STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555769	A. Building B. Wing	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Retirement Community at Davis	1515 Shasta Drive Davis, CA 95616

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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 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 observation, interview, and record review, the facility failed to maintain a safe and secure storage of medications for two of 17 sampled residents (Resident 8 and Resident 20), for a census of 36 when:1a.Resident 8's unlabeled medication was left at bedside;1b.Resident 8's discontinued controlled medications were stored in the medication cart;2. Resident 20's expired medication was stored in the medication room; and,3. Two bottles of expired vitamins were stored in the medication room.These failures increased the potential for medications to be accessible to other residents, increased the potential for drug diversion, and administration of vitamins with decreased effectiveness. Findings: 1a. During a review of Resident 8's admission records, the records indicated Resident 8 was admitted in May 2025 with diagnoses that included displaced fracture of lateral malleolus of left fibula (a break in the small bone on the outside of the ankle joint), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (a condition characterized by excessive worry and fear that can interfere with daily life). Resident 8's Minimum Data Set (MDS, a federally mandated resident assessment tool) indicated Resident 8 had moderate cognitive impairment. During a concurrent observation and interview on 9/16/25 at 9:28 a.m. with Resident 8 in her room, an unlabeled medication cup containing white powder was observed on top of Resident 8's nightstand. Resident 8 stated, .that's the powder that goes under my breast for itching. During an observation on 9/16/25 at 2:41 p.m. in Resident 8's room, Resident 8 was observed alert, sitting in wheelchair, and reading newspaper. The unlabeled medication cup with white powder was still observed at bedside. During a concurrent observation and interview on 9/16/25 at 3:09 p.m. with the Infection Preventionist (IP) in Resident 8's room, the IP stated a resident can be allowed to keep medications at bedside if the physician assessed that the resident could self-administer the medication. The IP confirmed the observation of the unlabeled medication containing white powder on top of Resident 8's nightstand and stated, .it doesn't say what it is, and since it doesn't have label, we don't know when it was prepared. The IP further stated, .It [powder] should not be here.The roommate does have cognitive issues.We don't know if roommate will take it or mix it with fluids. During a review of the facility's policy and procedure (P&P) titled MEDICATION STORAGE IN THE FACILITY, revised 5/16/18, the P&P indicated, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident-specific medication supplies are accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. 1b. A review of the admission Record indicated Resident 8 was initially admitted [DATE] with diagnosis including low back pain and generalized muscle weakness. A review of Resident 8's discontinued medications indicated, the physician order for Tramadol (a controlled substance used to treat moderate to severe pain) HCL (hydrochloride) 50 mg (milligram, unit of measurement) 1 tab by mouth every 8 hours as needed for pain was discontinued on 2/10/25. During a concurrent interview and record review with the Director of Nursing on 9/17/28 at 12:08 p.m., the DON stated Resident 8's Tramadol order was discontinued sometime February and the two bubble packs, each bubble pack containing 28 pills were stored in the narcotic drawer along with the active controlled medications inside the medication cart. The DON further stated the medication bubble packs should have been given to the DON. A follow up interview with the DON was conducted on 9/18/25 at 8:58 a.m. The DON stated all discontinued medications should be taken out from the active supply to prevent medication errors. The DON further stated there is a potential for drug diversion when discontinued controlled medications are not removed from the medication cart. 2. During a concurrent observation and interview on 9/17/25 at 1:35 p.m. inside the medication room with the Director of Staff Development (DSD). Two bottles of Vitamin E softgels, each bottle containing 100 softgels with an expiration date of 8/31/25 were stored inside the medication room with other over the counter medications. The DSD confirmed the 2 bottles of Vitamin E were expired. 