STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555757	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milpitas Care Center	120 Corning Avenue Milpitas, CA 95035

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform and provide written information to one of 5 residents (5), regarding the rights to formulate an advance directive (a legal document that explains how a resident wants medical decisions about him/her to be made if he/she cannot make the decisions himself/herself. It is used to guide the health care team and loved ones when they need to make these decisions or to decide who will make decisions for the resident when he/she can't). This failure had the potential for the facility to provide treatment and services against the residents' wishes. Findings: Review of Resident 5's admission Record indicated she was admitted to the facility on [DATE]. Review of Resident 5's clinical record indicated she did not have an advance directive and did not have an Advanced Directive Acknowledgement that an advance directive was addressed or if the resident/resident representative was helped in formulating an advance directive. During an interview with registered nurse A (RN A) on 6/25/25, at 3:50 p.m., RN A reviewed Resident 5's clinical record and confirmed that Resident 5 did not have an advance directive and did not have an Advanced Directive Acknowledgement that an advance directive was addressed or if the resident/resident representative was helped in formulating an advance directive. Review of the facility's policy, Advance Directives, dated 9/2022, indicated . If the resident or representative indicates that he or she had not established advance directives, the facility staff will offer assistance in establishing advance directives. The resident or representative is given the option to accept or decline assistance .

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to provide that one of 3 residents (Resident 132) reviewed for the SNF Beneficiary Protection Notification Review received a written copy of the Notice of Medicare Non-Coverage (NOMNC) at least two calendar days before the end of Medicare Part A coverage. This failure denied Resident 132 the knowledge to appeal the discharge. Findings: Record review of Resident 132's NOMNC indicated that it was issued to Resident 132's representative on 5/3/25, the date of Resident 132's discharge. Resident 132's last Medicare Part A covered day was also 5/2/25. The NOMNC was issued one day late. During an interview on 6/26/25 at 11:27 a.m., the Social Services Director (SSD) stated that the NOMNC should have been issued at least 72 hours before the last covered day, to allow the resident or representative time to appeal. The SSD acknowledged that the notification was not issued timely and that she did not inform Resident 132 or the representative about the last Medicare covered day prior to discharge. Review of an undated facility's policy titled Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10095, indicated, A Medicare health provider must give in advance, completed copy of the Notice of Medicare Non Coverage (NOMNC) to enrollees receiving skilled nursing, home health (including psychiatric home health), or comprehensive outpatient rehabilitation facility services, no later than two days before the termination of services .

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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 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 interview and record review, the facility failed to ensure 3 of 6 residents (5, 11, and 79) were free from unnecessary psychotropic medications (drugs that affect brain activities associated with mental processes and behaviors) when: 1. Resident 5 received Depakote (used to treat manic depressive illness) without monitoring for side effects and quarterly assessment; 2. Resident 11 received Depakote without quarterly assessment; and 3. Resident 79 received quetiapine (used to treat depressive and manic episodes), lorazepam (used to treat disorders that involve more than occasional worry or fear), haloperidol (used to treat nervous, emotional, and mental conditions), and bupropion (used to treat major depressive disorder) without monitoring for manifested behaviors. These failures resulted in unnecessary medications for the residents, which had the potential for increased risks associated with psychotropic medication use that include but not limited to sedation, respiratory depression, falls, constipation, anxiety, agitation, abnormal involuntary movements, and memory loss. Findings: 1. Review of Resident 5's admission Record indicated she was admitted to the facility on [DATE]. Review of Resident 5's physician order, dated 11/8/23, indicated she received two capsules of Depakote 125 milligrams (mg, a metric unit of mass) two times a day for mood stabilizer. Review of Resident 5's clinical record indicated she was not monitored for the side effects and was not quarterly assessed for the use of Depakote. During an interview with the interim director of nursing (IDON) on 6/27/25, at 2:52 p.m., she reviewed Resident 5's clinical record and confirmed that Resident 5 was not monitored for side effects and was not quarterly assessed for the use of Depakote. The IDON stated Resident 5 should be monitored for side effects and quarterly assessed for the use of Depakote. 2. Review of Resident 11's admission Record indicated she was admitted to the facility on [DATE]. Review of Resident 11's physician order, dated 1/13/25, indicated she received Depakote 250 mg in the evening for mood stabilization. Review of Resident 11's clinical record indicated she was not quarterly assessed for the use of Depakote. During an interview with the IDON on 6/27/25, at 2:49 p.m., she reviewed Resident 11's clinical record and confirmed that Resident 11 was not quarterly assessed for the use of Depakote. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident 79's admission Record indicated she was admitted to the facility on [DATE]. Review of Resident 79's physician orders, dated 6/20/25, indicated she had orders for bupropion 150 mg every day for low mood or sadness; haloperidol 2 mg/milliliters (ml, a metric unit of volume) give 0.25 ml, 0.5 ml, or 1 ml every 4 hours as needed for mild restlessness/nausea/vomiting, moderate restlessness/nausea/vomiting, or severe restlessness/nausea/vomiting; Lorazepam 2 mg/ml give 0.25 ml, 0.5 ml, or 0.75 ml every 2 hours as needed for mild nervousness, moderate nervousness, or severe nervousness; and quetiapine 25 mg at bedtime for continuous crying out/screaming. However, there was no monitoring on these behaviors for Resident 79. During an interview with the IDON on 6/27/25, at 2:18 p.m., she reviewed Resident 79's clinical record and confirmed that there was no monitoring on the behaviors for the use of bupropion, haloperidol, Lorazepam, and quetiapine for Resident 79. The IDON stated Resident 79's behaviors for the use of bupropion, haloperidol, Lorazepam, and quetiapine should be monitored. Review of the facility's policy, Psychotropic Medication Use, dated 7/2022, indicated . 3. Psychotropic medication management includes: . d. adequate monitoring for efficacy and adverse consequences; . 8. Consideration of the use of any psychotropic medication is based on comprehensive review of the resident. This includes an evaluation of the resident's signs and symptoms in order to identify underlying causes.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of Resident 10's admission Record indicated she was admitted to the facility on [DATE] with schizophrenia diagnosis. Review of Resident 10's PASARR Level I Screening, dated 11/22/22, indicated that Resident 10 did not have a serious diagnosed mental disorder such as schizophrenia. During an interview with registered nurse A (RN A) on 6/25/25, at 3:53 p.m., she reviewed Resident 10's 11/22/22 PASARR Level I Screening and confirmed that Resident 10's PASARR Level I Screening should have indicated she had a serious diagnosed mental disorder such as schizophrenia. Review of facility's policy and procedure (P&P) entitled admission Criteria dated 2001, the P&P indicated, .9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process b. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process . Based on interview and record review, the facility failed to accurately complete the Preadmission Screening and Resident Review (PASARR, a federally mandated program ensures individuals are not inappropriately placed in nursing homes for long-term care) for two (Resident 21 and Resident 10) out of 14 sampled residents when Resident 21's and Resident 10's mental illness diagnoses were not indicated in PASARR. These failures had the potential to result in the residents not receiving the appropriate PASARR level 2 evaluation (used to confirm mental illness and assess whether the resident requires specialized services). Findings: 1. A review of Resident 21's PASARR, dated 4/9/23 indicated, Level 1- Negative .Reason Code: No Serious mental illness .resolution: LII [level 2]: Not Required The individual who completed the PASARR answered No when asked if Resident 21 had a serious diagnosed mental disorder. A review of Resident 21's admission Record indicated Resident 21 was admitted on [DATE] with diagnoses including Schizophrenia (a severe mental illness that disrupts a person's ability to think, feel, and behave clearly). During a concurrent interview and record review on 6/24/25 at 4:51 p.m. with Registered Nurse (RN) A, RN A verified she completed PASARR Level 1 for Resident 21 on 4/9/23. RN A stated that Resident 21 came from a hospital prior to admission in the facility. RN A verified Resident 21's Hospital Discharge Summary prior to admission indicated a diagnosis of Schizophrenia. RN A verified Resident 21's PASARR Level 1 should have indicated the diagnosis of Schizophrenia.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to provide services that meet professional standards of quality for two of 14 sampled residents (Residents 4 and Resident 1) when: 1. For Resident 4, the facility staff did not document the apical pulse (the pulse that is felt at the bottom of the heart) before administering Digoxin (a medication used to treat certain heart conditions); and 2. Resident 1 was given the medication Carvedilol (used to treat high blood pressure) when her diastolic blood pressure (the bottom number in a blood pressure reading, representing the pressure in your arteries when your heart is at rest between beats) was low (a diastolic pressure reading below 60 is considered low) at 50 mmhg (millimeters of mercury, a unit of measurement). These failures had the potential to compromise the residents' care and could cause health complications. Findings: Review of Resident 4's admission record indicated that the resident had a diagnosis of unspecified atrial fibrillation (an irregular and often rapid heart rhythm that can lead to poor blood flow and increase the risk of stroke or heart failure). Review of Resident 4's active Order Summary Report indicated an order date of 1/24/24, for Digoxin 125 micrograms (mcg, unit of measurement) by mouth once daily for arrhythmia (an abnormal heart rhythm) and hold the dose if the heart rate (HR, the number of times the heart beats per minute) is less than 55 beats per minute. Review of Resident 4's Medication Administration Record (MAR) for June 2025 indicated Digoxin was administered at 9:00 a.m. every day, but no apical pulse reading recorded in the MAR prior to administration of Digoxin. Further review of the MAR showed that the apical pulse was recorded twice daily (BID) on the day and evening shifts. However, the readings were not taken during the 9:00 a.m. Digoxin dose and does not confirm the apical pulse was checked immediately before Digoxin administration. During a concurrent interview and record review with the Interim Director of Nursing (IDON) on 6/25/25 at 1:30 p.m., the IDON acknowledged that there was no documentation of an apical pulse recorded before giving Digoxin. She stated that it was the facility's practice for nurses to check the apical pulse before administering Digoxin and that the result should have been documented in the MAR next to the administration time. The IDON acknowledged that the BID monitoring of apical pulse does not confirm whether the apical pulse was taken during the 9:00 a.m. Digoxin dose. Review of the Lippincott Nursing Drug Guide (2024 edition) indicated standard nursing practice for Digoxin includes auscultating the apical pulse for one full minute before each dose and withholding the dose if the pulse is below the ordered threshold (typically less than 60 beats per minute). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a medication pass observation on 6/26/25 at 9:36 a.m., Licensed Vocational Nurse (LVN) D administered Carvedilol 3.125 mg (milligram, a unit of measurement) tablet orally to Resident 1. A review of Resident 1's Physician Order indicated, Carvedilol Oral Tablet 3.125 mg give 1 tablet by mouth two times a day for Hypertension [high blood pressure] hold SBP [systolic blood pressure, the top number in a blood pressure reading, and it measures the pressure in your arteries when your heart beats and pumps blood] < 105 Pulse < 55 A review of Resident 1's vital signs dated 6/26/25 at 7:47 a.m. indicated a blood pressure reading of 116/50 mmhg. During a concurrent interview and record review on 6/26/25 at 1:22 p.m. with the Interim Director of Nursing (IDON), the IDON verified Resident 1's physician order for carvedilol and the blood pressure reading of 116/50 mmhg prior to administration of the medication carvedilol by LVN D. The IDON stated Resident 1 was at risk for hypotension (low blood pressure). The IDON also stated that LVN D should have rechecked the blood pressure prior to administering the medication or notified the doctor if it was okay to give carvedilol with a blood pressure of 116/50 mmhg. A review of facility's policy and procedure (P&P) entitled Administering Medications revised April 2019, the P&P indicated, .11. The following information is checked/verified for each resident prior to administering medications: .b. Vital signs, if necessary .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents received the necessary care and services for one of 14 residents (15) when Resident 15 did not receive weekly weight and one-to-one feeding assistance with all meals as ordered by the physician. This failure had the potential to negatively affect the resident's nutritional status, health, and well-being. Findings: Review of Resident 15's admission Record indicated she was admitted to the facility on [DATE]. Review of Resident 15's Nutritional Assessment, dated 2/12/24, indicated she had insidious weight loss since 10/2023, and Resident 15 may benefit from one-to-one feeding assistance with all meals to promote intake and gradual weight gain. Review of Resident 15's physician orders indicated she had orders for one-to-one feeding assistance with all meals, started on 2/13/24, and weekly weight in the morning every Tuesday, started on 5/21/24. Review of Resident 15's weight document, from 5/17/24 to 6/2/25, indicated she was weighed about every month, not every week. During observations on 6/24/25, at 11:54 a.m., on 6/26/25, at 5:43 p.m., and on 6/27/25, at 11:54 a.m., Resident 15 was eating her meals herself with no one-to-one feeding assistance. During an interview with the interim director of nursing (IDON) on 6/27/25, at 2:31 p.m., she reviewed Resident 15's physician orders and confirmed that Resident 15 should have been weighed every week and have one-to-one feeding assistance with all meals as ordered by the physician. Review of the facility's undated job description, Registered Nurse, indicated Duties and Responsibilities: . Ensure direct resident care is always provided by licensed and certified nurses.

