterioration or contamination of the food. On 6/29/26 at 0800 hours, an initial tour of the kitchen was conducted with the DSS. The emergency food supply was observed inside a room labeled Emergency Food Storage. Inspection of the room failed to show a thermometer inside the room. The DSS verified the above findings. The DSS was asked about the monitoring of the temperature inside the emergency food supply room and the DSS stated the emergency food supply was moved to the new dry storage location a week ago. The DSS stated the temperature inside the room was not being monitored. 7. According to the USDA Food Code 2022, 3-304.15 Gloves, Use Limitation, showed hands must be washed before donning gloves.Review of the facility's P&P titled Hand Hygiene revised 2/2025, showed hand hygiene is always the final step after removing and disposing of personal protective equipment.On 6/30/26 at 1005 hours, during the puree food preparation observation with Dietary Aide 1, the following were observed:- Dietary Aide 1 was observed wearing gloves while preparing the tamale pie puree. Dietary Aide 1 was observed removing the gloves and donning a new pair of gloves. Dietary Aide 1 was not observed washing his hands prior to donning the new pair of gloves; and- Dietary Aide 1 was observed wearing gloves while preparing the pureed carrots. Dietary Aide 1 was observed flipping through the recipe book, removing the glove in his right hand, scooping thickener powder from the bin, donning a new glove, and adding thickener to the pureed carrots. Dietary Aide 1 was not observed washing his hands prior to donning the new glove.On 6/30/26 at 1105 hours, an interview was conducted with Dietary Aide 1. Dietary Aide 1 stated after the removal of the gloves and prior to donning a new pair of gloves, the hands should be washed. Dietary Aide 1 verified he did not wash his hands in between glove use and prior to donning a new pair of gloves during puree preparation. 8. Review of the facility's P&P titled Refrigerators and Freezers revised 1/2026, showed the Supervisors or maintenance staff will inspect the refrigerators and freezers monthly for gasket condition, fan condition, presence of rust, excess condensation, and any other damage or maintenance needs. The refrigerators and freezers will be kept clean, free of (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	debris, and mopped with a sanitizing solution on a scheduled basis and more often as necessary. On 6/29/26 at 0800 hours, an initial tour of the kitchen was conducted with the DSS. The following were observed:- the fan inside of refrigerator A was observed with blackish, fussy substances. A paper towel was used to wipe the fan and blackish-brown residue was observed on the paper towel, and- the fans inside Refrigerator B were observed with blackish-grey substances. A paper towel was used to wipe the fan and blackish-grey fuzzy residue were observed on the paper towel. The DSS verified the above findings. The DSS stated the refrigerators should be clean and the cleaning of the fans inside the refrigerators should be part of the cleaning schedule. On 7/2/26 at 1330 hours, an interview was conducted with the Administrator, RD, and DSS. The Administrator, RD, and DSS were informed and acknowledged the above findings.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to implement the facility's infection prevention and control program in accordance with the facility's P&P for three of 34 final sampled residents (Residents 117,154, and 231). * The facility failed to ensure PT Assistant 1 had donned on the proper PPE (gown) during transfer from bed to wheelchair for Resident 117 on enhanced barrier precautions. * The facility failed to ensure LVN 8 observed proper hand hygiene during Resident 231's wound care treatment. * The facility failed to ensure facility staff did not keep/store personal belongings in the clean laundry room and no Sani-cloth disinfectant wipe containers being kept with the clean linen. * The facility failed to ensure Resident 154's urinary catheter drainage bag was not touching the floor. These failures placed the residents at risk for increased risk of infection and transmissions of diseases. Findings: Review of the facility's P&P titled Enhanced Barrier Precautions revised 1/2025 showed the facility has an established infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. - Enhanced Barrier Precautions (EBP): An infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. - Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. - EBP should be used for any residents who meet the above criteria, wherever they reside in the facility. - The staff will implement EBP for residents who are indicated when performing the following high-contact resident care activities: Dressing, bathing/showering, and transferring. 1. On 6/30/26 at 1007 hours, an observation was conducted for Resident 117 with PT Assistant 1. Resident 117's outside door had a posted sign for EBP. PT Assistant 1 was observed with bilateral gloves and was not using a gown. Resident 117 was observed lying in bed and PT Assistant 1 helped Resident 117 to sit on the edge of the bed. PT Assistant 1 bent and wrapped around his hand on Resident 117's back and transferred the resident from bed to wheelchair. Medical record review for Resident 117 was initiated on 6/29/26. Resident 117 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 117's H&P examination dated 6/22/26, showed Resident 117 did not have decision-making capacity. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 117's Order Summary Report showed a physician's order dated 6/22/26, for enhanced barrier precautions (EBP) due to the gastrostomy tube (GT) device use. On 6/30/26 at 1011 hours, an interview was conducted with PT Assistant 1. PT Assistant 1 verified that he did not use the proper PPE when he transferred Resident 117 from bed to wheelchair. PT Assistant 1 further stated that he should have used the gown to prevent potential transmission of infection. On 7/2/26 at 0837 hours, an interview was conducted with DON. The DON was asked about the protocol when a resident was placed on EBP. The DON stated that she expected staff to wear the proper PPE when providing care for the residents. The DON verified above findings. On 7/2/26 at 1416 hours, an interview was conducted with the Administrator and Assistant Administrator. The Administrator and Assistant Administrator were informed and acknowledged the above findings. 2. Review of the facility's P&P titled Hand Hygiene revised February 2025 showed hand hygiene is always the final step after removing and disposing of personal protective equipment. The use of gloves does not replace hand hygiene procedures. Medical record Review for Resident 231 was initiated on 6/29/26. Resident was admitted to the facility on [DATE]. Review of Resident 231's Order Summary Report dated 6/30/26, showed the following physician's orders dated 6/25/26: - To cleanse left buttock extended to left ischium, and to left posterior leg deep tissue injury with normal saline, pat dry, apply skin prep and leave open to air every day. - To cleanse left buttock Stage 3 pressure injury with normal saline, pat dry, apply skin prep to wound perimeter, apply calcium alginate (wound dressing used by transforming from fiber to gel upon contact with wound fluid) to wound bed, and cover with 4X4 foam boarder dressing every day shift. - To cleanse right buttock Stage 3 pressure injury with normal saline, pat dry, apply skin prep to wound perimeter, apply calcium alginate to wound bed, and cover with 4X4 foam boarder dressing every day shift. - To cleanse right buttock extended to right ischium, and to right posterior leg deep tissue injury with normal saline, pat dry, apply skin prep and leave open to air every day. On 7/1/26 at 1122 hours, a wound care treatment observation was conducted for Resident 231 with LVN 8. LVN 8 was observed to have kept some spare gloves in her pocket. LVN 8 cleansed Resident 231's wound on the right buttocks, removed the gloves, donned new pair of gloves from her pocket, and placed the calcium alginate and dry dressing to the wound. LVN 8 washed her hands in the sink and put on a new pair of gloves. LVN 8 cleansed Resident 231's wound on the left buttocks, removed (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the gloves, donned new pair of gloves from her pocket, and placed the calcium alginate and the dry dressing over the wound. On 7/1/26 at 1215 hours, an interview was conducted with LVN 8. LVN 8 verified she failed to do hand hygiene after cleansing Resident 231's wounds and after removing the soiled gloves, prior to donning new gloves. LVN 8 stated she was used to keeping the pairs of gloves on her pocket and should stop this practice. On 7/2/26 at 1006 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. On 7/1/26 at 0756 hours, an inspection of the facility's clean laundry room was conducted with Laundry Aides 1 and 2 and a concurrent interview with the Laundry Aides and Maintenance Director. The following was identified in the clean linen area: - Staff's personal cellphone was sitting on the clean linen folding table, with direct contact to the clean linen. - Staff's personal lunch bag and purse were hanging on a hook touching clean sorting gowns. - Staff's personal plastic drinking bottle was sitting on the clean linen folding table, with direct contact to the clean linen. - A container of Sani-Cloth disinfectant wipes was left on clean linen folding table, with direct contact to the clean linen. - Staff's personal plastic water bottle was on the table touching a pile of clean residents' clothing. - A container of Sani-Cloth disinfectant wipes was on the table touching a pile of clean residents' clothing. The Maintenance Director and Laundry Aides 1 and 2 verified the above findings and stated the personal belongings and disinfectant wipes should not be near or in direct contact with the clean residents' clothing and linen. 4. On 6/29/26 at 1304 hours, during the initial tour of the facility, Resident 154 was observed in bed. Resident 154 had a urinary catheter and the drainage bag was observed to had been placed at the side of the bed and touching the floor. Medical record review for Resident 154 was initiated on 6/29/26. Resident 154 was admitted to the facility on [DATE]. Review of Resident 154's Order Summary Report dated 7/1/26, showed the following physician's order for the indwelling catheter dated 6/1/26: (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- For catheter bag change every week on Friday and as needed, and - For an indwelling catheter care daily and as needed. On 6/30/26 at 1429 hours, an observation and concurrent interview with CNA 3 at Resident 154 bedside was conducted. CNA 3 verified Resident 154 had an indwelling urinary catheter. CNA 3 stated she measured the urine output from the catheter bag and recorded it. CNA 3 was asked about Resident 154's catheter drainage bag touching the floor. CNA 3 verified and acknowledged the catheter bag was not placed on a basin and was directly touching the floor. On 7/1/26 at 0859 hours, an interview and concurrent medical record review for Resident 154 was conducted with the ADON. The ADON was informed of the findings. The ADON verified and stated the catheter drainage bag should not be touching the floor for infection control practices. On 7/2/26 at 1416 hours, an interview and concurrent medical record review for Resident 154 was conducted with the DON. The DON stated the catheter drainage bag should not touch the floor. The DON was informed and verified the above findings.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to maintain the essential equipment in a safe operating conditions for one of 34 final sampled residents (Resident 231) and three nonsampled resident (Resident 52, 171, and 235). * The facility failed to ensure Resident 52 and 231's the oxygen concentrator filter was free of thick, dust like particles. This failure had the potential to negatively affect the residents' respiratory health. * LVNs 4 and 11 used the non-facility issued automatic BP machines to take Resident 171 and 235's BP reading. This failure had the potential for the residents to have inaccurate BP measurements. Findings: Review of the facility's P&P titled Storage Maintenance and Handling of Oxygen revised January 2026 showed ensure any cleaning repair, or filling of oxygen equipment is performed by qualified trained staff. 