3. During a concurrent observation and interview on 9/17/25 at 1:54 p.m. inside the medication room with the DSD. A box of biotene mouth spray for Resident 20 with an expiration date of 8/27/25 was stored in the bottom drawer with other medications. The DSD confirmed the moisturizing spray was expired. In an interview on 9/19/25 at 7:37 a.m., the DON confirmed she was made aware of the expired medications and the DON stated this was unacceptable. The DON further stated the night shift nurse should be checking the medications in the medication room at least once a week. A review of the facility's P & P revised 1/1//23 and titled, Controlled Substance Storage indicated, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility .Controlled substance inventory is regularly reconciled to the Medication Administration Record (MAR) and Form: CONTROLLED SUBSTANCE RECORD .Completed accountability records are submitted to the director of nursing [sic] .Controlled substances remaining in the facility after the order has been discontinued .are retained in the facility in a securely locked area with restricted access until destroyed .Accountability records for discontinued controlled substances are maintained with the unused supply until it is destroyed or disposed of . A review of the facility's policy & procedure (P & P) revised 6/2024 and titled, Medication Administration: Disposition of Discontinued Medications indicated, It is the policy of the Company to manage the disposition, destruction and disposal of discontinued and/or out-of-date medications in accordance with the Federal and State regulations and in a manner that ensures maximum safety for (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents .Discontinued medications include physician-ordered discontinued medications (prescription and/or over-the-counter (OTC) .expired medications and out-of-date house stock medications .Give the discontinued controlled medication or narcotic to Director of Nursing . A review of the facility's P & P revised 1/1/2023 and titled, Storage of Medications indicated, .Outdated .medications .are immediately removed from inventory, disposed of according to procedures for medication disposal .All expired medications will be removed from the active supply and destroyed in the facility .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to store and prepare food in accordance with professional standards for food service safety for a census of 36 when: 1.Food items in the refrigerator were observed to be uncovered; and,2. Potentially hazardous food (food that requires time/temperature control for safety to limit the growth of organisms capable of causing a disease) had inaccurate labeling.These failures had the potential to result in foodborne illnesses. Findings: During a concurrent observation and interview, on 9/16/2025 at 8:18 a.m. of the walk-in refrigerator #8, with the Nutritional Services Supervisor (NSS), a large plastic bin of dark orange sauce was observed on the refrigerator shelf uncovered. The NSS confirmed all food items are to be covered. During a concurrent observation and interview, on 9/17/2025 at 9:33 a.m. of the walk-in refrigerator #8, with the NSS, a steel container of cooked lentils was observed on refrigerator shelf partially covered with plastic wrap. The NSS confirmed everything is to be covered. During a review of the facility's policy titled, Refrigerated Storage Standards, revised 5/03 indicated, Prepared Foods: Once foods are prepared, portioned and ready for service, caution should be taken to assure that they are stored properly to retain color, quality and moistness for eating.Covered foods.prevent items from falling into product. 2. During the dining observation on 9/16/25 at 12:23 p.m. in the dining hall, tuna salad was observed on a plastic container covered with a plastic sheet and was served for lunch. The label on the tuna salad indicated, .PREPARED: Tue [Tuesday] 09/16/25 1:27 PM. During a concurrent observation and interview on 9/16/25 at 12:26 p.m. with the Director of Dining Services (DDS) and the Nutrition Services Supervisor (NSS), the DDS and the NSS confirmed the tuna salad had an inaccurate label and that the preparation time was labeled in advance. The DDS stated, .That's interesting, maybe it's east coast [time].Tuna is good for four hours.If the tuna salad exceeded the four-hour danger zone, at that point, the food is on danger zone and potential for bacteria.The label is the basis when counting the danger zone time. During a follow-up observation and interview on 9/16/25 at 12:45 p.m. with the DDS and the NSS in the kitchen, the machine used to print labels indicated that the time was set at 2:46 p.m., which indicated the machine was set two hours ahead of the actual time. Three other label machines were inspected and all the machines indicated inaccurate times. The NSS stated that if the preparation time was not accurate, .we don't know the safe time zone, we don't know if it [food] is still good. During a review of the facility's policy and procedure (P&P) titled Data Code Genie (DCG) Food Labeling Standard, revised 4/2024, the P&P indicated, Food date marking should incorporate identified standards and criteria to ensure all food items are kept safe for consumption within a specific amount of time to minimize bacteria growth and spoilage. During a review of the facility's P&P titled General Food Storage Standards, revised 1/2023, the P&P indicated, .16. All potentially hazardous foods must be labeled with a date sticker as soon as the package is opened or the item is prepared.