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F 0692 Level of Harm - 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, and facility document review, the facility failed to ensure acceptable parameters of nutritional status were maintained for one of 18 sampled residents (Resident 12) when Resident 12 experienced an unplanned insidious weight loss of 10 pounds, 6.8% in three months and 16 pounds 9.8% weight loss in six months. This had the potential to result in muscle wasting, loss of independence, decreased quality of life, and increased disease complications. 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 March 15, 2005, 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/ Involuntary weight loss can lead to muscle wasting . depression and an increased rate of disease complications. Various studies demonstrated a strong correlation between weight loss and morbidity and mortality. (February 15, 2002/Volume 65, Number 4 www.aafp.org/afp American Family Physician). A publication titled Nutrition Care of the Older Adult from the Academy of Nutrition and Dietetics, dated 2016, indicated the goal of Medical Nutrition Therapy is to maintain or restore the individual's usual body weight. A publication from the Academy of Nutrition and Dietetics titled What Resources Are Available to Assist in Assessing Body Weight in Older Adults. July 1, 2025, indicated usual body weight (UBW), an individual's weight throughout adult life or a stable weight over time, is the preferred standard for older adults. Any recent weight changes, especially unintentional weight loss, would also need to be addressed in a care plan. UBW is considered more appropriate than desirable body weight or ideal body weight for weight-related interventions in older adults. During a review of the Academy of Nutrition and Dietetics Evidence Analysis Library regarding Unintended Weight Loss for Older Adults Evidence-Based Nutrition Practice Guidelines (2007-2009), indicated the Registered Dietitian (RD) should monitor and evaluate weekly body weights of older adults with unintended weight loss, until body weight has stabilized, to determine effectiveness of medical nutrition therapy (MNT). The State Operations Manual (SOM) provides a definition for insidious weight loss: Gradual unintended weight loss over time is known as insidious weight loss. This can be where an older adult loses only 1-2 pounds per month, but for a continued period. When addressing unintentional weight loss, one needs to figure out why, if possible, the root cause of unintended weight loss (Geriatric Dietitian, 3/31/22). (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the facility Policy and Procedure (P&P) titled Weight Assessment and Intervention dated 2001, showed resident weights are monitored for undesirable or unintended weight loss or gain. Residents are weighed upon admission and at intervals established by the interdisciplinary team. Unless notified of significant weight change, the dietitian will review the unit weight record monthly to follow individual weight trends over time. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a. 1 month - 5% weight loss is significant; greater than 5% is severe; b. 3 months- 7.5 % weight loss is significant; greater than 7.5% is severe; c. 6 months - 10% weight loss is significant; greater than 10% is severe. Undesirable weight change is evaluated by the treatment team whether or not the criteria for significant weight change has been met. The evaluation includes but is not limited to the resident's target weight range and the resident's calorie, protein, and other nutrient needs compared with the resident's current intake and the relationship between current medical condition or clinical situation and recent fluctuations in weight; and whether and to what extent weight stabilization or improvement can be anticipated. The physician and the multidisciplinary team identify conditions and medications that may be causing anorexia (an eating disorder characterized by a restriction of food intake leading to low body weight), weight loss or increasing risk of weight loss. Interventions for undesirable weight loss are based on careful consideration of the following including but not limited to: Resident choice and preferences; nutrition and hydration needs; the use of supplementation. Review of the admission Record (a document containing the most pertinent information for a resident) for Resident 12, indicated Resident 12 was [AGE] years old. Resident 12 was initially admitted on [DATE] and readmitted on [DATE]. Diagnoses included but were not limited to: acute chronic congestive heart failure (worsening of an existing heart failure symptoms), type 2 diabetes (a condition in which the body has trouble controlling blood sugar), hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone which can disrupt things such as heart rate, body temperature, and metabolism), Alzheimer's disease (a progressive disease that destroys memory and other important functions), and dementia (a group of thinking and social symptoms that interfere with daily functioning). A record review of Minimum Data Set (MDS, an assessment used to plan care) Section K - Swallowing/Nutritional Status from 5/24/24 to 4/3/25 created for Resident 12 showed: 5/24/24 Quarterly Assessment: Weight 170 pounds, no weight loss of 5% in 1 month or 10% in 6 months; no swallowing issues, received a therapeutic diet. 8/24/24: Quarterly Assessment: Weight 165 pounds, no weight loss of 5% in 1 month or 10% in 6 months; no swallowing issues, received a therapeutic diet. 11/24/24 Quarterly Assessment: Weight 164 pounds, no weight loss of 5% in 1 month or 10% in 6 months; no swallowing issues, received a therapeutic diet. 2/22/25 Annual Assessment: Weight 160 pounds, no weight loss or weight gain of 5% in 1 month or 10% in 6 months, no swallowing issues, received a therapeutic diet. 3/12/25 Significant Change Assessment: Weight 158 pounds, no weight loss of 5% in 1 month or 10% in 6 months, no swallowing issues, received a therapeutic diet. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	3/21/25 Discharge Assessment: Weight 158 pounds, no weight loss of 5% in 1 month or 10% in 6 months, no swallowing issues, received a therapeutic diet. 4/3/25 readmission Assessment: Weight 154 pounds, no weight loss of 5% in 1 month or 10% in 6 months, no swallowing issues, received a therapeutic diet. During a record review of Resident 12's Weights and Vitals Summary from 4/3/24 to 6/23/24, the following monthly weights for Resident 12 were shown: 4/3/24: 175 lbs 5/3/24: 163 lbs (6.9 %, - 12 lb weight loss in 30 days [comparison weight 4/3/24 175 lbs]) 6/8/24 164.2 lbs 7/12/24 167.2 lbs 8/5/24 165 lbs 9/2/24 164 lbs 9/30/24 163 lbs 11/11/24 164 lbs 12/4/24: 164 lbs 1/2/25: 162 lbs 2/4/25: 160 lbs 3/3/25: 158 lbs 3/27/25: 154.6 lbs 5/1/25: 154 lbs 6/2/25: 148 lbs Resident 12's documented weights represented an insidious loss in body weight of 16 pounds/9.8% from 12/4/24 to 6/2/24, and 10 pounds, 6.8% in three months from 3/3/25 to 6/2/25. (continued on next page)

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Milpitas Care Center	120 Corning Avenue Milpitas, CA 95035

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A record review showed on 12/18/24, Resident 12 was prescribed MedPass Sugar Free 90 ml, QD. (MedPass Sugar Free is a nutrition supplement providing extra calories and protein and typically provided during the medication pass. It provides approximately 160 - 180 calories per 90 ml). RD recommended MedPass to be discontinued on 2/20/25 due to resident refusals. The Medication Administration Record [MAR] dated 1/1/25-1/31/25 showed out of 31 days Resident 12 was offered MedPass, he consumed 10% two (2) days, 20% one (1) day, 25% three (3) days, 50% four (4) days, and 100% 7 days. The MAR dated 2/1/25-2/28/25, showed out of the 21 days Resident 12 was offered MedPass, he consumed 100% two (2) days, and 50% three (3) days. A record review for orders showed on 6/19/24 Add snacks BID [twice a day], Document % intake. This order was discontinued on 3/24/24 and was not started again after readmission on [DATE]. On 6/5/25, the RD recommended adding snacks BID. A record review showed Resident 12 was prescribed a No added Salt, Consistent Carbohydrate (CCHO; a diet typically prescribed to maintain blood sugar) diet from 6/8/24 to 3/27/25. A record review showed when Resident 12 was readmitted on [DATE], his diet order was a Cardiac - Low Fat Low Cholesterol, Low Salt, Diabetic No Concentrated Sweets (NCS) diet (a diet restricting foods and drinks with added sugars and simple carbohydrates; According to a progress note dated 6/5/25 RD recommended to change NCS diet to CCHO in house diet). A professional review titled, Management of Diabetes in Long-term Care and Skilled Nursing Facilities: A Position Statement of the America Diabetes Association, Diabetes Care 2016 showed, Liberal diets have been associated with improvement in food and beverage intake in the LTC population to better meet caloric and nutrient requirements. While carbohydrate intake should be taken into consideration, no concentrated sweets or no sugar diet orders are ineffective for glycemic management and should not be recommended. Instead, a consistent carbohydrate meal plan that allows for a wide variety of food choices may be more beneficial for both nutritional needs and glycemic control in patients with type 1 diabetes or type 2 diabetes on mealtime insulin. Review of the facility's 2023 Diet Manual for Long Term Care Facilities showed the CCHO diet provided 1900 - 2000 calories per day; and the Low Fat/Low Cholesterol Diet provided 1800 - 2000 calories per day. Calculations in accordance with the Diet Manual show a CCHO diet provided (the combination of a CCHO diet and Low Fat/Low Cholesterol may have provided fewer calories according to the diet manual): 1444- 2000 calories with an intake of 76-100%. 969 - 1500 calories with an intake of 51-75% 494 - 900 calories with an intake of 26-75% Review of Resident 12's record included a physician Progress Note dated 3/30/25, showed Resident 12 was transferred out on 3/21/25 for chest pain and was readmitted to the facility on [DATE]. A record review from December 2024 to June 2025 showed the following RD Nutrition Progress Notes and Assessments: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Nutrition Assessment dated 2/20/25 showed Resident 12's weight was 160 pounds, estimated caloric needs were 1818 - 2181 kcals (kilocalories, often referred to as calories), meal intake was 76-100% on average, supplement MedPass Sugar Free 90 ml (milliliters) QD (every day), refusing MedPass supplement on average. No significant weight changes in the last 30, 90, and 180 days. PO intake is meeting ENN [estimated nutrition needs include caloric intake and protein intake]. RD's only recommendation in this assessment was to discontinue the nutritional supplement MedPass due to the resident refusing the supplement. Although the RD documented Resident 12's intake was meeting his ENN in her 2/20/25 Nutrition Assessment, no additional interventions were implemented to address the insidious weight loss of 164 to 160 pounds from 12/4/24 to 2/25. While the RD documented in her 2/20/25 Nutrition Assessment, Resident 12's average meal intake was 76-100%, no time frame was specified. A record review of the Meal intake Documentation Nutrition - Amount Eaten for Resident 12, from 12/1/24 to 2/19/25, showed: from 12/21/24-12/31/24, Resident 12 consumed 76-100% for 62% of meals (56 out of 90 meals); from 1/1/25 to 1/31/25, Resident 12 consumed 76-100% for 59% of meals (54 out of 92 