1. On 6/29/26 at 1133 hours, during the initial tour of the facility, Resident 52's oxygen concentrator was at bedside. The oxygen concentrator was observed with grayish dust like particles. Medical record review for Resident 52 was initiated on 6/22/26. Resident 52 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 52's H&P examination dated 1/20/26, showed Resident 52 had no capacity to understand and make decision. On 6/29/26 at 1531 hours, an observation of Resident 52's oxygen concentrator and concurrent interview was conducted with RN 3. RN 3 verified Resident 52's oxygen concentrator had grayish dust like particles. On 7/2/26 at 1022 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. On 6/29/26 at 1012 hours, during the initial tour of the facility, Resident 231's oxygen concentrator was at bedside. The oxygen concentrator was observed with grayish dust like particles. Medical record Review for Resident 231 was initiated on 6/29/26. Resident 231 was admitted to the facility on [DATE]. Review of Resident 231's Order Summary Report dated 6/30/26, showed a physician's order dated 6/24/26, to administer oxygen at a rate of 2-3 liters per minute via nasal cannula continuously. On 6/29/26 at 1516 hours, an observation of Resident 231's oxygen concentrator and concurrent interview was conducted with LVN 12. LVN 12 verified Resident 231's oxygen concentrator had grayish dust like particles. (continued on next page)		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/2/26 at 1023 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. Review of the facility P&P titled Maintenance Services &ndash; General dated 11/2025 showed the purpose of the policy is to ensure the facility maintains safe, functional, and sanitary physical conditions through a scheduled maintenance program that complies with federal, state, and life safety requirements. Further review of the policy showed to maintain all essential equipment, building systems, and structures in good repair. Review Blood Pressure Monitor Instruction Manual # TMB-1598-S (undated) showed under precaution This device is intended for indoor, home use . On 6/29/26 at 0926 hours, a medication administration observation for Resident 171 was conducted with LVN 4 inside Resident 171's room. Prior to administering the medications for Resident 171, LVN 4 obtained Resident 171's BP reading using a non-facility issued automatic wrist BP machine (TMB-1598-S). The first name of LVN 4 was observed written in black ink on the non-facility issued BP machine. LVN 4 stated Resident 171's BP reading was 138/58 mmHg and the heart rate was 60 beats per minute using the non-facility issued BP machine. On 6/29/26 at 1443 hours, an interview was conducted with LVN 4. LVN 4 stated the automatic wrist BP machine belonged to her and was brought from home. LVN 4 stated the automatic wrist BP machine was bought from a store. LVN 4 stated the maintenance had not checked the BP machine to make sure it was functioning properly. 4. On 6/30/26 at 0919 hours, a medication administration observation for Resident 235 was conducted with LVN 11 inside Resident 235's room. LVN 11 stated Resident 235's BP was checked using the automatic wrist BP machine (TMB-1598-S). However, LVN 11 did not remember what Resident 235's first set of BP readings was. LVN 11 was then observed checking Resident 235's second set of BP readings using an automatic arm BP machine (Blood Pressure Monitor Model No: C02). LVN 11 stated Resident 235's BP reading was 138/80 mmHg and the heart rate of 69 beats per minute. The first name of LVN 11 was observed labeled on the non-facility issued BP machines. On 6/30/26 at 0937 hours, an interview was conducted with LVN 11. LVN 11 stated the automatic wrist BP machine (TMB-1598-S) and automatic arm BP machine (Blood Pressure Monitor Model No: C02) belongs to her and was bought from the store. LVN 11 stated the maintenance had not checked the BP machine to make sure it was functioning properly. On 7/1/26 at 1002 hours, an interview was conducted with the DON. The DON stated the facility would provide medical equipment to assess the residents and keep them in the medication carts. The DON stated they told the staff to use the facility equipment. The DON further stated the staff should not be using personal equipment brought from home. On 7/2/26 at 1010 hours, a document review and concurrent interview was conducted with the DON. The DON verified the automatic wrist BP machine (TMB-1958-S) manual showed the device was intended for home use. (continued on next page)		

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

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/2/26 at 1108 hours, a follow-up interview was conducted with the DON. The DON stated the facility's resident care equipment was for industrial use and more accurate.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 34 final sampled resident (Resident 5) and one nonsampled resident (Resident 108) was assessed for safe self-administration of medications. * The facility failed to ensure Resident 5 was safe to administer the saline nasal spray (medication to relieve nasal congestion) medication found at bedside. * The facility failed to ensure Resident 108 was safe to administer the Salonpas Lidocaine Plus (a topical anesthetic to temporarily numb localized muscle, joint and nerve pain) roll on medication and maximum strength Neuropathy (manage tingling, burning and sharp nerve discomfort in your hands, feet and legs) cream found at bedside. These failures had the potential for Residents 5 and 108 to administer the medication inaccurately and negatively impact the health and safety of the residents. Findings: Review of the facility's P&P titled Self-Administration of Medication revised 1/2026 showed the interdisciplinary team supports the right of each resident to self-administer medications when this practice is clinically appropriate. A resident may only self-administer medication after the IDT has determined which medication may be self-administer. Medications self-administered by the resident and which the resident has been determined safe to be maintained at bedside, shall be stored in a locked container to maintain safety. 1. Medical record review for Resident 5 was initiated on 6/29/26. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE]. On 6/29/26 at 0841 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 5. Resident 5 was observed sitting in bed, and a bottle of saline nasal spray medication was observed on the resident's overbed table. Resident 5 stated the saline nasal spray was her medication and she would use the medication to spray her nose. Review of Resident 5's H&P examination dated 6/1/26, showed Resident 5 had the capacity to understand and make decisions. Review of Resident 5's Order Summary Report for 7/1/26, did not show a physician's order for the saline nasal spray. Further review of Resident 5's medical record failed to show a physician's order for Resident 5 to self-administer medications, and there was no documentation of an assessment for Resident 5 to safely self-administer the saline nasal spray. On 6/29/26 at 0851 hours, an observation, interview, and concurrent medical record review for Resident 5 was conducted with LVN 3. LVN 3 verified the saline nasal spray at Resident 5's overbed table. LVN 3 stated Resident 5 should have no medication at bedside, and other residents can get the saline nasal spray and can use the spray. LVN 3 further stated there was no physician's order for the nasal spray and for Resident 5 to self-administer the medication. 2. Medical record review for Resident 108 was initiated on 6/29/26. Resident 108 was admitted to the facility on [DATE]. On 6/29/26 at 0956 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 108. Resident 108 was observed sitting in her bed, a Salonpas Lidocaine Plus roll on medication and a jar of maximum strength Neuropathy cream was observed on the resident's overbed table. Resident 108 stated the Salonpas Lidocaine Plus roll on and maximum strength Neuropathy was her medication. Resident 108 further stated she would use the Salonpas and Neuropathy medications when she had pain. Review of Resident 108's H&P examination dated 6/12/26, showed Resident 108 had the capacity to understand and make decisions. Review of Resident 108's Order Summary Report did not show a physician's order for the Salonpas Lidocaine Plus roll on medication and maximum strength Neuropathy cream. Review of Resident 108's Plan of Care with the printed date of 7/1/26, did not show a care plan problem to address Resident 108's safe self-administration of the medications. Further review of Resident 108's medical record failed to show a physician's order for (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 108 to self-administer the Salonpas Lidocaine Plus roll on medication and a jar of maximum strength Neuropathy cream, and there was no documentation of an assessment for Resident 108 to safely self-administer medications. On 6/29/26 at 1010 hours, an observation, interview, and concurrent medical record review was conducted for Resident 108 with the DSD. The DSD verified the medication at bedside. The DSD stated Resident 108 should have no medication at the bedside, and other residents can get the medication and can use the medication. The DSD verified there was no physician's order for the Salonpas Lidocaine Plus roll on and maximum strength Neuropathy cream. The DSD verified there were no self-administration assessment and no care plan for the use of Salonpas Lidocaine Plus roll on and maximum strength Neuropathy medications. On 7/2/26 at 0837 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated an IDT needs to do a self-administration assessment for all the residents and the residents would need to demonstrate they were capable to self-administer their own medications. The DON verified Residents 5 and 108 had no physician's order, assessment, and care plan for the self-administration of any medications. On 7/2/26 at 1416 hours, an interview was conducted with the Administrator and Assistant administrator. The Administrator and Assistant Administrator were informed and acknowledged the above findings.		

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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** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the physician was informed of a change of condition for one or five final sampled residents (Resident 13) reviewed for nutrition. * The facility failed to notify Resident 13's physician and the resident's responsible party of the 9 lbs. (12.2%) weight loss from 2/3/26 to 3/4/26. This failure had the potential for Resident 13 to not receive the necessary care and treatment to manage the resident's weight loss and the resident's responsible party to not be aware of the resident's current condition. Findings: Review of the facility's P&P titled Notification of Changes revised 1/2026 showed the facility shall immediately or as soon as practicable, inform the resident, consult with the resident's physician, and notify, consistent with his or her authority, the resident representative(s) when there is: a. An accident involving the resident which results in injury and has the potential for requiring physician intervention. b. A significant change in the resident's physical, mental, or psychosocial status. c. A need to alter treatment significantly; and d. A decision to transfer or discharge the resident from the facility. The licensed personnel will provide timely, accurate, and standardized communication with the physician or licensed practitioner when a resident experiences a significant change in condition, using the SBAR (Situation-Background-Assessment-Recommendation) communication tool or documented equivalent in the nursing progress notes. Medical record review for Resident 13 was conducted on 6/28/26. Resident 13 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 13's MDS assessment dated [DATE], showed Resident 13 had severe impaired cognition. Review of Resident 13's Weights and Vitals Summary from 2/3/26 through 4/4/26, showed the following weights and comparisons:- dated 2/3/26, weight = 74 lbs.; - dated 3/4/26, weight = 65 lbs. (-9 lbs., a 12.2% severe weight loss in one month since 2/3/26); and- dated 4/4/26, weight = 62 lbs. Review of Resident 13's medical record failed to show documentation Resident 13's physician or responsible party were informed of Resident 13's current weight of 65 lbs. and weight loss of 9 lbs. On 7/1/26 at 1006 hours, an interview and concurrent medical record review for Resident 13 was conducted with LVN 4. LVN 4 stated for the weight variance of five pounds weight loss in a week or 5% weight loss in a month, the physician would be informed, an SBAR would be initiated to address the change in resident's condition, and the resident would be monitored. When asked about Resident 13's documented weight loss on 3/4/26, LVN 4 reviewed Resident 13's medical record and stated there was no documentation if the resident's physician or responsible party were informed of the 9 lbs. (12.2%) weight loss from 2/3/26 to 3/4/26. On 7/2/26 at 0913 hours, an interview was conducted with the DON. The DON stated a weight loss of more than 10% in one month was considered a severe weight loss. The DON stated the licensed nurse should compare the most recent weight with the previous weight to determine if there was a significant weight variance and if there was a weight variance noted, the nurse should inform the physician and family and initiate an SBAR for monitoring. On 7/2/26 at 1420 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. Cross Reference to F692.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive care plan was developed to reflect the individual care needs for two of 34 final sampled residents (Residents 106 and 144). * The facility failed to ensure care plan was developed for Resident 106's use of the CPAP machine. * The facility failed to ensure a care plan was developed to address Resident 144's difficulty in hearing. These failures posed the risk of not providing the residents with the appropriate, consistent, and individualized care. Findings: Review of the facility P&P titled Develop-implement Comprehensive Care Plans revised 1/2026 showed the facility develops a person-centered comprehensive care plan that is culturally competent and trauma-informed, developed and implemented to meet each resident's preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. Each resident will have a person-centered comprehensive care plan developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs with seven days after the completion of the comprehensive assessment. 