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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 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, and record review, the facility failed to maintain and follow an effective infection prevention and control program for a census of 36 when:1.Resident 40's CPAP (continuous positive airway pressure- ensures uninterrupted breathing and oxygen) mask and distilled water used for the treatment were not properly stored;2. Staff did not consistently follow transmission-based precautions (TBP) for Resident 37;3. Resident 20's distilled water used for CPAP treatment was observed unlabeled and on the floor; 4. Dirty linens were observed on the floor of the laundry room; and5. The facility management was not informed of positive Legionella (a type of bacteria found in [NAME] that can cause a serious type of lung infection) testing results. These failures increased the potential for Resident 40 and Resident 20 to develop respiratory infections, and decreased the facility's potential in preventing transmission of diseases among residents and staff.Findings: 1. A review of the admission Record indicated Resident 40 was admitted [DATE] with diagnosis including Parkinson's disease (a brain disorder causing problems with movement and balance) with dyskinesia (involuntary, uncontrolled, & repetitive muscle movements) and obstructive sleep apnea (intermittent airflow blockage during sleep). A concurrent observation and interview was conducted on 9/16/25 at 9:41 a.m. inside Resident 40's room. Resident 40 confirmed the CPAP machine at bedside belonged to him. The CPAP mask was not covered and there was an opened, unlabeled 1 gallon container of distilled water on the floor. A follow up observation and interview was conducted on 9/16/25 at 10:43 a.m. inside Resident 40's room with Certified Nursing Assistant 2 (CNA 2). The CNA 2 stated when she came in this morning Resident 40 was off his CPAP. The CNA 2 further stated the CPAP mask should be inside the bag. The CNA 2 showed a black mesh bag located near the CPAP machine on top of the nightstand. The CNA 2 confirmed the container of distilled water was on the floor, opened and unlabeled, and used for Resident 40's CPAP. The CNA 2 stated the container of distilled water should be on the counter, inside the cabinet or on top of the nightstand. A review of Resident 40's physician orders on 9/16/25 did not include orders for CPAP mask cleaning. A concurrent interview and record review was conducted on 9/18/25 at 12:01 p.m. with the Director of Nursing (DON). The nurse surveyor showed the photos taken on 9/16/25 with the DON. When the DON saw the photos of Resident 40's CPAP mask and distilled water, the DON stated, that's an infection control issue. The DON further stated the CPAP mask should be inside the bag and the distilled water should have been dated and should not be on the floor. The DON stated the CPAP mask cleaning should have been placed on admission. The DON confirmed there was no documented evidence the CPAP mask was cleaned since admission. A review of the facility's policy and procedure revised 8/2024 and titled, Aerosol Generating Procedures (AGPs)- BIPAP [or bi-level positive airway pressure]/CPAP indicated, The purpose of this policy is to guide prevention of infection associated with respiratory treatment tasks and equipment .AGPs among ALL residents and staff .'CPAP', or continuous positive airway pressure, is a respiratory therapy intervention used to provide a patent airway during periods of sleep apnea. It uses air pressure generated by a machine, delivered through a tube into a mask that fits over the nose or mouth .Sterile distilled water used in respiratory treatments must be dated and initialed when opened (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.Clean reusable equipment with mild soap and water once treatment is completed . 2. A review of Resident 41's medical record indicated Resident 41 was admitted to the facility in September of 2025 with diagnoses of Malignant Neoplasm of Anus (Anal cancer), Enterocolitis due to Clostridium Difficile (c-diff; an inflammation of the small and large intestines caused by the bacterium Clostridium Difficile), and resistance to multiple antimicrobial drugs [a medication used to treat and prevent infections caused by microorganisms such as bacteria, viruses and fungi]. Resident 41's Minimum Data Set (MDS, a federally mandated resident assessment tool) indicated Resident 41 had no cognitive impairment. During an observation and interview on 9/16/25 at 3:30 p.m. with Resident 41 and Resident 41's family member, it was observed that Resident 41 had an isolation cart outside of her room, and signs labeled, Contact Precautions [transmission based precautions used to prevent the spread of infectious agents spread through contact] and Droplet Precautions [transmission based precautions used to prevent the spread of infectious agents spread through droplet; such as when coughing] taped to the wall next to the room entrance. Resident 41's room door was observed to be open. When asked about the reason for being on contact and droplet isolation, Resident 41 stated she is a cancer patient who has a cough and diarrhea. Per Resident 41's family member, .we were told that everyone who enters this room has to wear a gown, mask and wear gloves. you should not have washed your hands in her bathroom .staff told us that we have to wash our hands at the nurse's station. During an observation on 9/16/25 at 4:30 p.m., Licensed Nurse 4 (LN 4) was observed entering Resident 41's room and left the door open while providing care. During a follow up observation on 9/16/25 at 4:35 p.m., the door of Resident 41's room remained open. LN 4 was observed removing her PPE [personal protective equipment] in the room at the trashcan by the door. LN 4 was not observed washing her hands with soap and water after removing her PPE. LN 4 used hand sanitizer and walked down the hall to the nurse's station. During an interview on 9/16/25 at 4:40 p.m. with LN 4, LN 4 stated Resident 41 is on contact and isolation precautions due to having c-diff and a cough. LN 4 confirmed she did not wash her hands in Resident 41's room and that she washed her hands at the nurse's station after caring for Resident 