meals); and from 2/1/25 to 2/19/25, Resident 12 consumed 76-100 % for 58% of meals (32 out of 55 meals). Progress Note dated 3/20/25 showed Resident 12 weighed 158 pounds, average meal intake was 84%, average snack intake was 50%. . No significant weight changes in the last 30, 90, 180 days. PO (by mouth) intake meeting ENN . no new recommendations at this time . Although the RD stated Resident 12 was meeting his ENN in her 3/20/25 progress note, Resident 12 experienced an insidious weight loss of 6 pounds between 12/4/24 and 3/3/25. While RD documented in her 3/20/25 progress note, Resident 12's average meal intake was 84%, no time frame was specified. A record review of the Meal intake Documentation Nutrition - Amount Eaten for Resident 12, from 2/21/25 to 3/19/25 (dates between RD nutrition assessment on 2/20/25 and RD progress note on 3/20/25), showed: from 2/21/25-2/28/25, Resident 12 consumed 76-100% for 67% of meals (16 out of 28 meals); and from 3/1/25 to 3/19/25; Resident 12 consumed 76-1 00% for 48% of meals (25 out of 52 meals). Nutrition Assessment dated 4/3/25 showed Resident 12 weighed 154 pounds, estimated caloric needs were 1750 - 2100, average meal intake was 50-75%, and no supplements. PO intake meeting ENN. No new recommendations at this time. While RD documented Resident 12's intake was meeting ENN in her 4/3/35 Nutrition Assessment, calculations including percent intake and calories provided by the diet manual, showed Resident 12 did not meet ENN. RD stated Resident 12's average meal intake was 50-75%, but no time frame was specified. RD did not show how many calories 50-75% intake provided. According to the diet manual 50-75% intake of a CCHO diet provided [PHONE NUMBER] calories which did not meet Resident 12's ENN of 1750-2100 calories per RD's assessment dated [DATE]. Resident 12 experienced insidious weight loss of 9.4 pounds between 12/4/24 and 3/27/25. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Progress Note dated 6/5/25, showed Weight changes: -3.9%/-6# x 30 days, -6.3%/-10# x 90 days, -9.8%/-16# x 180 days . [AGE] year old male noted with significant weight loss of -6 # [pounds] x 30 days . Weight loss is undesirable as resident is meeting only 93% of IBW [Ideal Body Weight] . Resident may benefit from resuming snacks BID to increase calorie and protein intake and monitor on weekly weights x 4 weeks. RD did not recommend interventions to address weight loss until Resident 12 experienced an unplanned weight loss of 6 pounds between 5/1/25 and 6/2/25, 10 pounds between 3/3/25 and 6/2/25, and 16 pounds between 12/4/24 and 6/2/25. During a concurrent phone interview and record review with Registered Dietitian (RD) on 6/25/25 at 9:53 a.m. , Resident 12's weight log, progress notes, assessments, and physicians' orders from 3/5/2024 to present, were reviewed. RD stated she began working at the facility in January 2025. RD confirmed Resident 12 continuously lost weight from 12/4/24 to 6/2/25. RD stated she considered Resident 12's weight loss to be insidious. RD stated insidious weight loss was a weight loss that was slowly down trending. RD stated she did not consider interventions for weight loss from January to June 2025 because Resident 12's meal intake was meeting his estimated nutrient needs (ENN) according to PO nutrition intake documentation. RD confirmed she did not recommend an intervention for weight loss until 6/5/25 when she documented Resident 12 had significant weight loss of 6 pounds between 5/1/25 and 6/2/25. In addition, RD stated she was not involved with Interdisciplinary Team (IDT) meetings. RD stated she did not know what was discussed in the IDT meetings. RD also stated she did not speak to resident representatives (RPs), it was up to the dietary manager to speak with RPs to determine resident weight goals, and she did not attend IDT meetings since she worked at the facility only four hours a week. During a meal observation on 6/25/25 at 11:54 p.m., Resident 12 ate his lunch in the dining room. Resident 12 consumed 50% of his milk (8 ounce cup), 100% his juice (6 ounce cup), 100% of his dessert (which he ate first), less than 25% of his vegetables, and 25% of his fish filet. Resident 12 appeared agitated and yelled at staff no when staff asked if he wanted anything else to eat. In an interview on 6/25/25 at 12:01 p.m., Licensed Vocational Nurse (LVN) D stated Resident 12 ate in his room or the dining room depending on his mood. LVN D stated his food intake at meals was inconsistent. During an interview on 6/25/25 at 2:30 p.m., RD stated weight loss was discussed with nursing only when residents trigger for significant weight loss. During an interview with the Interim Director of Nursing (IDON) on 6/25/25 at 3:02 p.m., IDON stated RD came into the facility weekly and reviewed resident weights. Resident weights were discussed in weight variance IDT meetings only when there is a significant weight change. IDON confirmed the RD was not present in the IDT meetings. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During a consecutive interview and document review with IDON on 6/26/25 at 9:59 a.m., weight variance IDT meeting documentation was reviewed. From 12/2024 to 6/2025, weight variance IDT meeting documentation showed there were no weight variance IDT meetings to address Resident 12's insidious weight loss of 10 pounds from 12/4/24 to 5/1/25. An IDT meeting was not held until 6/6/2025 after the RD documented Resident 12 had a significant weight loss of 6 pounds from 5/1/25 and 6/2/25. The documentation showed the only staff present in the meeting were the Certified Dietary Manager (CDM), IDON, and a Minimum Data Set (MDS) staff. Only information repeated from RD 6/5/25 progress was documented in the weight variance IDT meeting minutes, such as Resident 12's weight at 148 pounds, a weight loss of 6 pounds in a month, recommend snacks twice a day, and start weekly weights. IDON confirmed the RD was not present for IDT meetings. IDON stated dietary manager presents the RD recommendations from the RD assessments/progress notes, but possible causes of weight loss were not discussed. IDON confirmed she could not find documentation to show the Resident 12 was on a planned/prescribed weight loss program. During an interview and concurrent record review on 6/26/25 at 10:43 a.m., the MDS Coordinator (MDSC) reviewed MDS Section K - Swallowing/Nutritional Status dated 5/24/24 for Resident 12. MDSC confirmed stated Resident 12's significant weight loss of 6.9% in one month (4/3/24 to 5/3/24) was not reflected on the 5/24/24 MDS section K but the weight loss should have been reflected. MDSC stated a Registered Nurse (RN) reviewed section K for accuracy. During an interview and concurrent document review on 6/26/25 at 11:19 a.m., IDON reviewed MDS Section K - Swallowing/Nutritional Status dated 5/24/24 for Resident 12. IDON confirmed an RN was to review section K of the MDS for accuracy. IDON confirmed Resident 12's 5/24/24 MDS section K should show Yes [loss of 5% or more in the last month .] not on a physician-prescribed weight-loss regimen because Resident 12 lost more than 5% weight in one month from 4/3/24 to 5/3/34 and he was not on a physician prescribed weight loss program. On 6/26/25 at 11:40 a.m., Resident 12's Responsible Party (RP) was interviewed. RP stated his father (Resident 12) was always overweight before he was admitted to the facility. RP stated his father began losing weight when he was admitted to the facility. RP stated he visited the facility on the weekends, and his father expressed he did not like the facility food, that it had no taste. RP stated his father mainly liked Filipino food. During a dining observation on 6/26/25 at 12 p.m., Resident 12 at lunch in his room. Resident 12 consumed 100% of his milk, 80% of his juice, 25% of rice, 75% of chicken, 100% of dessert, did not eat any vegetables, and did not eat his bread. During an interview and concurrent record review with RD on 6/26/25 at 12:21 p.m., RD confirmed weight maintenance was her goal for Resident 12. RD stated weight loss due to PO intake was not desirable for Resident 12. RD stated weight loss can be caused by other things other than food intake, such as skin breakdown and medication. RD confirmed she did not discuss possible causes of weight loss with IDT. RD also stated prescribed snacks equal about 100 to 150 calories, so snacks BID would add about 200 to 300 calories a day. During an interview on 6/26/25 at 2:04 pm., CDM stated she did not talk to family members or RP regarding Resident 12's food preferences, instead she spoke to Resident 12. CDM stated Resident 12 was not picky with food and liked coffee. CDM stated currently Filipino food was not served at the facility. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	While CDM stated she could speak to Resident 12, a record review of the MDS for Resident 12, dated 4/3/25, indicated Resident 12 had a score of 4 on the Brief Interview for Mental Status (BIMS, an assessment of a resident's cognition skills; a score of 0-7 indicates severe cognitive impairment).

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to conduct performance review at least once every 12 months for one of 4 certified nursing assistants (CNA F) and one of two licensed vocational nurses (LVN G). This failure resulted in unidentified training needed for the CNA and the LVN to improve their skills in resident care every year. Findings: Review of CNA F's personal file indicated she was hired on 9/26/22, and she did not have a performance review done in 2023. Review of LVN G's personal file indicated she was hired on 8/18/22, and she did not have any performance review done. During an interview with the director of staff development (DSD) on 6/26/25, at 3:05 p.m., she reviewed CNA F's and LVN G's personal files and confirmed that CNA F did not have a performance review done in 2023, and LVN G did not have any performance review done since 8/18/22 when she was hired. The DSD acknowledged that staff performance review should be done every year. Review of the facility's policy, Performance Evaluations, dated 9/2020, indicated The job performance of each employee shall be reviewed and evaluated at least annually.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure an accurate record of medication disposition when number of counted Lorazepam (medication that helps calm the brain and nervous system) tablets for destruction was not correctly documented. This failure had the potential for misuse or diversion of controlled medications. Findings: During a concurrent observation, interview, and record review on 6/24/25 at 10:20 a.m. with the Interim Director of Nursing (IDON), and the Administrator (ADM), a random audit of medications for destruction was done. The IDON verified a bottle of lorazepam 0.5 mg (milligram, a unit of measurement) tablets for destruction contained 24.5 tablets. The IDON and ADM verified the record sheet indicated 14.5 tablets were to be destructed. The IDON stated it should have been recorded as 24 tablets. The IDON also stated she counted the medications with Licensed Vocational Nurse (LVN) B prior to documentation. During a concurrent observation, interview, and record review on 6/24/25 at 10:28 a.m. with LVN B, LVN B verified there were 24.5 tablets of lorazepam to be destructed. LVN B also stated, she counted the lorazepam tablets with the IDON prior to documentation. A review of facility's policy and procedure (P&P) entitled Discarding and Destroying Medications revised November 2022, the P&P indicated, 10. The medication disposition record contains, as a minimum, the following information: .f. The quantity destroyed .