1. On 6/29/26 at 0825 hours, during the initial tour, Resident 144 was observed in bed. Resident 144 was spoken to and unable to hear. Resident 144 was spoken to by talking close to the resident's ear. Resident 144 stated she lost her hearing aid in the facility. Medical record review for Resident 144 was initiated on 6/29/26. Resident 144 was admitted to the facility on [DATE]. Review of Resident 144's MDS assessment dated [DATE], showed Resident 144's hearing was adequate with the use of the hearing aid. Resident 144's BIMS score was 14 which indicated the resident was cognitively intact. Review of Resident 144's Care Plan Report failed to show a care plan was developed to address Resident 144's difficulty in hearing or the use and care of Resident 144's hearing aid. On 7/1/26 at 0900 hours, a follow-up observation and concurrent interview was conducted with Resident 144. Resident 144 was in the room lying in bed. Resident 144 had difficulty in communicating. Words were repeated to Resident 144 three to four times and was spoken to very close to the resident's ear. Resident 144 had no alternative means of communication in the room. Resident 144 stated she felt frustrated because she lost her hearing aid and was not able to hear. On 7/1/26 at 0904 hours, an interview was conducted with CNA 2. CNA 2 stated Resident 144 was admitted with hearing aid and was able to communicate well with the use of the hearing aid. CNA 2 stated Resident 144 had hard time hearing now because she had lost her hearing aide. CNA 2 further stated you would need to talk close to her ears. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/1/26 at 0914 hours, an interview was conducted with Social Services Coordinator 3. Social Services Coordinator 3 stated Resident 144's hearing aid was lost between 6/14/26 & 6/16/26. Social Services Coordinator 3 verified there was no plan of care developed on how to communicate with Resident 144 effectively. On 7/1/26 at 1436 hours, an interview and concurrent record review for Resident 144 was conducted with LVN 13. LVN 13 verified Resident 144 had difficulty with hearing. LVN 13 verified Resident 144's Care Plan Report failed to show a care plan was developed to address the use and care of resident's hearing aid, or difficulty in hearing without the use of hearing aid. On 7/2/26 at 1039 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings as above. Cross reference to F685. 2. Medical record review for Resident 106 was initiated on 6/30/25. Resident 106 was admitted to the facility on [DATE]. Review of Resident 106's H&P examination dated 6/22/26, showed Resident 106 had the capacity to understand and make decisions. Review of Resident 106's Order Summary Report showed a physician's order dated 6/25/26, for CPAP continuously at NOC (bedtime) and PRN for respiratory distress. Review of Resident 106's Care Plan Report did not show if the care plan problem and interventions were developed to address Resident 106's use of the CPAP machine. On 7/1/26 at 0830 hours, an interview and concurrent medical record review for Resident 106 was conducted with the ADON. The ADON was asked about the care plan for Resident 106's use of the CPAP machine. The ADON verified there was no care plan for the use of Resident 106's CPAP machine. On 7/2/26 at 1416 hours, an interview and concurrent medical record review for Resident 106 was conducted with the DON. The DON was informed and verified the above findings. Cross reference to F 695, example # 9.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive person-centered care plan was revised to reflect the residents' current care needs and interventions for two of 34 final sampled residents (Residents 3 and 154). * The facility failed to ensure Resident 3's care plan interventions for the use of the pain medications was revised to include the nonpharmacological interventions as per physician's order. * The facility failed to ensure Resident 154's care plan for the risk for fall was revised to include the use of the pad alarm in bed as per the physician's order. These failures posed the risk for the residents to not receive individualized and person-centered care in accordance with their assessed needs. Findings: Review of the facility's P&P titled Develop-Implement Comprehensive Care Plans revised 1/2026 showed the care plans must be person-centered and reflect the resident's goals for admission and desired outcomes, interventions that reflect the resident's cultural preferences, values, and practices. The interdisciplinary team, including the physician, a registered nurse, the resident or the resident's representative and other staff determined by the resident's needs will develop the care plan with corresponding interventions for care that are in accordance with professional standards of practice and accounting for residents' experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident. 1. Medical record review for Resident 3 was initiated on 7/1/26. Resident 3 was readmitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 2/13/26, showed Resident 3 had capacity to understand and make decisions. Review of Resident 3's Order Summary Report showed the following physician's orders: - dated 12/20/23, acetaminophen (pain reliever): nonpharmacological approach attempted prior to administration of pain medication- (1) repositioning; (2) dim light/quiet environment; (3) hot/cold application; (4) relaxation techniques; (5) distraction; (6) music; (7) other every shift; - dated 12/20/23, hydrocodone-acetaminophen (pain reliever): nonpharmacological approach attempted prior to administration of pain medication- (1) repositioning; (2) dim light/quiet environment; (3) hot/cold application; (4) relaxation techniques; (5) distraction; (6) music; (7) other every shift; - dated 12/29/25, morphine sulfate (pain reliever): nonpharmacological approach attempted prior to administration of pain medication- (1) repositioning; (2) dim light/quiet environment; (3) hot/cold application; (4) relaxation techniques; (5) distraction; (6) music; (7) other every shift; and (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 12/20/23, tramadol(pain reliever): nonpharmacological approach attempted prior to administration of pain medication- (1) repositioning; (2) dim light/quiet environment; (3) hot/cold application; (4) relaxation techniques; (5) distraction; (6) music; (7) other every shift; Review of Resident 3's care plan showed the care plan problem to address the following: - the resident's use of Norco (hydrocodone) medication for pain management revised on 8/4/25, did not include the physician's ordered nonpharmacological approach as interventions; - resident's risk for pain related to fibromyalgia revised on 8/4/25, included to administer analgesia as per orders but did not include the physician ordered nonpharmacological approach as interventions; and - the resident's use of the morphine sulfate medication for pain management revised on 2/6/26, did not include the physician's ordered nonpharmacological approach as interventions. On 7/1/26 at 1455 hours, an interview and concurrent medical record review for Resident 3 was conducted with the ADON. The ADON verified the above findings for Residents 3. The ADON stated the care plans should reflect all the interventions including the nonpharmacological interventions being provided to the resident per the physician's order. On 7/2/26 at 1339 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 3. 2. On 6/29/26 at 1304 hours, during the initial tour of the facility, Resident 154 was observed in bed with the pad alarm in placed in bed. Medical record review for Resident 154 was initiated on 6/29/26. Resident 154 was admitted to the facility on [DATE]. Review of Resident 154's H&P examination dated 6/3/26, showed Resident 154 had no capacity to understand and make decision. Review of Resident 154's Fall Risk Evaluation dated 6/1/26, showed Resident 154 was high risk for falls. Review of Resident 154's Order Summary Report dated 7/1/26, showed a physician's order dated 6/6/26, for a pad alarm when in bed to alert the staff when the resident attempts to get up from the bed unassisted, poor safety awareness, and increase fall risk. Review of Resident 154's plan of care showed a care plan problem dated 6/2/26, addressing Resident 154's risk for fall. However, the care plan interventions failed to show the use of pad alarm in bed as ordered was included. On 6/30/26 at 1429 hours, an observation and concurrent interview with CNA 3 at Resident 154's (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bedside. CNA 3 was asked about Resident 154's pad alarm placed in bed. CNA 3 verified Resident 154's use of the bed alarm because the resident getting up unassisted from the bed. On 7/1/26 at 1423 hours, an interview and concurrent medical record review for Resident 154 was conducted with the ADON. The ADON verified the physician order for the pad alarm in bed for unassisted getting out of bed and for safety. The ADON verified Resident 154 was a high risk for fall. The ADON was asked for the care plan for fall and was able to show the care plan for fall dated 6/2/26. The ADON verified the pad alarm was not included on the interventions for fall. On 7/2/26 at 1416 hours, an interview and concurrent medical record review for Resident 154 was conducted with the DON. The DON was informed and verified the above findings.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one of 34 final sampled resident (Resident 144) was provided with proper care to maintain resident's ability to hear. * The facility failed to ensure Resident 144's had no difficulty in communication when the hearing aide got lost in the facility. This failure had caused the resident difficulty in communication and potentially cause not to meet her needs and psychosocial harm. Findings: 1. On 6/29/26 at 0825 hours, during the initial tour, Resident 144 was observed in bed. Resident was observed unable to hear. Resident was spoken to by talking close to the resident's ear. Resident stated she had lost her hearing aid in the facility. Medical record review for Resident 144 was initiated on 6/29/26. Resident 144 was admitted to the facility on [DATE]. Review of Resident 144's MDS assessment dated [DATE], showed the resident's hearing was adequate with the use of the hearing aid. Resident's BIMS score was 14, which indicates resident was cognitively intact and functioning normally. Review of Resident 144's Care Plan Report failed to show a care plan was developed to address the resident's difficulty in hearing or use and care of the resident's hearing aid. On 7/1/26 at 0900 hours, an observation and a concurrent interview was conducted with Resident 144. Resident was in the room lying in bed. Resident had difficulty in communicating. Words were repeated to the resident three to four times and was spoken to very close to the resident's ear. Resident had no alternative communication in the room. Resident 144 stated she felt frustrated because she had lost her hearing aid and was not able to hear. On 7/1/26 at 0904 hours, an interview was conducted with CNA 2. CNA 2 stated Resident 144 was admitted with hearing aid and was able to communicate well with the use of the hearing aid. CNA 2 stated the resident had hard time hearing now because she had lost her hearing aide, and need to talk close to her ears. On 7/1/26 at 0914 hours, an interview was conducted with Social Services Coordinator 3. Social Services Coordinator 3 stated the resident's hearing aid was lost between 6/14/26 - 6/16/26. Social Services Coordinator 3 verified there was no plan of care developed to communicate with the resident effectively. Social Services Coordinator 3 stated he spoke with the resident's representative and was informed the facility will reimburse the resident with the lost of the hearing aid on 6/30/26. On 7/1/26 at 1436 hours, a concurrent record review for Resident 144 and an interview was conducted with LVN 13. LVN 13 verified resident had difficulty with hearing. On 7/2/26 at 1039 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings as above. Cross reference F656.