41. During an interview and observation on 9/17/25 at 9:55 a.m. with Certified Nursing Assistant 3 (CNA 3), CNA 3 stated that Resident 41 is on contact and droplet precautions. CNA 3 confirmed the door to Resident 41 was open. During an observation on 9/17/25 at 10:00 a.m., a Housekeeper (HK) was observed in Resident 41's room. The door to Resident 41's room was left open while HK cleaned the room. The HK was observed removing PPE in the room, at the trashcan by the door, and left the room without washing her hands with soap and water. The door to Resident 41's room was left open. During an interview on 9/18/25 at 8:45 a.m. with Infection Preventionist (IP), the IP stated Resident 41 was on contact precautions due to a c-diff diagnosis. The IP stated Resident 41 was on droplet precautions due to . she also has MDRO [multidrug-resistant organism] in her respiratory track and has an active cough. IP confirmed that she educated staff to wash their hands in Resident 41's room after removing their PPE and to use a paper towel to turn off the water. IP stated that . because some of them don't feel comfortable with using her [Resident 41] bathroom because of the c-diff. they walk with their hands up so people know their hands are dirty and they will wash hands at the nursing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	station with soap and water. During an interview on 9/18/25 at 8:45 a.m. with the Director of Nursing (DON), the DON stated that her expectation for proper hand hygiene after taking care of a patient that is on contact precautions for c-diff is that they wash their hands with soap and water in the patient's room prior to exiting the room. The DON stated her expectation for someone who is on droplet precautions is that the door to their room be kept closed to prevent spread of the infection. A review of the facility Policy and Procedure (P&P) last revised 5/2023 titled Clostridioides Difficile Associated Disease, the P&P indicated in . When caring for residents with diarrhea or fecal incontinence, staff will maintain vigilant hand washing with soap and water, rather than alcohol-based hand rubs, for mechanical removal of Clostriduim difficle spores from hands. the Resident will have their hands washed thoroughly prior to leaving their room. Hand Hygiene is CRITICAL for staff and residents; (spores are NOT killed by hand sanitizers) . A review of the facility Policy and Procedure (P&P) last revised 7/2025 titled Infection Control Precautions- Categories of Transmission Based Precautions indicated, . Resident Placement During Droplet Precautions: Place the resident in a private room with the door closed . 3. During a review of Resident 20's admission records, the records indicated Resident 20 was admitted to the facility in August 2025 with diagnoses that included sleep related hypoventilation (breathing becomes abnormally slow or shallow during sleep), and sleep apnea (breathing repeatedly stops and starts). During a review of Resident 20's physician order, dated 8/30/25, the order indicated, CPAP: Apply at Factory setting 9mmH2O [millimeters of water, a unit of pressure measurement] with heated humidification [adding moisture to the air] at bedtime – remove in the morning. During an observation on 9/16/25 at 10:39 a.m. in Resident 20's room, two jugs of one-gallon distilled water were observed on the floor, one jug was closed, and the other one was observed opened, unlabeled and contained approximately 100ml (milliliters, a unit of measurement). During a concurrent observation and interview on 9/16/25 at 2:30 p.m. with Resident 20 in his room, the two jugs were still observed on the floor. Resident 20 stated, I use CPAP every night. The staff are putting the water on the CPAP. During a concurrent observation and interview on 9/16/25 at 3:42 p.m. with the Infection Preventionist (IP), the IP confirmed the observation of the two jugs on the floor and stated distilled water used for CPAP should not be on the floor because of the risk of contamination and spilling. During an interview on 9/18/25 at 2:48 p.m. with the Director of Nursing (DON), the DON stated, .For CPAP supplies, water should be labeled and dated, stored on the shelf, not on the floor. 4. During a concurrent observation and interview on 9/17/25 at 1:12 p.m. with the Environmental Services Manager (ESM) in the laundry room, two dirty linens were observed on the floor at the back of one of the washers. The ESM stated, I'm in the process of getting the washer fixed, water shoots up and spill on the floor, linens were used to not flood the room.It's been doing that for about a week. The ESM further stated the linens should have been picked up from the floor already and confirmed it was not sanitary. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/18/25 at 3:25 p.m. with the IP, photo of the linens on the floor was shown. The IP confirmed the linens on the floor were not sanitary and stated, .they [linens] are on the floor, it shouldn't be there, looking at the discoloration, that is a growth, it could be rusty or bacteria harboring. During a review of the facility's policy and procedure (P&P) titled Laundry & Linen, revised 4/2017, the P&P indicated, The purpose of this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linen. During a review of the facility's P&P titled Laundry Services: Linens SNF [Skilled Nursing Facility], revised 11/2017, the P&P indicated, It is the policy of the Company to assure that laundry services are provided in a manner that meets State and Federal regulations, follow standard guidelines of Center for Disease Control and Prevention, and meets residents' needs.Linens are to be transported and stored by methods that ensure cleanliness, and protect from dust and soil during intra/inter-facility loading, transport, and unloading and to prevent the spread of infection and cross contamination. 