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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 and record review, the facility failed to ensure two of 6 residents (25 and 79) were free from unnecessary medications when Resident 25 and Resident 79 received apixaban (a blood thinner to prevent blood clots) but were not monitored for the side effects and not care-planned on the use of the medication. This failure had the potential for the residents to experience unrecognized adverse effects. Findings: 1. Review of Resident 25's admission Record indicated she was admitted to the facility on [DATE]. Review of Resident 25's physician order, dated 6/4/25, indicated she had an order for apixaban 2.5 milligrams (mg, a metric unit of mass) two times a day. However, review of Resident 25's clinical record did not indicate that Resident 25 was monitored for the side effects and care-planned on the use of the medication. During an interview with the interim director of nursing (IDON) on 6/27/25, at 2:44 p.m., she reviewed Resident 25's clinical record and confirmed that Resident 25 was not monitored for the side effects and was not care-planned on the use of apixaban. 2. Review of Resident 79's admission Record indicated she was admitted to the facility on [DATE]. Review of Resident 79's physician order, dated 6/20/25, indicated she had an order for apixaban 2.5 mg two times a day. However, review of Resident 79's clinical record did not indicate that Resident 79 was monitored for the side effects and care-planned on the use of the medication. During an interview with the IDON on 6/27/25, at 2:06 p.m., she reviewed Resident 79's clinical record and confirmed that Resident 79 was not monitored for the side effects and was not care-planned on the use of apixaban. The IDON stated the residents should be monitored for the side effects and care-planned on the use of apixaban. Review of the facility's policy, Anticoagulation - Clinical Protocol, dated 11/2018, indicated 1. a. Assess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications.

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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. Based on observation, interview, and record review, the facility had a medication error rate of 8% when two medication errors occurred out of 25 opportunities during medication administration for 1 out of seven residents (Residents 129) when Resident 129's medications, Metformin (medication primarily used to a condition where the body doesn't use insulin properly to control blood sugar levels) and Insulin Lispro (a rapid-acting form of insulin used for the treatment of high blood sugar) were not given according to the Physician's Orders. The deficient practice resulted in medications not given in accordance with the prescriber's orders and/or manufacturer's specifications, which may result in residents not receiving the full therapeutic effect of the medications. Findings: During a medication pass observation on 6/24/25 at 4:25 p.m. with Licensed Vocational Nurse (LVN) C, LVN C administered the medications Metformin 1000 mg (milligram, a unit of measurement) tablet orally and insulin lispro 4 units injected subcutaneously (into the tissue layer between the skin and the muscle) to Resident 129. There were no observed snacks or food on Resident 129's bedside. During an interview on 6/24/25 at 5:10 p.m. with Registered Nurse (RN) A, RN A stated dinner was served at 5:30 p.m. A review of Resident 129's Physician Orders indicated, Metformin Hcl [hydrochloride] Oral Tablet 1000 mg give 1 tablet by mouth two times a day for DM [diabetes mellitus, condition where your blood sugar levels are too high] give with meals and Admelog Injection Solution 100 unit/ml [milliliter, unit of measurement] (Insulin Lispro) Inject 4 units subcutaneously with meals for DM2 [Diabetes mellitus Type 2] management. During a concurrent interview and record review on 6/26/25 at 12:17 p.m. with the Interim Director of Nursing (IDON), the IDON verified Resident 129's physician orders for the medications Metformin and Insulin Lispro. The DON stated it should have been given with food. A review of facility's policy and procedure (P&P) entitled Administering Medications revised 2019, the P&P indicated, .4. Medications are administered in accordance with prescriber orders, including any required time frame .5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: a. enhancing optimal therapeutic effect of the medication; .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure proper medication storage and labeling of medications when an opened lorazepam oral concentrate (medication that helps calm the brain and nervous system) was found inside the refrigerator without an open-date label. The deficient practice had a potential for residents to receive medications with unsafe and reduced potency which could lead to unsafe and ineffective medications for the residents. Findings: During a concurrent observation and interview on 6/23/25 at 9:01 a.m. with the Interim Director of Nursing (IDON) in the Medication Room, the IDON verified an opened box of used lorazepam oral concentrate inside the refrigerator. The IDON also verified there was no label for its open-date. The IDON stated it should have been labeled when it was opened. A review of facility's policy and procedure (P&P) entitled Medication Labeling and Storage dated 2001, the P&P indicated, .6. Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurses' station or other secured location. Medications are stored separately from food and are labeled accordingly .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure food that was regular and pureed potatoes were flavorful and served at a palatable temperature. These failures had the potential for residents who received potatoes to eat less and have a decreased amount of nutrient intake. Findings: During a concurrent test-tray observation and interview with the The Certified Dietary Manager (CDM) on 6/23/25 at 12:14 p.m., the temperature of a regular diced potatoes was measured with a calibrated thermometer by CDM at 100 degrees Fahrenheit (F). The CDM mentioned that there was always issues with potatoes temperature. When the potatoes were tasted, they barely felt warm in the mouth. During a concurrent test-tray observation and interview with the CDM on 6/23/25 at 12:20 p.m., when potatoes were tasted, the regular diced potatoes did not have much flavor (bland), and the pureed potato were even more bland. The CDM verified the taste and described the pureed potatoes as milky-bland; and the regular potatoes did not have much flavor. During an interview with the CDM on 6/23/25 at 1:43 p.m., the CDM stated that the service temperature of the food delivered to resident should have been 110 to 120 degrees F. A review of facility's policy and procedure (P&P) titled Meal Service, dated 2023, indicated, the temperature of the food when the resident receives it is based on palatability. The goal is to serve cold food cold and hot food hot. The recommended temperature at delivery to resident for hot entrée, waffles/pancakes, French toast starch, vegetables is equal to or greater than 120 degrees F. In addition, the P&P titled Food Preparation, dated 2023 indicated, prepared food will be sampled to be sure the food has a satisfactory flavor. Increased amounts of herbs and spices (not salt) may be added. It is the position of the American Dietetic Association (ADA; currently known as the Academy of Nutrition and Dietetics) that the quality of life and nutritional status of older residents in long-term care facilities may be enhanced by a liberalized diet. A diet that is not palatable or acceptable to the individual can lead to poor food and fluid intake, which results in weight loss and undernutrition, followed by a spiral of negative health effects. [NAME], B., [NAME] K. C., & [NAME] P.K. (2002). Position of the American Dietetic Association: Liberalized Diets for Older Adults in Long-Term Care. Journal of the American Dietetic Association 102(9), 1316-1323. https://doi.org/10.1016/S0002-8223(02)90289-0