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care was provided to prevent the development of pressure injuries for one of two final sampled residents (Resident 231) reviewed for pressure ulcer/ injury. * The facility failed to ensure the LVN (LVN 8) assessed Resident 231's pain prior providing the wound care treatment. This failure had the potential for not providing the necessary care and services and effectively managing the resident's needs. Findings: 1. Review of the facility's P&P titled Treatment Services to Prevent/ Heal Pressure Ulcers dated January 2025 showed the assessment and treatment of a resident's pain are integral components of pressure ulcer or pressure injury prevention and management. Pain that interferes with movement and/or affects mood may contribute to immobility and contribute to the potential for developing or for delayed healing or non-healing of an already existing pressure ulcer or pressure injury. Medical record review for Resident 231 was initiated on 6/29/26. Resident 231 was admitted to the facility on [DATE]. Review of Resident 231's Order Summary Report dated 6/30/26, showed the following physician's orders dated 6/25/26:- To assess pain for treatment process: First- Pretreatment; Second- During treatment; and Third- After treatment every day shift. - To cleanse left buttock extended to left ischium, and to the left posterior leg deep tissue injury with normal saline, pat dry, apply skin prep and leave open to air every day. - To cleanse left buttock Stage 3 pressure injury with normal saline, pat dry, apply skin prep to wound perimeter, apply calcium alginate to wound bed, and cover with 4X4 foam boarder dressing every day shift. - To cleanse right buttock Stage 3 pressure injury with normal saline, pat dry, apply skin prep to wound perimeter, apply calcium alginate to wound bed, and cover with 4X4 foam boarder dressing every day shift. - To cleanse right buttock extended to right ischium and to right posterior leg deep tissue injury with normal saline, pat dry, apply skin prep and leave open to air every day. Review of Resident 231's Care Plan Report dated 6/26/26, showed a care problem for deep tissue injury on left ischium and right inner buttock with an intervention for pain management/medication as ordered. On 7/1/26 at 1122 hours, a wound care treatment observation was conducted for Resident 231 with LVN 8. LVN 8 failed to assess Resident 231 for pain prior initiating the wound care treatment. In the middle of wound care, Resident 231 complained of pain. LVN 8 assessed for pain level, and Resident 231 responded the pain was at scale of 7 (0:no pain, 1-3 mild as noticeable but manageable; 4-6 moderate as harder to ignore; and 7-10 severe or dominates one's attention). On 7/1/26 at 1215 hours, an interview was conducted with LVN 8. LVN 8 verified she failed to assess Resident 231's pain prior to initiating the wound care treatment. LVN 8 verified she should have assessed Resident 231's pain prior wound care treatment to medicate the resident if needed for comfort. On 7/2/26 at 1006 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and P&P review, the facility failed to ensure one of five final sampled residents (Resident 13), reviewed for nutrition, received the appropriate services needed to maintain acceptable parameters of nutritional status. * The facility failed to ensure an effective monitoring of acceptable parameters of nutritional status were implemented through systematic approach when Resident 13 experienced severe weight loss. The severe weight loss of nine lbs. in one month was not assessed and monitored timely as per the facility's P&P. In addition, the facility failed to ensure the physician was notified of Resident 13's severe weight loss and poor PO (per oreum or by mouth) intake and failed to ensure Resident 13 received the hashbrowns for her morning breakfast meal. These failures had the potential for adverse nutritional outcomes and to negatively affect Resident 13's well-being. Findings: A professional reference review of the National Library of Medicine titled, An approach to the management of unintentional weight loss in elderly people dated 3/15/05, showed in part, Unintentional weight loss, or the involuntary decline in total body weight over time, is common among elderly people who live at home. Weight loss in elderly people can have a deleterious effect on the ability to function and on quality of life and is associated with an increase in mortality over a 12-month period. Unintentional weight loss is the involuntary decline in total body weight over time. In clinical practice, it is encountered in up to 8% of all adult outpatients and 27% of frail people 65 years and older. Weight loss is an important risk factor in elderly patients. It is associated with increased mortality, which can range from 9% to as high as 38% within 1 to 2.5 years after weight loss has occurred. Weight loss of 4%-5% or more of body weight within 1 year, or 10% or more over 5-10 years or longer, is associated with increased mortality or morbidity or both. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC552892/ Review of the facility's P&P titled Weight Management revised 1/2026 showed the facility strives to maintain acceptable parameters of nutritional status unless the resident's clinical condition demonstrates that this is not possible; to provide a therapeutic diet for residents with nutritional problems. The weights will be recorded monthly unless ordered more or less frequently by the physician or upon the discretion of the IDT. The weight management committee will meet weekly and residents with nutritional and/or weight concerns are evaluated during the meeting. The criteria for a resident to be reviewed may include, but is not limited to:- Residents who have a sudden change in nutritional intake and are at risk for significant weight loss or exhibit gradual weight loss/gain.- Residents who have lost or gained five lbs. since the last recorded weight.- Residents who have lost or gained >5% of their body weight in the last month. The committee shall document in the clinical record the review and subsequent recommendations. Review of the facility's P&P titled Notification of Changes revised 1/2026 showed the facility shall immediately or as soon as practicable, inform the resident, consult with the resident's physician, and notify, consistent with his or her authority, the resident representative(s) when there is:- An accident involving the resident which results in injury and has the potential for requiring physician intervention.- A significant change in the resident's physical, mental, or psychosocial status.- A need to alter treatment significantly; and- A decision to transfer or discharge the resident from the facility. The licensed personnel will provide timely, accurate, and standardized communication with the physician or licensed practitioner when a resident experiences a significant change in condition, using the SBAR (Situation-Background-Assessment-Recommendation) communication tool or documented equivalent in the nursing progress notes. Medical record review (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for Resident 13 was conducted on 6/28/26. Resident 13 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 13's MDS assessment dated [DATE], showed Resident 13 had severely impaired cognition. a. Review of Resident 13's Weights and Vitals Summary from 2/3/26 through 4/4/26, showed the following weights comparisons for Resident 13:- On 9/3/25, weighed 77 lbs.;- On 12/5/25, weighed 75 lbs.;- On 2/3/26, weighed 74 lbs.; and- On 3/4/26, weighed 65 lbs., a weight loss of nine lbs., a 12.2% severe weight loss in one month since 2/3/26; a weight loss of 10 lbs., a 13.3% severe weight loss in three months since 12/5/25, and a weight loss of 12 lbs., a 15.6% weight loss in six months since 9/3/25. Review of Resident 13's medical records failed to show documentation of the physician and Resident 13's responsible party being informed of Resident 13's weight of 65 lbs. and the resident's weight loss of nine lbs., 12.2% in one month, 13.3% weight loss in three months, and 15.6% weight loss in six months. Additionally, Resident 13's medical record failed to show documentation the weight management committee meeting to discuss Resident 13's weight loss until 4/13/26. On 7/1/26 at 0902 hours, an interview was conducted with RNA 1. RNA 1 stated the RNAs were responsible for obtaining the residents' weights for new admissions, weekly weights, and monthly weights. RNA 1 stated the weights were entered into PCC (Point Click Care, an electronic health record system). RNA 1 stated for any weight loss or gain of five lbs. in one week or month, the RNA should report to the licensed nurse. On 7/1/26 at 1006 hours, an interview and concurrent medical record review for Resident 13 was conducted with LVN 4. LVN 4 stated for the weight variance of five- pounds weight loss in a week or 5% weight loss in a month, the physician would be informed, an SBAR (Situation/Background/Assessment/Recommendation, a communication tool) would be initiated to address the change in condition and the resident would be monitored. When asked about Resident 13's documented weight loss on 3/4/26, LVN 4 reviewed Resident 13's medical record and stated there was no documentation the physician or responsible party were informed of Resident 13's nine lbs. or 12.2% weight loss from 2/3/26 to 3/4/26. b. Review of Resident 13's Documentation Survey Report for February 2026, showed the following documentation of Resident 13's meal intake and amount:- Dated 2/26/26, for the lunch meal: Resident 13 ate 26-50% of the meal, an alternative meal was not offered,- Dated 2/26/26, for the dinner meal: Resident 13 ate 26-50% of the meal, an alternative meal was offered,- Dated 2/27/26, for the breakfast meal: Resident 13 ate 26-50% of the meal, an alternative meal was not offered, and- Dated 2/27/26, for the lunch meal: Resident 13 ate 0-25% of the meal, an alternative meal was not offered. Review of Resident 13's Licensed Nurse Weekly Summary dated 3/4/26, showed the licensed nurse documented no nutritional concerns within the last week (from 2/25/26 to 3/4/26). Further review of Resident 13's medical records failed to show any documentation to address Resident 13's poor PO intake of 50% or less for the above dates and failed to show the documentation of the physician and Resident 13's responsible party being informed of Resident 13's poor PO intake. On 6/30/26 at 1416 hours, an interview was conducted with CNA 1. CNA 1 stated Resident 13 tried to feed herself; however, the resident required staff assistance when eating. CNA 1 stated if Resident 13 ate less than 50% of the meal, the resident would be offered alternatives or substitutes and to notify the licensed nurse. On 7/1/26 at 1335 hours, an interview was conducted with LVN 4. LVN 4 stated when a resident had poor PO intake, the resident would be encouraged to eat more and offered snacks and alternatives as tolerated. LVN 4 stated if the resident had frequent episodes of poor PO intake of 50% or less, for three meals, the physician would be informed and a Change in Condition evaluation would be completed to monitor the resident. On 7/2/26 at 1415 hours, an interview and concurrent medical record review for Resident 13 was conducted with the DON. The DON stated if the resident had poor PO intake of less than 50%, for three consecutive meals, the licensed nurse should inform the physician and initiate an SBAR so the (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident could be monitored. The DON reviewed Resident 13's medical record and verified the above findings. c. Review of Resident 13's Nutritional Assessment/Evaluation by the RD dated 3/2/26, showed the following documentation:- Resident 13 weighed 74 lbs. on 2/3/26, with the usual body weight (UBW) of 73 to 78 lbs. (over 1.5 years), the goal weight was 75 to 80 lbs.;- No significant weight change;- The nutritional goals showed to maintain weight more than or equal to 74 lbs. with the possible gain to 80 lbs.;- The nutritional interventions showed the RD spoke with the physician with orders to add multivitamins and minerals and change the diet to fortified- no added salt. The RD documented will continue to monitor: monthly weights for changes, laboratories as available, and skin. Review of Resident 13's Dietary/Nutritional Progress Notes dated 3/27/26, showed the following documentation by the RD:- Resident 13's current weight of 65 lbs. as of 3/4/26, with a nine lbs (12%) weight loss in a month and 12 lbs. (16%) weight loss in six months.- Resident 13's intake was 25 to 100%, often 50-75%, and fed by staff.- Resident 13 was on Remeron (antidepressant medication) to stimulate appetite, on medication for hypertension (high blood pressure) which can cause diuresis (process in which the kidneys filter excess fluid from the blood to produce extra urine).- Resident 13 had a urinary tract infection with antibiotic treatment on 2/2026 may have impacted appetite.- Will try offering Boost VHC (very high calorie) again and monitor acceptance. Also recommended to have laboratories checked and to assess status and weekly weights for four weeks. Review of Resident 13's IDT Progress Notes-Weight Variance and Nutritional condition dated 4/13/26, showed documentation by the IDT having met to discuss Resident 13's weight variance. On 7/1/26 at 1345 hours, an interview and concurrent medical record review for Resident 13 was conducted with the RD. The RD stated at the beginning of each month she printed the monthly weights to identify the residents with weight variances in one-, three-, and six-month intervals. The RD stated upon review of the weights and the identification of the residents with weight variances, she would conduct a nutritional assessment/evaluation for the identified residents. The RD further stated if there was a physician's order for an RD evaluation, she would assess the resident within one to two days. The RD reviewed Resident 13's medical record and stated she had identified Resident 13's with nine lbs. (12%) weight loss when she printed the monthly weights at the beginning of March and had placed the resident on her list of residents to review. The RD verified she did not assess/evaluate Resident 13 until 3/27/26 and requested for an IDT meeting to discuss the resident's weight variance but was not done until 4/13/26. When asked, the RD agreed the residents with significant weight variances should be assessed and evaluated as soon as possible to address the weight loss and determine the appropriate interventions to prevent further weight loss. The RD further stated if there was a physician's order for an RD evaluation, she would have prioritized the resident's nutritional evaluation sooner. On 7/2/26 at 0913 hours, an interview was conducted with the DON. The DON stated a weight loss of more than 10% in one month was considered a severe weight loss. The DON stated the RD was responsible for reviewing the resident's monthly weights and checking for any weight variances. Additionally, the DON stated the licensed nurses when completing the licensed nurses' weekly summary, should review the residents' weights to determine if there were any weight variances. The DON stated the licensed nurse should compare the most recent weight with the previous weight to determine if there was a significant weight variance. The DON stated if there was a weight variance noted, the nurse should inform the physician and resident representative and initiate an SBAR for monitoring. d. Review of Resident 13's Order Summary Report dated 7/1/26, showed a physician's order dated 3/2/26, to provide Resident 13 with a fortified, no added salt (NAS), soft and bite-sized texture diet. Resident 13 was approved for regular bread and dessert. On 7/1/26 at 0829 hours, a breakfast meal observation and concurrent interview was conducted with CNA 1. Resident 13 was (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed in bed with the head of bed elevated. CNA 1 was observed assisting Resident 13 with her breakfast meal. Resident 13 was observed with the following items on her breakfast tray: two slices of bread, scrambled eggs, a bowl of oatmeal cereal, a cup of milk, a cup of cranberry juice, and a carton of Boost (nutritional supplement). Review of Resident 13's breakfast meal ticket showed the following items listed for Resident 13's breakfast meal: cranberry juice, super cereal, breakfast sandwich, hashbrowns, whole milk, coffee, and Boost. However, Resident 13's tray did not include hashbrowns. CNA 1 verified Resident 13's breakfast tray did not have the hashbrowns. On 7/1/26 at 0833 hours, an interview and concurrent observation was conducted with LVN 14. LVN 14 reviewed Resident 13's meal ticket and breakfast tray and verified the above findings and stated he would inform the kitchen. LVN 14 stated the resident should have the hashbrown on her tray for breakfast. On 7/2/26 at 1420 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. Cross reference to F580.