5. During a review of the Legionella testing summary report provided by the facility, dated 5/1/25, the report indicated two of the three sampled sources tested positive for Legionella. The report indicated the Theoretical Detection Limit Legionella was 1 CFU/mL (colony forming units per milliliters, a unit of measurement), and the sample taken from PWH [Potable Water Hot] Healthcare HW [Hot water] Distal had a Total Legionella of 6 CFU/mL and the sample taken from PWH Healthcare HW Near, had a Total Legionella of 5 CFU/mL. During a review of the facility provided document titled Legionella Analytical, dated 2021, the document indicated, Analytical results are reported as colony forming units (CFU) of Legionella per milliliter of sample if Legionella are detected. According to OSHA [Occupational Safety and Health Administration] guidance for Legionellosis [type of pneumonia caused by Legionella].positive sampling results indicate that Legionella is growing in the sampled water system or part of the sampled water system.Analytical results are reported as Total Legionella, which includes all detected species.The presence of any species of Legionella warrants corrective action.when the bacterium is identified in a water system, the US-CDC (United States Centers for Disease Control and Prevention) recommends determining the source and cause for growth, and that corrective action be taken to remove the bacteria from the water, known as remediation.The decision to implement remedial action lie with the facility owner or the management team. During an interview on 9/18/25 at 3:25 p.m. with the IP, the IP stated the maintenance department monitored Legionella and that she did not review Legionella testing reports and stated, If anything comes up, they let us know. The IP stated there were no positive Legionella results reported to the facility. During an interview on 9/19/25 at 9:07 a.m. with the Facilities Operations Manager (FOM), the FOM confirmed two of three samples tested positive on 5/1/25 but unable to determine which site the positive samples were taken from. The FOM stated the company that did the testing recommended flushing the pipes and removing the water softener. The FOM was not able to provide documentation to confirm if recommendations were followed or corrective actions were taken. The FOM stated she believed that the previous maintenance director communicated the results to management. During an interview on 9/19/25 at 9:45 a.m. with the Administrator (ADM), the ADM stated the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility's Maintenance Director will inform the facility management if there were any positive Legionella results and stated, Anything that affects the SNF water, they need to communicate with me. The ADM confirmed that she was not notified of the positive results from 5/1/25 and stated, IP should be aware also of the positive result.That's something we need to report.Nothing was communicated during QAPI [Quality Assurance and Performance Improvement] meetings.They should report it to me so we can take actions and report to licensing and county. During a review of the facility's P&P titled Legionella/Legionnaires Disease, revised 7/2023, the P&P indicated, .Surveillance activities are part of the water management program established by facility services which includes logging data of each water source tested and results of those tests.When positive test results are discovered by facility services, the Executive Director, Health Care Administrator, the facility Medical Director and Infection Preventionist are to notified [sic].

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review, the facility failed to ensure call light systems were accessible for two of 17 sampled residents (Resident 23 and Resident 25) when:1. Resident 25's call light was observed under the bed and not within reach; and2. Resident 23's shower room call device did not have a string to operate.These failures had the potential to negatively affect Resident 23 and Resident 25's safety by preventing the residents from communicating requests for assistance when needed.Findings:1. During a review of Resident 25's admission records, the records indicated Resident 25 was admitted to the facility in April 2023 with diagnoses that included palliative care (care focused on providing relief of pain and other symptoms of a serious illness), osteoporosis (weak and brittle bones), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia (a progressive state of decline in mental abilities). Resident 25's Minimum Data Set (MDS, a federally mandated resident assessment tool) indicated Resident 25 had severe cognitive impairment and was dependent on staff for toileting and personal hygiene.During a review of Resident 25's care plan, initiated 4/25/23, the care plan indicated, [Resident 25] has high risk for falls r/t [related to] poor safety awareness due to cognitive deficits and weakness.Keep resident's call light within reach and encourage the resident to use it for assistance as needed. The resident needs prompt assistance to all requests for assistance.During an observation on 9/16/25 at 9:55 a.m. in Resident 25's room, Resident 25 was observed lying in bed, eyes closed, respirations even and unlabored. Resident 25's call light was observed under the bed and not within reach.During a concurrent observation and interview on 9/16/25 at 10:12 a.m. with Resident 25 in her room, call light was still observed under the bed. Resident 25 stated she used the call light if she needed assistance. Resident 25 was observed moving her right hand to search for the call light.During a concurrent observation and interview on 9/16/25 at 10:14 a.m. with Licensed Nurse 1 (LN 1), LN 1 confirmed Resident 25's call light was under the bed and not within reach and stated, .It [call light] should be within reach, so they [residents] have access if they need help.2. During a review of Resident 23's admission records, the records indicated Resident 23 was admitted to the facility in February 2024 with diagnoses that included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), cerebral infarction (a condition where blood flow to the brain is interrupted, leading to tissue damage), and psychotic disorder with delusions (disorder that cause abnormal thinking and perceptions). Resident 23's MDS indicated Resident 23 had severe cognitive impairment.During a review of Resident 23's care plan, initiated on 2/23/24, the care plan indicated, The resident is high risk for falls r/t Hx [history] of falls.Be sure The resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.The resident needs a safe environment.a working and reachable call light.During an observation on 