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555757	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milpitas Care Center	120 Corning Avenue Milpitas, CA 95035

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food safety when: 1. While feeding the two residents (Residents 25 and 3) certified nursing assistant (CNA) E touched the resident cups without conducting hand hygiene between helping the residents; 2. While assisting a resident (Resident 25) with feeding, CNA E handled the drinking surface of resident's cup; 3. The dry food storage shelves were in poor condition; and 4. Certified Nursing Assistant H (CNA H) walked out of Resident 6's room, did not sanitize her hands, and shifted residents' lunch trays in the meal cart up and down. These failures had the potential to result in bacterial or physical contamination of residents food which could lead to foodborne illness further compromising the health status of 26 residents who received meals. Findings: 4. During an observation on 6/24/25, at 11:50 a.m., certified nursing assistant H (CNA H) walked out of Resident 6's room and did not sanitize her hands. CNA H went to the meal cart which was parked in the hallway and shifted residents' lunch trays up and down. During a concurrent interview with CNA H, she stated she should sanitize her hands went walking out of the residents' rooms and before touching the residents' lunch trays. During an interview with the infection preventionist (IP) on 6/27/25, at 1:59 p.m., she stated the staff should sanitize their hands went walking out of the residents' rooms and before picking up the residents' lunch trays. Review of the facility's policy, Handwashing/Hand Hygiene, dated 10/2023, indicated This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. 1. On 6/24/25 at 11:48 a.m., during a dining observation in the dining room, CNA E assisted Resident 25 with drinking juice. CNA E handled the cup to place in the resident's hand. Then CNA E then helped another resident, Resident 3, who was seated across from Resident 25. CNA E handled resident 3's cup to place it closer to her. Resident 3 picked up the cup to drink from. CNA E did not perform hand hygiene between touching Resident 25 and Resident 3 cups. During an interview with the Interim Director of Nursing (IDON) on 6/24/25 at 1:35 p.m., the IDON stated when a staff assist a resident, the staff was expected to perform hand hygiene prior to attending to another resident. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, dated October 2023, the P&P revealed, Hand hygiene is indicated: immediately before touching a resident; after touching a resident; after touching the resident's environment. 2. On 6/24/25 at 11:48 p.m., during a dining observation in the dining area, Certified Nursing Assistant (CNA) E assisted Resident 25 drinking juice. CNA E handled Resident 25's drinking cup by the rim where Resident 25's mouth came in contact to drink. During an interview with the Interim Director of Nursing (IDON) on 6/24/25 at 1:35 p.m., the IDON stated the staff should have grasp the cup by the lower portion rather than the top to prevent cross contamination and ensure infection control. According to FDA Food Code 2022 indicated, cleaned and sanitized utensils are to be handled so that lip-contact surfaces is prevented. 3. During a concurrent kitchen observation and interview with the Certified Dietary Manager (CDM) on 6/23/25 at 8:55 a.m., it was observed that the shelving in the storeroom, where shelf-stable items and produce were stored, had peeling paint. The shelves had a rough texture due to layers of paint, some of which was coming off. Additionally, a black residue was noted on the surfaces of the shelves. The CDM acknowledged the rough condition of the surfaces and the peeling paint present on the shelving. According to FDA Food Code 2022, physical facilities shall be maintained in good repair. In addition, food is to be protected from contamination by storing the food in a clean location. Materials used in food contact surfaces of equipment may not allow the migration of deleterious substances and under normal conditions are to be durable, corrosion-resistant, finished to have a smooth, easily cleanable surface.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain consent (permission or agreement from someone having authority or power) for Coronavirus Disease (COVID-19, a mild to severe respiratory illness that is airborne and is spread from person to person or by contact with infectious material such as respiratory droplets in the air and to a lesser degree on high touch surfaces in the environment) vaccination for one of 5 residents (4). This failure had the potential to result in Resident 4's responsible party (RP, the party responsible to making health care decisions when the principal party is unable to make) not being aware of the risks and benefits of COVID-19 vaccine, and therefore unable to make an informed healthcare decision regarding the vaccine. Findings: Review of Resident 4's admission Record indicated he was admitted to the facility on [DATE], and he had one of his sons as his RP. Review of Resident 4's COVID-19 Immunization Record indicated on 10/30/24, Resident 4's family refused for him to have COVID-19 vaccine. During an interview with the infection preventionist (IP) on 6/26/25, at 5:17 p.m., she reviewed Resident 4's clinical record and was unable to locate the consent from Resident 4's RP on COVID-19 vaccine refusal on 10/30/24. The IP stated the consent should have been obtained for the residents' vaccinations. Review of the facility's policy, Coronavirus Disease (COVID-19) - Vaccination of Residents, dated 5/2023, indicated . 9. Residents must sign a consent to vaccinate form prior to receiving the vaccine. The form is provided to the resident in a language and format understood by the resident or representative.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview and record review, the following multi-resident rooms provided less than 80 square feet per resident: Findings: Room Total Sq. Ft. Sq. Ft./Bed No. of Beds 6 287.86 71.965 4 7 287.86 71.965 4 10 286.66 71.665 4 During observations throughout the survey, none of the rooms were observed to inhibit the staff from providing care or the residents from receiving adequate care. The staff and the residents moved freely in the rooms. The residents and staff verbalized no complaints or concerns regarding space and privacy. Continuance of the room waiver is recommended.