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to provide the necessary care and services to maintain the IV accesses for two of two final sampled resident (Residents 37 and 224) reviewed for IV therapy consistent with professional standards of practice. * The facility failed to ensure Resident 37's PICC line was monitored accurately when the facility failed to measure IV line on insertion site and arm circumference as ordered.* The facility failed to ensure Resident 224's peripheral IV was correctly labeled and dated. These failures posed the risk for Resident 37 and 224 to develop complications related to the IV therapy. Findings: 1. On 6/29/26 at 1035 hours, during the initial tour, Resident 37 was observed with PICC line catheter inserted on her left upper arm with a dressing dated 6/25/26. Medical record review for Resident 37 was initiated on 6/29/26. Resident 37 was admitted to the facility on [DATE]. Review of Resident 37's PICC insertion record showed the PICC line was inserted on 6/17/26. Review of Resident 37's Order Summary Report showed the following physician's orders dated: -6/17/26, for measurement if IV lines from insertion site on admission/after dressing change, and arm circumference (in inches) every night shift every 7 days. Review of Resident 37's IV MARs for June 2026 showed no documented evidence of the nurse' initials on 6/23/26, evening shift for Resident 37's IV line from insertion site and arm circumference. Further review of Resident 37's medical record failed to show any documentation of measurement resident's IV line from insertion site and arm circumference on 6/23/26 was completed. On 6/30/26 at 1419 hours, an interview and concurrent record review for Resident 37 was conducted with RN 2. RN 2 verified the physician's order and MAR as above. RN 2 stated the IV PICC line should have been measured on 6/23/26, to make sure the IV site was in place. RN 2 verified the resident's medical record failed to show a measurement was completed on 6/23/26. On 7/2/26 at 1016 hours, an interview was conducted with the DON. The DON stated the expectation was for the assigned RN to complete the measurement of the central line and document weekly. 2. During the initial tour of the facility on 6/29/26 at 0812 hours, an observation was conducted for Resident 224. Resident 224 was lying in bed, and observed left hand with peripheral IV with no date (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and label when it was inserted. Medical record review for Resident 224 was initiated on 6/29/26. Resident 224 was admitted to the facility on [DATE]. Review of Resident 224's H&P examination dated 6/25/26, showed Resident 224 has limited decision-making capacity. Review of Resident 224's Order Summary Report failed to show a physician's order for use of peripheral IV. On 6/29/26 at 0828 hours, an observation and interview for Resident 224 was conducted with DSD. The DSD verified the above findings. The DSD stated the licensed nurse who inserted the IV needed to label the dressing with the date and initial. The DSD further stated when the peripheral IV was no longer needed, then to discontinue the peripheral IV to prevent infection. On 7/2/26 at 0837 hours, an interview was conducted with the DON. The DON verified the above findings. The DON stated that licensed nurse who inserted the peripheral line was expected to label the dressing with the date and initial. On 7/2/26 at 1416 hours, an interview was conducted with the Administrator and Assistant Administrator. The Administrator and Assistant Administrator were informed and acknowledged the above findings.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review and facility P&P review, the facility failed to provide the necessary pain management care and services for three of five residents (Residents 3, 6, and 69) reviewed for unnecessary medications. * The facility failed to ensure the nonpharmacological interventions were provided and documented prior to administering the pain medications to Residents 3, 6 and 69. These failures posed the risk for the residents to receive unnecessary pain medications and negatively affect the residents' well-being. Findings: Review of the facility's P&P titled Pain Assessment and Management revised 1/2025 under the Strategies for Pain Management section showed developing and implementing both non-pharmacological and pharmacological interventions/approaches to pain management, depending on factors such as whether the pain is episodic, continuous, or both. Under the Use of Opioids for Pain Management section, showed the physician considers alternative pain management approaches related to increasing opioid addiction, abuse, and overdoses prescribers should use caution when prescribing opioids, and consider using alternative pain management approaches, when appropriate. Under the Non-Pharmacological Interventions section showed:- Physical activity and exercise can be an effective part of treatment programs for chronic pain;- Activity can be supported by conventional physical therapy and exercise approaches, or by a wide range of movement therapies including independent and group exercise activities;- Some non-pharmacologic interventions may need to be ordered by the provider while others can be provided by facility staff during routine care; and- Examples of non-pharmacological interventions may include, but are not limited to:a. Altering the environment for comfort (such as adjusting room temperature, tightening and smoothing linens, using pressure redistributing mattress and positioning, comfortable seating, and assistive devices);b. Physical modalities, such as ice packs or cold compresses (to reduce swelling and lessen sensation), mid heat (to decrease joint stiffness and increase blood flow to an area), neutral body alignment and repositioning, baths, transcutaneous electrical nerve stimulation (TENS), massage, acupuncture/acupressure, chiropractic, or rehabilitation therapy;c. Exercises to address stiffness and prevent contractures as well as restorative nursing programs to maintain joint mobility; andd. Cognitive/Behavioral interventions (e.g., relaxation techniques, reminiscing, diversions, activities, music therapy, offering spiritual support and comfort, as well as teaching the resident coping techniques and education about pain). 1. Medical record review for Resident 3 was initiated on 7/1/26. Resident 3 was readmitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 2/13/26, showed Resident 3 had no capacity to understand and make decisions. Review of Resident 3's Order Summary Report showed the following physician's orders:- dated 12/20/23, hydrocodone-acetaminophen (pain reliever): Nonpharmacological approach attempted prior to administration of pain medication: (1) repositioning; (2) dim light/quiet environment; (3) hot/cold application; (4) relaxation techniques; (5) distraction; (6) music; (7) other, every shift; and- dated 4/1/26, to administer hydrocodone-acetaminophen oral 5-325 mg (hydrocodone-acetaminophen) one tablet by mouth two times a day for pain management not to exceed three grams of acetaminophen/24hrs from all sources. Review of Resident 3's MAR for June 2026 showed Resident 3 was administered with hydrocodone-acetaminophen medication on the following dates and times:- 6/11/26 at 2100 hours, for pain level of 7 (in a 0-10 scale, 0=no pain and 10-worst pain);- 6/13/26 at 0900 hours, for pain level of 9;- 6/14/26 at 0900 hours, for pain level of 6, and 2100 hours, for pain level of 9;- 6/15/26 at 2100 hours, for pain level of 7;- 6/17/26 at 2100 hours, for pain level of 7;- 6/22/26 at 2100 hours, for pain level of 6; and- 6/29/26 at 2100 hours, for pain (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	level of 5. Further review of Resident 3's medical records failed to show documented evidence the nonpharmacological interventions were provided prior to the administration of hydrocodone-acetaminophen medication to Resident 3 on the dates and times above. 2. Medical record review for Resident 6 was initiated on 7/1/26. Resident 6 was readmitted to the facility on [DATE]. Review of Resident 6's H&P examination dated 9/24/25, showed Resident 6 had no capacity to understand and make decisions. Review of Resident 6's Order Summary Report showed the following physician's orders:- dated 3/14/26, to administer hydrocodone-acetaminophen 5-325 mg two tablets by mouth every six hours as needed for severe pain (8-10):- dated 3/14/26, for acetaminophen/hydrocodone: Nonpharmacological approach attempted prior to administration of pain medication: (1) repositioning; (2) dim light/quiet environment; (3) hot/cold application; (4) relaxation techniques; (5) distraction; (6) music; (7) other, every shift; and Review of Resident 6's MAR for June 2026 showed Resident 6 was administered with hydrocodone-acetaminophen medication two tablets on the following dates and times:- 6/14/26 at 1234 hours, for pain level of 8;- 6/26/26 at 1449 hours, for pain level of 8; and- 6/28/26 at 0849 hours, for pain level of 8. Further review of Resident 6's medical records failed to show documented evidence the nonpharmacological interventions were provided prior to the administration of hydrocodone-acetaminophen medication on the dates and times above. 3. Medical record review for Resident 69 was initiated on 7/1/26. Resident 69 was readmitted to the facility on [DATE]. Review of Resident 69's H&P examination dated 6/5/25, showed Resident 69 had the capacity to make decisions. Review of Resident 69's Order Summary Report showed the following physician's orders:- dated 12/20/23, for Percocet (pain reliever): Nonpharmacological approach attempted prior to administration of pain medication: (1) repositioning; (2) dim light/quiet environment; (3) hot/cold application; (4) relaxation techniques; (5) distraction; (6) music; (7) other, every shift;- dated 12/20/23, for Tramadol (pain reliever): Nonpharmacological approach attempted prior to administration of pain medication: (1) repositioning; (2) dim light/quiet environment; (3) hot/cold application; (4) relaxation techniques; (5) distraction; (6) music; (7) other, every shift;- dated 11/11/24, to administer Percocet 10-325 mg two tablets by mouth three times a day for pain management not to exceed three grams of acetaminophen/24hrs from all sources. Hold if RR (respiratory rate) is less than 12 and notify the physician; scheduling at 0830 hours, 1430 hours, and 2030 hours; and- dated 3/2/25, to administer Tramadol Hydrochloride 50 mg one tablet by mouth three times a day for pain management. Hold if RR is less than 12 and notify the physician; scheduling at 0930 hours, 1530 hours, and 2130 hours. Review of Resident 69's MAR for June 2026 showed the following:a. Resident 69 was administered with Percocet medication two tablets on the following dates and times:- 6/1 to 6/3, 6/5 to 6/12, 6/14 to 6/19, 6/22, and 6/26 to 6/30/26 at 0830 hours;- 6/1 to 6/3, 6/5 to 6/12, 6/14 to 6/19, 6/22, and 6/26 to 6/30/26 at 1430 hours; and- 6/1 to 6/3, 6/5 to 6/11, 6/14 to 6/18, 6/22, and 6/26 to 6/30/26 at 2030 hours b. Resident 69 was administered with Tramadol medication on the following dates and times:- 6/1 to 6/3, 6/5 to 6/12, 6/14 to 6/20, and 6/22 to 6/30/26 at 0930 hours;- 6/2 to 6/3, 6/8 to 6/11, 6/14 to 6/19, 6/22 to 6/23, 6/25 to 6/28, and 6/30/26 at 1530 hours; and- 6/1 to 6/4, 6/7 to 6/11, 6/13 to 6/30/26 at 2130 hours. Further review of Resident 69's medical records failed to show documented evidence the nonpharmacological interventions were provided prior to the administration of Percocet and Tramadol medications to Resident 69 on the dates and times above. On 7/2/26 at 1000 hours, an interview and concurrent medical record review for Residents 3, 6, and 69 was conducted with the ADON. The ADON verified the above findings for Residents 3, 6, and 69. The ADON stated the nonpharmacological interventions should be provided prior to the administration of the pain medications as per the physician's order. On 7/2/26 at 1339 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Residents 3, 6, and 69.		