9/16/25 at 9:22 a.m. in Resident 23's shower room, the call device was observed installed approximately five feet from the floor, and missing the string to operate it.During a concurrent observation and interview on 9/18/25 at 8 a.m. with Certified Nursing Assistant 1 (CNA 1) in Resident 23's shower room, CNA 1 stated Resident 23 used the room for showers and confirmed the call light did not have a string. CNA 1 stated call lights are important in cases of emergency and that the missing call light string should have been reported to the maintenance department immediately.During a concurrent observation and interview on 9/18/25 at 8:10 a.m. with LN 2, LN 2 stated call lights should always be accessible and within reach .because residents' needs should always be attended to. LN 2 stated call lights should be present in the bathrooms and showers and must be accessible to residents and to the staff, especially during emergencies. LN 2 confirmed Resident 23's shower area had a call light but no string to pull in case the resident was on the floor. While checking Resident 23's belongings inside the bathroom, LN 2 found the missing call light string mixed with Resident 23's bathroom items. LN 2 stated, .it must have been pulled out and no one reported it to the (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	maintenance.During a concurrent observation and interview on 9/18/25 at 8:20 a.m. with the Maintenance Staff (MS), MS confirmed Resident 23's shower room call light had no string or cord attached to the call device. The MS stated Resident 23 or the staff will need the cord in case of emergency or if someone fell on the floor and stated, .we don't want anyone crawling on the floor to reach the closest call light which was about 10 feet away. The MS further stated the expectation was for staff to report to maintenance if there was anything that needed repair especially call lights because those are really important especially in cases of emergencies.During an interview on 9/18/25 at 8:30 a.m. with the Director of Nursing (DON), the DON stated call lights should be within reach at all times and should be available in bathroom and shower areas. The DON further stated all rooms should be equipped with call lights with cords so residents or staff can pull the device in case they need help. The DON added that residents can also go to bathroom or shower area by themselves and if the residents needed help, they could use the call light to alert staff. When the photo of Resident 23's call device was shown, the DON confirmed the call device did not have a string on it and stated Resident 23 will not be able to call for help in case of emergency. The DON also confirmed the call device was also high and that it would be hard to reach without a string or if the resident was on the floor.During a review of the facility's policy and procedure (P&P) titled Call Lights, revised 2/2023, the P&P indicated, It is the policy of the Company to assure that residents always have a method of calling for assistance and that staff answers the residents' calls in a timely and professional manner.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of 17 sampled residents (Resident 40) was treated with dignity and the right to privacy when Resident 40's urinary catheter drainage bag was not completely covered while in the dining room.This failure increased the potential for Resident 40 to experience emotional or psychological distress.A review of the admission Record indicated Resident 40 was admitted [DATE] with diagnosis including Parkinson's disease (a brain disorder causing problems with movement and balance) with dyskinesia (involuntary, uncontrolled, & repetitive muscle movements) and generalized muscle weakness. Further review of Resident 40's clinical records indicated the following information:- An Order Summary Report dated 9/9/25 indicated Urinary Catheter: Cover Urinary Drainage Bag for privacy every day and evening shift;- A care plan dated 9/10/25 indicated, [Resident 40] has Indwelling Suprapubic Catheter [a tube surgically placed in the lower abdomen into the bladder to drain urine continuously] R/T [related to] Obstructive & Reflux Uropathy [blockage in the urinary tract & urine flows backward]; and,- A Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen, and identify memory, orientation, and judgement status of the resident) dated 9/10/25 indicated Resident 40 was cognitively intact. During a dining observation conducted on 9/16/25 at 12:40 p.m., Resident 40 was assisted by a staff member in the Dining Room. Resident 40 was in a wheelchair, and his urinary catheter bag had a blue material cover. The bottom portion of the catheter bag was visible. A concurrent observation and interview was conducted on 9/16/25 at 12:46 p.m. with Certified Nursing Assistant 2 (CNA 2). The CNA 2 stated the purpose of the blue material was to cover Resident 40's catheter bag. When CNA 2 checked Resident 40's catheter cover, the snap that kept the cover together was broken. The CNA 2 further stated the cover for Resident 40's catheter bag was broken and the whole drainage bag should be covered. A subsequent observation was conducted on 9/16/25 at 12:50 p.m. inside the dining room. The CNA 2 replaced Resident 40's catheter bag cover in the dining room without providing privacy. During a concurrent interview and record review with the Director of Nursing (DON) on 9/18/25 at 12 p.m. The nurse surveyor showed the photo of Resident 40's drainage bag taken on 9/16/25 and DON stated, It's not acceptable, it's a dignity issue. The DON stated Resident 40's broken drainage bag cover should have been replaced before resident was assisted in the dining room. A review of the facility's policy revised 8/2013 and titled, Privacy of Care indicated, It is the policy of the Company to treat all residents with dignity and respect and assure them of their basic resident's rights by providing adequate privacy . A review of the facility's undated document titled, NOTICE OF RESIDENT RIGHTS UNDER FEDERAL LAW indicated, As a resident at the skilled nursing facility .you have the following rights .The right to be treated with respect and dignity, and to be cared for in a manner and in an environment that promotes maintenance or enhancement of your quality of life .