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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** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure safe and effective pharmaceutical services was observed for one of 34 final sampled residents (Resident 148) and two nonsampled residents (Residents 120 and 171).[*] The facility failed to ensure LVN 10 flushed Resident 148's GT (gastrostomy tube) with 30 ml of water after the final medication administration as per the physician's order and the facility policy. This failure had the potential to affect the resident's well-being by not being given the prescribed GT flushes during medication administration.[*] The facility failed to ensure Resident 120's pregabalin (controlled substances medication) was wasted/disposed of by two licensed nurses in accordance with the facility policy. In addition, LVN 9 failed to ensure pregabalin was recorded and accounted for in Resident 120's Drug Control Receipt Record/Disposition Form. These failures posed a risk for drug diversion of the controlled medications[*] The facility failed to ensure Resident 171's finasteride (used to treat male pattern hair loss and enlarged prostate) medication was handled in safe manner. LVN 4 failed to used gloves during medication preparation and administration of the finasteride medication in accordance with the professional standards of practice when handling cytotoxic medication. This failure posed a risk for the staff to have serious reproductive risks and other adverse health effects from cytotoxic drugs. Findings: 1. Review of the facility's P&P titled Medication Administration Through Gastrostomy Tube revised 1/2026 showed under Procedure 21, to flush with a minimum of 30 cc of water after the final medication is administered or as ordered by the physician. Medical record review for Resident 148 was initiated on 6/30/26. Resident 148 was admitted to the facility on [DATE]. On 6/30/26 at 0840 hours, a medication administration observation for Resident 148 was conducted with LVN 10 inside Resident 148's room. LVN 10 prepared the following medications for Resident 148:- glycopyrrolate (drug to reduce excessive secretions) 1 mg one tablet;- lactulose (drug to treat constipation) 10 gm/15ml liquid 45 ml; and- docusate sodium (stool softener drug) 100 mg one tablet. During the medication administration, LVN 10 was observed to perform the following:- crushed the glycopyrrolate and docusate sodium medications and poured into separate medication cups;- poured water in each medication cups to dissolve the crushed medications;- flushed Resident 148's GT with 10 ml of water;- poured the lactulose medication in the syringe connected to the GT, and added water to the syringe, and then poured 10 ml of water into the syringe to flush the GT;- poured the glycopyrrolate medication in the syringe connected to the GT and then poured 10 ml of water into the syringe to flush the GT; and- poured the docusate sodium medication in the syringe connected to the GT and then 10 poured 10 ml of water into the syringe to flush the GT. However, LVN 10 was not observed flushing the GT with 30 ml of water after the final medication administration to Resident 148. Review of Resident 148's Order Summary Report showed the following physician's orders:- dated 5/14/26, to flush feeding tube with 30 ml water before and after medication administration;- dated 5/14/26, to administer docusate sodium 100 mg one tablet via PEG-Tube two times a day;- dated 5/26/26, to administer lactulose oral solution 10 gm/15 ml 45ml via PEG-Tube every 12 hours; and- dated 6/16/26, to administer glycopyrrolate 1 mg one tablet via PEG-Tube two times a day; On 6/30/26 at 0903 hours, an interview was conducted with LVN 10. LVN 10 stated they gave 10 ml of water flushing in between medications and after all the medications administrations to Resident 148. On 6/30/26 at 1358 hours, a follow-up interview was conducted with LVN 10. LVN 10 stated Resident 148's order was to flush with 30 ml of water after all the medications were administered. On 7/2/26 (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 1100 hours, an interview was conducted with the DON. The DON was informed and verified the findings above. The DON stated they were informed LVN 10 gave 10 ml of water for the final flush. The DON further stated LVN 10 should have given 30 ml of water instead for the final flush after medication administration to Resident 148. 2. Review of the facility P&P titled Medication Destruction revised 1/2025 showed under Guidelines, Wasted medications are defined as medications contaminated or refused that require disposal. Staff should not place wasted medications back in their original containers, and wasted controlled medications should be destroyed by two nurses employed by facility and the disposal should be documented on the accountability record on the line representing that dose. Medical record review for Resident 120 was initiated on 6/30/26. Resident 120 was admitted to the facility on [DATE]. On 6/30/26 at 1159 hours, a concurrent observation, interview, and record review was conducted with LVN 9 for Resident 120. A pregabalin medication bubble pack was observed inside Medication Cart A for Resident 120. The pregabalin medication bubble pack count for Resident 120 was 75 capsules. However, Resident 120's Drug Control Receipt Record/Disposition Form for the pregabalin medication showed 76 capsules. LVN 9 stated he dropped one pregabalin capsule on the floor in the morning and LVN 9 wasted the one pregabalin capsule by himself. LVN 9 stated the facility process for wasting a controlled substance was to have another licensed nurse witness the medication was wasted and document on the resident's Drug Control Receipt Record/Disposition Form with the two licensed nurses' signatures. Further review of Resident 120's Drug Control Receipt Record/Disposition Form showed no documentation of wasting Resident 120's pregabalin medication. LVN 9 stated he should have documented immediately after wasting the medication for accuracy. Review of Resident 120's Order Summary Report showed a physician's order dated 4/22/24, to administer Lyrica (Pregabalin) Oral Capsule 50mg, to give one capsule by mouth three times a day. Review of Resident 120's MAR for June 2026 showed the pregabalin medication was last administered on 6/30/26 at 0900 hours. On 7/2/26 at 1100 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings above. The DON stated LVN 9 should have another licensed nurse to witness controlled substances disposal. The DON also stated the two nurses should have documented the narcotic waste disposal on the narcotic sheet (accountability record). 3. Review of the facility P&P titled Administering Medications revised 3/2023 showed the purpose of the policy was to provide employees with guidelines for the safe and timely administrations of medications. Medical record review for Resident 171 was initiated on 6/29/26. Resident 171 was admitted to the facility on [DATE]. Review of the NIOSH List of Hazardous Drugs in Healthcare Settings dated 2024 showed The drugs in Table 2 meet the NIOSH definition of a hazardous drug .These drugs may exhibit one or more of the types of toxicity described in the NIOSH definition of a hazardous drug. Some of these drugs may also present an occupational hazard to those workers who are actively trying to conceive, who are pregnant or may become pregnant, and who are breastfeeding because the drugs may be excreted in breast milk. Table 2 .finasteride (drug to treat an enlarged prostate) .Developmental and/or Reproductive Hazard. On 6/29/26 at 0926 hours, a medication administration observation for Resident 171 was conducted with LVN 4 inside Resident 171's room. LVN 4 prepared the following medications for Resident 171:- vitamin C (supplement) 500 mg 0.5 tablet;- Eliquis (blood thinner drug) 5 mg one tablet;- escitalopram (antidepressant drug) 10 mg one tablet;- finasteride (used to treat male pattern hair loss and enlarged prostate) 5 mg one tablet;- gabapentin (drug to manage nerve damage) 100 mg one capsule;- tamsulosin (drug to treat an enlarged prostate) 0.4 mg two capsules;- benazepril (antihypertensive drug) 5 mg one tablet;- carvedilol (antihypertensive drug) 12.5 mg one tablet;- lactobacillus (supplement) one capsule;- multivitamin with minerals (supplement) one tablet; and - azelastine spray (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	0.1% nasal spray (to treat allergy symptoms). LVN 4 was observed preparing Resident 171's finasteride without wearing gloves. LVN 4 was observed administering the finasteride medication to Resident 171 without wearing gloves. Review of Resident 171's Order Summary Report showed physician's order dated 1/17/22, for finasteride tablet 5 mg to give one tablet by mouth one time a day with instructions if pregnant use gloves to handle Proscar (brand name for finasteride) and to use mask and gloves if crushing is required. Review of Resident 171's finasteride medication bubble pack had a yellow sticker showing cytotoxic caution handle with gloves. On 6/29/26 at 1443 hours, an interview was conducted with LVN 4. LVN 4 verified Resident's 171's finasteride medication bubble pack had a yellow sticker showing cytotoxic caution handle with gloves. LVN 4 stated they should wear gloves to protect themselves from the medication. On 7/1/26 at 0951 hours, a concurrent interview and record review was conducted with the DON. The DON verified the directions and the yellow sticker on Resident 171's finasteride medication bubble pack showing cytotoxic caution handle with gloves. The DON stated they expected the licensed nurses to wear gloves when handling the cytotoxic medications. On 7/2/26 at 1225 hours, a telephone interview was conducted with the Consultant Pharmacist . The Consultant Pharmacist stated if the finasteride medication was on the NIOSH drug list, the nurse had to wear gloves for the safe handling of the medications.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure two of 34 final sampled residents (Residents 3 and 228) was free from the unnecessary medications. * The facility failed to ensure the monitoring for the signs and symptoms of bleeding was completed related to use of apixaban medication (anticoagulant, use to prevent blood clots) to Resident 3. * The facility failed to follow the physician's order to hold the carvedilol and nifedipine (medications to treat high blood pressure) medication when Residents 228's systolic blood pressure was below 110 mmHg. These failures had the potential for the residents to receive unnecessary medications and develop significant side effects. Findings: Review of the facility's P&P titled Administering Medication revised 3/2023, showed to provide employee with guidelines for the safe and timely administration of medications per physician order. Medications must be administered in accordance with the orders. The following information must be checked/verified for each resident prior to administering medication: vital signs, as indicated. 1. Medical record review for Resident 228 was initiated on 6/29/26. Resident 228 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 228's H&P examination dated 6/23/26, showed Resident 228 had a decision-making capacity. Review of Resident 228's Order Summary Report dated 7/1/26, showed the physician's order dated 6/22/26, to administer carvedilol 6.25 mg one tablet by mouth two times a day, hold if systolic blood pressure was below 110 mmHg for hypertension (high blood pressure) and nifedipine 60 mg one tablet by mouth everyday, hold if systolic blood pressure below 110 mmHg for hypertension (high blood pressure). Review of Resident 228's MAR for June 2026 showed Resident 228 was administered with carvedilol 6.25 mg on 6/27/26 at 0900 hours when Resident 228's systolic blood pressure was 108 mmHg. Further review of Resident 228's MAR for June 2026 showed Resident 228 was administered nifedipine 60 mg on 6/27/26 at 0900 hours when Resident 228's systolic blood pressure was 108 mmHg. On 7/2/26 at 1028 hours, an interview and concurrent medical record review for Resident 228 was conducted with LVN 1. LVN 1 stated for the administration of the BP medications to the residents, the licensed nurse would check the resident's BP prior to administering the BP medication. LVN 1 stated if the BP reading was within the parameters as ordered by the physician, LVN 1 would then administer the medication. LVN 1 stated if the BP reading was outside of the ordered parameters, the medication would be held. LVN 1 verified Resident 228's carvedilol and nifedipine medications were administered even when Resident 228's the systolic blood pressure was below 110 mmHg. (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/2/26 at 1342 hours, an interview was conducted with DON. The DON was made aware of the above findings. The DON stated licensed nurses need to follow the physician's order. The DON further stated the licensed nurse should have held the BP medications, when the resident's systolic blood pressure was below 110 mmHg. On 7/2/26 at 1416 hours, an interview was conducted with the Administrator and Assistant Administrator. The Administrator and Assistant Administrator were informed and acknowledged the above findings. 2. Review of the facility's P&P titled Anticoagulation Clinical Protocol dated 11/2024 showed: - The licensed nurse will for any signs or symptoms related to adverse drug reactions due to medication use; - The licensed nurse will monitor the resident and assess for evidence of effects related to the subtherapeutic or greater than therapeutic drug level related to that particular drug (for example, a resident with an above therapeutic level of an anticoagulation medication should be assessed for bleeding); - The staff and physician will monitor for possible complications in individuals who are being anticoagulated and will manage related problems; and - If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant. According to DailyMed, the most common clinically adverse effect of the enoxaparin sodium injection medication was the risk of serious and potentially fatal bleeding. Medical record review for Resident 3 was initiated on 7/1/26. Resident 3 was readmitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 2/13/26, showed Resident 3 had no capacity to understand and make decision. Review of Resident 3's Order Summary Report showed the following physician's order: - dated 12/29/25, to monitor for the signs and symptoms of bleeding related to the use of apixaban medication (abnormal or unexplained bruising, petechiae, internal bleeding, nosebleeds, bleeding gums, abnormal bleeding) by (+) YES or (-) NO and notify the physician if (+) every shift; and - dated 3/31/26, to administer apixaban 5 mg one tablet by mouth two times a day for AFib/DVT prophylaxis. Review of Resident 3's Care Plan revised 2/6/26, showed a care plan focus problem addressing (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 3's was on anticoagulant therapy. The interventions included to monitor/document/report to the physician as needed the signs and symptoms of anti-coagulant complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB, loss of appetite, sudden changes in mental status and/or significant or sudden changes in vital signs. Review of Resident 3's MAR for June 2025 showed Resident 3 received the apixaban medication on 6/30/26 at 1700 hours. Further review of the MAR under the monitoring for signs and symptoms of bleeding related to the use of apixaban medication box failed to show Resident 3 was monitored on the evening shift of 6/30/26. On 7/2/26 at 100 hours, an interview and concurrent medical record review for Resident 3 was conducted with the ADON. The ADON verified the above findings for Resident 3. On 7/2/26 at 1339 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above finding for Resident 3.		