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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 ensure the electronic record reflected the resident's treatment decisions for one of 17 sampled residents (Resident 2) when Resident 2's code status (a status indicating what should be done if the resident had no pulse and not breathing) was not indicated on the electronic medical record and was not available to staff, and had no physician order.This failure decreased the facility's potential to respond appropriately based on Resident 2's choices in the event of a medical emergency.Findings:During a review of Resident 2's admission records, the records indicated Resident 2 was admitted in [DATE] with diagnoses that included periprosthetic fracture (a fracture that occurs around or near an artificial joint), dementia (a progressive state of decline in mental abilities), anxiety (a condition characterized by excessive worry and fear that can interfere with daily life), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), and delirium (a serious disturbance in a person's mental abilities that results in a decreased awareness of one's environment and confused thinking). Resident 2's Minimum Data Set (MDS, a federally mandated resident assessment tool) indicated Resident 2 had moderate cognitive impairment.During a review of Resident 2's Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of-life care), dated [DATE], the POLST indicated Resident 2 was DNR (Do Not Attempt Resuscitation) and on Comfort-Focused Treatment (primary goal of maximizing comfort).During a review of Resident 2's electronic medical record, the record did not indicate Resident 2's DNR or comfort-focused care status. The record also did not contain a physician order for Resident 2's DNR status.During an interview on [DATE] at 8:10 a.m. with Licensed Nurse 2 (LN 2), LN 2 stated that in case of emergency, staff refer to the code status note on the resident's electronic chart and refer to the physician order. LN 2 further stated if code status was not available on either, staff needed to dig in more on the admission records, which cannot be done during an emergency situation. LN 2 added that the code status and physician order is important to make sure staff are aware of the resident's code status and will not provide CPR (cardiopulmonary resuscitation, an emergency procedure that combines chest compression and rescue breathing to restart a person's breathing and heartbeat) for residents on DNR, and full code (indicates that all life-saving measures, including CPR, should be used) residents received CPR during emergency situations.During a concurrent interview and record review on [DATE] at 8:30 a.m. with the Director of Nursing (DON), the DON stated that in cases of emergency, the code status of residents can be found in the code status note in the electronic medical chart. The DON also stated the record should have a physician order on the code status of the resident and stated, .important so the staff is aware on what to do during emergency, providing CPR to full code residents and not providing CPR for DNR residents. The DON further stated, .if there was no note and no physician order, we usually consider the resident as full code. The DON confirmed Resident 2's electronic medical record did not indicate Resident 2's code status and that there was no physician order for the code status. The DON further confirmed Resident 2's POLST indicated Resident 2 was DNR and stated, .the code status should have been entered upon admission. The DON stated Resident 2 could have received CPR if there was an emergency because the code status was not available for the staff.During a review of the facility's policy and procedure (P&P) titled Advance Directives, revised 5/2025, the P&P indicated, .3. If a resident has completed an updated Advance Directive or POLST, the Social Services Director or designee will document this in the Advance Directive section of the medical record and include a copy of the Advance Directive as well.4. If the resident or legal representative has executed one or more advance directive(s), these documents are obtained, incorporated and consistently maintained in the same section of the resident's health (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	information record readily retrievable by any facility staff, and the facility will communicate the resident's wishes to the resident's direct care staff and physician.6. In the absence of an Advanced Directive or POLST or in the absence of a physician order consistent with the resident's wishes, the facility will proceed with full code measures.9. The Advanced Directive, related documents, and physician orders will be audited quarterly or upon significant change of condition by the Clinical Records Coordinator or designee to ensure the Electronic Health Record reflects the resident most recent wishes regarding resuscitation.

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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. Based on observation, interview and record review, the facility failed to maintain acceptable parameters of nutritional status for one of 36 sampled residents, (Resident 32) when Resident 32's unplanned weight loss was not assessed and managed. This failure had the potential for Resident 32 to experience continued weight loss.Findings:A review of Resident 32's medical record indicated Resident 32 was admitted to the facility in the Spring of 2021 with diagnoses of Protein Calorie Malnutrition (lack of sufficient protein or calories), Chronic Kidney Disease and Acute on Chronic Heart Failure. Resident 32's Minimum Data Set (MDS, a federally mandated resident assessment tool) indicated Resident 32 had no cognitive impairment. During a medical record review, Resident 32's weights were as follows:9/13/25 weight 103.3 lbs9/12/25 weight 103.4 lbs9/11/25 weight 111.2 lbs The medical records indicated that Resident 32 had a 7.8 lb weight loss between 9/11/25 and 9/12/25. During an observation and interview on 9/18/25 at 10:20 a.m. with Resident 32, Resident 32 appeared thin and fragile. Resident 32 stated she had concerns with her weight loss. Resident 32 stated, I normally weigh around 115 pounds, but I started to lose weight. they gave me shakes but I have not had them in 2 weeks or so now.Based on The Center of Disease Control and Prevention (CDC) website (www.cdc.gov) dated 6/2024, a Body Mass Index (BMI) is based on mathematical formula that uses height and weight to estimate body fat and is used to categorize individuals into categories like underweight, healthy weight or overweight. During a review of Resident 32's medical record, Resident 32's weight and height record indicated Resident 32 measured 64 inches tall (5 feet and 3 inches) and on 9/12/25, weighed 103.4 pound(s) (lb/lbs). Per the recorded height and weight, Resident 32's Body Mass Index (BMI) is in the underweight category.During an interview and concurrent record review on 9/18/25 at 10:58 a.m. with Licensed Nurse 3 (LN 3), when asked what the policy and procedure is for managing weight loss for the residents in this facility, LN 3 stated, . I would notify the Dr [doctor], do a COC [change of condition assessment] and then tell the DON and RD [Registered Dietitian].we would offer snacks or shakes that are ordered. it should be in the Care Plan. we have to find the cause of the weight loss LN 3 was unable to find a COC or Care Plan in the electronic health record (EHR) for Resident 32's weight loss on 9/12/25. During an interview and concurrent record review on 9/18/25 at 11:30 a.m. with the Director of Nursing (DON), the DON reviewed the weights documented on 9/11/25 and 9/12/25 and stated, there was a .7.8-pound difference in one day. The DON further stated, That should have triggered a re-weigh and a COC . The DON was unable to find a re-weigh weight and/or a COC for this weight loss. The DON stated her expectation is . the CNA should have re-weighed the resident and the nurse should have completed a COC and notified me [DON]. if there was drastic weight loss, there are things we could have done in the meantime while waiting for that meeting with the RD.During a review of Resident 32's medical record, in a note titled, Weight Change Note on 6/5/25 the RD stated that, . Patient [Resident 32] has shown a 10.2 lb/8.7% weight loss in the past 6 months .Recommend addition of fortified meals for support of weight maintenance. Continue to monitor weight trend. During an interview and concurrent record review on 9/18/25 at 12 p.m. with the Registered Dietitian (RD), the RD stated, . Based on her height of 64 inches, her ideal body weight would be 120 pounds.she is now 104 pounds. based on her BMI, she is underweight. I did make recommendations that she be put on a fortified diet. she did have an order to give her shakes BID [2 times a day] . I am not sure why they stopped giving the shakes. When asked what diet Resident 32 is on, the RD stated that she had recommended a fortified diet due to her weight loss and stated, . She is on a Regular diet, minced and moist. I see that she is not currently on a fortified diet.I am not sure why they changed that either. The RD stated that, . weight loss contributes to an overall decline in health status. A review of the facility Policy and Procedure (P&P), last revised 4/2025, titled Change in Condition, the P&P indicated .the Licensed Nurses will assume the responsibility of making sure that any change in condition is brought to the attention of the Director of Nursing Services. The Licensed Nurses will notify the physician .and will document (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	such notification in the health information record .the residents Care Plan will be reviewed and updated as needed to reflect the change of condition .A review of the facility Policy and Procedure (P&P), last revised 10/2023, titled Weight, the P&P indicated . It is the policy of the Company to weigh residents according to State and Federal guidelines with focus on measures to prevent unintended weight changes, promote good hydration and monitor for change in condition .Any significant weight variance .will require the designated staff member do a reweigh for that resident .If there continues to be a significant weight variance, the physician will be notified by licensed staff, RD or RCM/MDS Coordinator will be contacted to assess, and appropriate interventions instituted.