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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** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 12% when the prescribed medications were not administered to two residents (Residents 148 and 171) during two of five medication administration observation. * The facility to administer the riluzole (medication used to change the activity of certain natural substances in the body that affect nerves and muscles) and cyclosporine (an immunosuppressant medication) medications to Resident 148. * The facility failed to administer the ferrous sulfate (iron supplement) medication to Resident 171. These failures had the potential risk for the residents to experience adverse clinical outcomes, complications, and disease progression. Findings: Review of the facility's P&P titled Administering Medications revised 3/2023 showed for the Guidelines: Medications must be administered in accordance with the orders. 1. Medical record review for Resident 171 was initiated on 6/29/26. Resident 171 was admitted to the facility on [DATE], with diagnosis of anemia. Review of Resident 171's H&P examination dated 11/5/25, showed Resident 171 had no capacity to understand and make decisions. On 6/29/26 at 0926 hours, a medication administration observation for Resident 171 was conducted with LVN 4 inside Resident 171's room. LVN 4 prepared and administered Resident 171 the following medications:- vitamin C (supplement) 500 mg 0.5 tablet;- Eliquis (blood thinner) 5 mg one tablet;- escitalopram (antidepressant) 10 mg one tablet;- finasteride (drug to treat an enlarged prostate) 5 mg one tablet;- gabapentin (drug to manage nerve damage) 100 mg one capsule;- tamsulosin (drug to treat an enlarged prostate) 0.4 mg two capsules;- benazepril (antihypertensive) 5 mg one tablet;- carvedilol (antihypertensive) 12.5 mg one table;- lactobacillus (supplement) one capsule;- multivitamin with mineral (supplement) one tablet; and- azelastine spray 0.1% nasal spray (to treat allergy symptoms). LVN 4 stated Resident's 171's ferrous sulfate medication will not be administered at this time. LVN 4 was observed not administering the ferrous sulfate to Resident 171. Review of Resident 171's Order Summary Report showed a physician order dated 5/22/23, for ferrous sulfate oral tablet delayed release 324 mg (ferrous sulfate) to give one tablet by mouth one time a day every Monday, Wednesday, Friday. Review of Resident 171's Mar for June 2026 for the administration of ferrous sulfate on 6/29/26 at 0900 hours, showed 5 (Hold/See Nurse Notes). On 6/29/26 at 1443 hours, an interview was conducted with LVN 4. LVN stated they had not contacted the prescriber yet to clarify the ferrous sulfate medication order. Review of Resident 171's Progress Note dated 6/29/26 at 1456 hours, showed LVN 4 documented need to clarify medication dose for the ferrous sulfate medication. 2. Medical record review for Resident 148 was initiated on 6/30/26. Resident 148 was admitted to the facility on [DATE], with diagnosis of amyotrophic lateral sclerosis. Review of Resident 148's MDS assessment dated [DATE], Resident 171's BIMS score was 15 meaning cognitively intact. On 6/30/26 at 0840 hours, a medication administration observation for Resident 148 was conducted with LVN 10 inside Resident 148's room. LVN 10 prepared and administered Resident 148 the following medications:- glycopyrrolate (drug to reduce excessive secretions) 1 mg one tablet;- lactulose (stool softener) 10 gm/15 ml liquid 45 ml; and- docusate sodium (stool softener) 100 mg one tablet. LVN 10 stated Resident 148's riluzole and cyclosporine eye drops will not be administered because they did not have the two medications available. LVN 10 was observed not administering the riluzole and cyclosporine eye drops to Resident 148. Review of Resident 148's Order Summary Report showed the following physician's orders: - dated 5/14/26, for cyclosporine ophthalmic emulsion 0.05% to instill one drop in both eyes every 12 hours, and- dated 5/15/26, for riluzole oral tablet 50 mg to give one (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tablet via PEG-Tube two times a day Review of Resident 148's MAR for June 2026 had documentation dated 6/29/26 at 0900 hours, for the following medication:- cyclosporine ophthalmic emulsion 0.05% showed 9 meaning other/see nurse notes, and - riluzole oral tablet 50 mg documented 9 meaning other/see nurse notes Review of Resident 148's Progress Notes showed the following:- dated 6/30/26 at 0841 hours, LVN 10 documented awaiting delivery from pharmacy, will follow-up for the riluzole 50 mg medication; and- dated 6/30/26 at 0848 hours, LVN 10 documented will follow-up with the pharmacy for the cyclosporine eye drops. On 6/30/26 at 0903 hours, an interview was conducted with LVN 10. LVN 10 stated the medication bubble pack for Resident 148's riluzole medication was empty and the cyclosporine eye drops were not available in the medication cart. LVN 10 stated she had to order the riluzole and cyclosporine eye drops from the pharmacy. On 6/30/26 at 1358 hours, a follow up interview was conducted with LVN 10. LVN 10 stated Resident 148's riluzole and cyclosporine eye drops were still not available in the facility to be administered to Resident 148. On 7/2/26 at 1100 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated when the residents' medications were due, the medications should be available to give. The DON stated if there were no medication available, the medication nurse should call the physician after the medication administration.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the menu was followed for 16 residents who received a pureed diet of 168 residents who receive food from the kitchen.* The facility failed to ensure the pureed tamale pie recipe was followed. This failure had the potential to not meet the residents' nutritional needs and negatively impact the residents' nutritional health. Findings: Review of the facility's document titled Diet Roster Rollup dated 6/29/26, showed 168 of 172 residents in the facility received food prepared in the kitchen, and 16 of 168 residents who received a pureed diet. Review of the facility's P&P titled Menus revised 1/2025, showed menus meet basic nutritional needs by providing meals based on individual nutritional assessment, the individualized plan of care, and established national guidelines and are periodically updated to mitigate the risk of menu fatigue. Review of the facility's document titled Tamale Pie undated, showed for the dysphagia/pureed diet: for every five portions needed, add five teaspoons (one teaspoon is the equivalent of five milliliters) of margarine. On 6/30/26 at 1005 hours, an observation of the tamale pie pureed preparation was conducted with Dietary Aide 1. Dietary Aide 1 was observed measuring 10 scoops of the tamale pie into the blender. Dietary Aide 1 then added 10-30 ml scoops of margarine to the blender. Dietary Aide 1 then added water and blended the mixture. When done, Dietary Aide 1 poured the pureed mixture into a pan and continued preparing additional tamale pie pureed. On 6/30/26 at 1105 hours, an interview and concurrent review of the recipe for the tamale pie was conducted with Dietary Aide 1. Dietary Aide 1 stated he was usually responsible for the puree preparation. Dietary Aide 1 stated during the puree preparation, he followed the recipe's instruction and added one tablespoon of margarine for every scoop of the tamale pie. Dietary Aide 1 reviewed the recipe for tamale pie and verified the recipe showed to add five teaspoons of margarine for every five scoops of the tamale pie (or one teaspoon of margarine for every scoop of tamale pie). Dietary Aide 1 verified the scoop he used to add the margarine to the blender during the puree preparation was 30 milliliters. On 7/2/26 at 1330 hours, an interview was conducted with the Administrator, RD, and DSS. The Administrator, RD, and DSS were informed and acknowledged the above findings.		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and the facility's assessment (document describing resident population and needs to determine staff and other resources necessary to competently care for residents) review did not address or include a contingency plan for the facility staffing needs. These failures placed the residents at risk for unmet care needs if their assessed population's needs and resources were not comprehensively identified and addressed. Findings: Review of Facility Assessment (FA) dated 9/17/25, failed to include a contingency plan for staffing needs. On 7/1/26 at 1607 hours, an interview was conducted with the Administrator. The Administrator stated the contingency plan was part of the emergency plan. The Administrator was informed and acknowledged the above findings.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medical records for five of 34 final sampled residents (Resident 37, 226, 227, 228, and 230) were complete and accurately documented. * Resident 37's IV MAR for was incomplete and/or inaccurate. * The facility failed to ensure copy of the Advance Directive for Resident 226 was correct. In addition, the copy of the DPOA for property management was found on the medical record. * The facility failed to ensure Resident 227 and 228's blood pressure access site was accurately documented in the medical record. * Resident 230's advance directive and POLST (Physician Orders for Life-Sustaining Treatment) form did not match. These failures have the potential for the residents' care needs not being met as their medical information was inaccurate and incomplete. Findings: 1. On [DATE] at 1035 hours, during the initial tour, Resident 37 was observed with PICC (Peripherally Inserted Central Catheter, is a long, flexible tube inserted into a large vein in the upper arm and threaded to a major vein near the heart) line catheter inserted on her left upper arm with a dressing dated [DATE]. Medical record review for Resident 37 was initiated on [DATE]. Resident 37 was admitted to the facility on [DATE]. Review of Resident 37's PICC insertion record showed the PICC line was inserted on [DATE]. Review of Resident 37's Order Summary Report showed the following physician's orders dated: - [DATE], for measurement of the IV lines from insertion site on admission/ after dressing change, and arm circumference (in inches) every night shift every 7 (seven) days. - [DATE], flush IV line to remain accessed, blood return check, then flush with 5 cc NS (normal saline) followed by 3 cc heparin (a fast-acting, injectable blood thinner, used to prevent and treat blood clots) 10 unit/cc before and after medication administration. - [DATE], monitor IV line site. Observe for reactions during infusion. Observe for signs and symptoms of infiltration or phlebitis before and after medication administration. - [DATE], blood return check, then flush with 10 cc of NS before and after medication administration every shift. - [DATE], to administer Piperacillin-tazobactam (antibiotic) solution, reconstituted 4-0.5 gm. intravenously every eight hours (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 37's IV MARs for [DATE] showed blank and/or missing initials on [DATE], evening shift for the following orders: - dated [DATE], flush IV line to remain accessed, blood return check, then flush with 5cc NS (normal saline) followed by 3 cc heparin (a fast-acting, injectable blood thinner, used to prevent and treat blood clots) 10 unit/cc before and after medication administration. - dated [DATE], monitor IV line site. Observe for reactions during infusion. Observe for signs and symptoms of infiltration or phlebitis before and after medication administration. - dated [DATE], Blood return check, then flush with 10 cc of NS before and after medication administration every shift. - dated [DATE], to administer Piperacillin-tazobactam solution, reconstituted 4-0.5 gm. intravenously every eight hours. In addition, Resident 37's IV insertion site and arm circumference was not documented on [DATE]. On [DATE] at 1416 hours, an interview and concurrent record review for Resident 37 was conducted with RN 2. RN 2 verified the physician's order and MAR as above. RN 2 stated the IV MAR should have been initialed by the nurse. On [DATE] at 1016 hours, an interview was conducted with the DON. The DON stated the expectation was for the assigned RN to complete the documentation in the IV MAR. Cross reference F694. 2. Medical record Review for Resident 230 was initiated on [DATE]. Resident was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident's Order Summary Report dated [DATE], showed a physician's order dated [DATE], for Do Not Resuscitate (DNR). In Section D, for the advance directive (a legal document that states a person's wishes about receiving medical care if that person is no longer able to make decisions) showed advanced directive was not available. Review of Resident 237's POLST dated [DATE], showed in Section A, Cardiopulmonary Resuscitation (CPR) showed do not attempt to resuscitate (allow natural death). Review of Resident 237's advanced directive dated [DATE], showed in the section for CPR, the resident would like CPR attempted. On [DATE] at 1359 hours, an interview and concurrent medical record review for Resident 237 was conducted with LVN 12. LVN 12 stated Resident 237's code status was DNR. Resident 237's physician order showed the resident was DNR. LVN 12 verified Resident 237's POLST form and advance directive as above. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1457 hours, an interview and concurrent medical record review for Resident 237 was conducted with Social Services Coordinator 3. Social Services Coordinator 3 stated the resident's code status was DNR. Social Services Coordinator 3 verified Resident 237's POLST form and advance directive as above. Social Services Coordinator 3 stated he received resident's advance directive from the resident's representative few days ago and uploaded the advanced directive in the electronic medical record yesterday. Social Services Coordinator 3 stated he had not informed nursing about the resident's advance directive. Social Services Coordinator 3 stated he will reach out to the resident's representative to make the changes. On [DATE] at 1013 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. Review of the facility's P&P titled Dialysis-Care Planning dated 12/2025 showed no blood pressure monitoring, restraining, injections, IV access or blood draws from the dialysis access arm or site unless ordered by the nephrologist. During the initial tour of the facility on [DATE] at 1029 hours, an observation and concurrent interview was conducted for Resident 227. Resident 227 was observed lying in bed. Resident 227 stated she goes to dialysis every Monday, Wednesday, and Friday. Resident 227 further stated she has a left upper chest perma-catheter and left AV shunt. Medical record review for Resident 227 was initiated on [DATE]. Resident 227 was admitted to the facility on [DATE]. Review of Resident 227's H&P examination dated [DATE], showed Resident 227 had decision-making capacity. Review of Resident 227's Order Summary Report showed a physician's order dated [DATE], do not take blood pressure or blood draws on the left arm. Review of Resident 227's care plan for ESRD (End Stage Renal Disease)/dialysis dated [DATE], showed interventions included to avoid taking the blood pressure or doing intravenous punctures in the arm with fistula/shunt. Review of Resident 227's documentation of BP for [DATE] showed the following: - On [DATE] at 1736 hours, a BP reading of 124/51 mmHg on the left arm; - On [DATE] at 1324 hours, a BP reading of 121/76 mmHg on the left arm; - On [DATE] at 0110 hours, a BP reading of 120/76 mmHg on the left arm; - On [DATE] at 0701 hours, a BP reading of 108/64 mmHg on the left arm; - On [DATE] at 1429 hours, a BP reading of 132/71 mmHg on the left arm; (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On [DATE] at 1021 hours, a BP reading of 132/68 mmHg on the left arm; and - On [DATE] at 1357 hours, a BP reading of 128/78 mmHg on the left arm. On [DATE] at 1026 hours, an interview was conducted with Resident 227. Resident 227 stated she never allowed the licensed nurses to take her BP on the left upper arm. On [DATE] at 0752 hours, an interview and concurrent medical record review for Resident 227 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated taking the blood pressure on the left arm will damage the AV shunt. 4. Medical record review for Resident 228 was initiated on [DATE]. Resident 228 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 228's H&P examination dated [DATE], showed Resident 228 had decision-making capacity. Review of Resident 228's Order Summary Report showed a physician's order dated [DATE], do not take blood pressure or blood draws on the left arm. Review of Resident 228's care plan for ESRD (end stage renal disease)/dialysis dated [DATE], showed interventions included to avoid taking the blood pressure or doing intravenous punctures in arm with fistula/shunt. Review of Resident 228's documentation of BP for [DATE] showed the following: - On [DATE] at 0022 hours, a BP reading of 122/74 mmHg on the left arm; - On [DATE] at 0630 hours, a BP reading of 99/50 mmHg on the left arm; - On [DATE] at 0853 hours, a BP reading of 118/70 mmHg on the left arm; - On [DATE] at 1236 hours, a BP reading of 146/70 mmHg on the left arm; - On [DATE] at 0324 hours, a BP reading of 102/80 mmHg on the left arm; - On [DATE] at 0953 hours, a BP reading of 138/73 mmHg on the left arm; - On [DATE] at 1727 hours, a BP reading of 102/68 mmHg on the left arm - On [DATE] at 0135 hours, a BP reading of 112/68 mmHg on the left arm; - On [DATE] at 0135 hours, a BP reading of 140/88 mmHg on the left arm; and (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On [DATE] at 1328 hours, a BP reading of 128/78 mmHg on the left arm. On [DATE] at 1318 hours, an observation and concurrent interview was conducted with Resident 228. Resident 228 was sitting in bed with left upper arm dressing. Resident 228 stated she just came back from hemodialysis and has left arm AV shunt. On [DATE] at 1015 hours, an interview was conducted with Resident 228. Resident 228 stated she never allowed the licensed nurses to take her BP on the left upper arm. On [DATE] at 0757 hours, an interview and concurrent medical record review for Resident 228 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated taking the blood pressure on the left arm will damage the AV fistula. On [DATE] at 0837 hours, an interview was conducted with DON. The DON verified the above findings. The DON verified blood pressures were not taken on Resident 227 and 228's left arm and the documentation for the BP readings for [DATE] were inaccurate. The DON further stated taking the blood pressure on the access site, increase the resident risk for infection and blood clot to the left AV shunt. On [DATE] at 1416 hours, an interview was conducted with the Administrator and Assistant Administrator. The Administrator and Assistant Administrator were informed and acknowledged the above findings. 5. Medical record review for Resident 226 was initiated on [DATE]. Resident 226 was admitted to the facility on [DATE]. Review of Resident 226's POLST dated [DATE], showed Resident 226 have an advance directive dated [DATE], available and reviewed. Further review of Resident 226's medical record showed the Durable Power of Attorney for Management of Property and Personal Affairs dated [DATE], was found on the section for the advance directive. On [DATE] at 1023 hours, an interview and concurrent medical record review for Resident 226 was conducted with the SSD. The SSD verified Resident 226 had an advance directive and on the record. The SSD was asked to review Resident 226's copy of advance directive. The SSD verified Resident 201's DPOA for property management. The SSD stated he asked the resident's family and the copy on the record was submitted by the resident's family member. The SSD acknowledged he did not read the submitted form and verified there was no advance directive available on the record for Resident 226. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1416 hours, an interview and concurrent medical record review for Resident 226 was conducted with the DON. The DON was informed and verified the above findings.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary care and services for one of two final sampled residents (Resident 10) reviewed for hospice services. * The facility failed to ensure the hospice visitation monthly calendar for June 2026 was completed to show the scheduled visits by the hospice skilled nurse. In addition, the facility failed to ensure the hospice visit notes were available in the resident's medical record for June 2026. These failures posed the risk for delay in communication and/or uncoordinated medical care between the facility and hospice provider which may affect Resident 10's care. Findings: Review of the facility's P&P titled Hospice Services revised 1/2026 showed the facility ensures the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services, the care meets the assessed needs of each resident, and the hospice is certified for participation in the Medicare program. The Facility staff should monitor the delivery of hospice care to ensure the hospice provides services to the resident in a way that meets his/her needs in a timely manner including: a. Observation of interactions and care provided by the hospice staff sufficient to ensure the hospice services meet professional standards of care. b. Interviews with the resident/designated representative regarding hospice care and services such as during routinely scheduled care conferences; and c. Review of the resident's record for pertinent documentation regarding the delivery of hospice care. Review of the facility's document titled Inpatient Services Agreement between the facility and Hospice Provider A dated 4/1/26, showed for Resident 10, under the section Services To Be Furnished by the Hospice- Documentation, showed all members of the hospice interdisciplinary group will document their care and services provided at each visit to the hospice patient. The documentation is placed in the nursing facility's patient chart; a copy shall be maintained in the hospice medical record. Medical record review for Resident 10 was initiated on 6/29/26. Resident 10 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 10's H&P examination dated 9/12/25, showed Resident 10 had the capacity to understand and make decisions. Review of Resident 10's Order Summary Report for June 2026 showed a physician's order dated 4/7/26, to admit Resident 10 to Hospice Provider A under routine level of care. The Order Summary Report failed to show the frequency of hospice staff visits. Review of Resident 10's Hospice document titled Current Treatment/Medication/ DME list (undated) showed the hospice admission order dated 4/2/26, for skilled nurse visits two times a week and three as needed visits for pain and symptom management. a. Review of Resident 10's hospice calendar for June 2026 showed the following scheduled hospice skilled nurse visits: - for the week of 6/1/26: on 6/5/25,- for the week of 6/7/26: the skilled nurse visits were not documented,- for the week of 6/14/26: on 6/19/26,- for the week of 6/21/26: on 6/24/26,- for the week of 6/28/26: on 6/30/26. However, Resident 10 should have been scheduled to be visited by the hospice skilled nurse two times a week. On 7/1/26 at 1107 hours, an interview and concurrent medical record review for Resident 10 was conducted with LVN 7. LVN 7 stated Resident 10 was visited by the hospice skilled nurse two to three times a week. LVN 7 stated the hospice calendar should be up to date so the facility would be aware of when the resident would be visited by the hospice staff. LVN 7 verified the above findings. b. Review of Resident 10's hospice record and medical record (facility's) failed to show any visit notes by the hospice skilled nurse for the above dates. On 7/1/26 at 1447 hours, an interview and concurrent medical record review for Resident 10 was conducted with Social (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555733	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER The Pavilion at Sunny Hills		STREET ADDRESS, CITY, STATE, ZIP CODE 2222 N. Harbor Blvd. Fullerton, CA 92835	
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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Services Coordinator 1 and 2. Social Services Coordinator 2 stated the hospice provider was responsible for ensuring the resident's hospice binder was up to date. Social Services Coordinator 2 reviewed Resident 10's medical records and hospice binder and verified the above findings. On 7/2/26 at 0933 hours, an interview was conducted with the DON. The DON stated the resident's hospice binder should be accurate and complete. The DON stated the hospice calendar should be completed at the end of every month and available for the next month, so the facility staff would know when the hospice staff would visit the resident, to coordinate the resident's care. The DON stated the resident's medical record should be up to date to include the hospice staff visit notes. The DON stated the Medical Records staff were responsible for following-up with the hospice provider to ensure the visit notes were available and uploaded to the resident's medical record. On 7/2/26 at 1420 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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F 0655 Level of Harm - Potential for minimal harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the baseline care plan was initiated upon admission for one of 34 final sampled residents (Resident 225). * The facility failed to ensure the baseline care plan was initiated for Resident 225 use of the oxygen. This failure put Resident 225 at risk of not receiving resident-centered care. Findings: Review of the facility's P&P titled Baseline Care Plan with revised date 1/2026 showed completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan. Each resident's baseline care plan includes the instructions needed to provide effective and person-centered care for the immediate needs of the resident that meet professional standards of quality care. On 6/29/26 at 0949 hours, during the initial tour of the facility, Resident 225 was observed in bed receiving oxygen therapy from the oxygen concentrator machine at a rate of 1.5 liters per minute via nasal cannula. Medical record review for Resident 225 was initiated on 6/29/26. Resident 225 was admitted to the facility on [DATE]. Review of Resident 225's plan of care failed to show a baseline care plan was formulated addressing Resident 225 use of the oxygen. On 7/1/26 at 0843 hours, an interview and concurrent medical record review for Resident 225 was conducted with the ADON. The ADON was asked about the care plan for Resident 225 oxygen therapy. The ADON verified there was no baseline care plan formulated when the resident was admitted to the facility. On 7/2/26 at 1416 hours, an interview and concurrent medical record review for Resident 225 was conducted with the DON. The DON was informed and verified the above findings.		