

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555781	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Villa Del Rio		STREET ADDRESS, CITY, STATE, ZIP CODE 7002 Gage Avenue Bell Gardens, CA 90201	
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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide sufficient staffing when certified nursing assistants (CNAs) were assigned two resident work assignments (assigned residents for the staff member to provide care to). This deficient practice had the potential to result in a delay in care and unsafe care practices. Findings: 1. During a review of Certified Nursing Assistant (CNA) 4's Personnel Action Form (PAF), dated [DATE], the PAF indicated CNA 4 was hired to the facility on [DATE]. During a review of CNA 4's Notice of Certification, dated [DATE], the Notice of Certification indicated CNA 4's Nurse Assistant Certification was valid from [DATE] through [DATE]. During a review of CNA 4's Certification Verification, dated [DATE], the Certification Verification indicated CNA 4's Nurse Assistant Certification was valid from [DATE] through [DATE]. During a review of the facility's unnamed document containing the nursing staffing assignment for the day, dated [DATE] through [DATE], the document indicated CNA 4 had a resident work assignment (assigned residents for the staff member to provide care to) for three shifts. During a phone interview on [DATE] at 12:17 p.m., with CNA 4, CNA 4 stated her Nurse Assistant Certification expired on [DATE] and there was an issue with processing her certification renewal. CNA 4 stated her Nurse Assistant Certification was renewed on [DATE]. CNA 4 stated she did not provide direct care to the residents assigned to her while her certification was expired and assisted the other nursing staff. During an interview on [DATE] at 7:59 a.m., with the Assistant Director of Staff Development (ADSD), the ADSD stated CNA 4 was assigned a resident work assignment, however, CNA 4 was partnered with another CNA near CNA 4's assigned area. The ADSD stated CNA 4 was instructed not to perform any direct resident care and to assist the CNA she was partnered with. The ADSD stated the partnered CNA was assigned daily and not indicated on the staffing sheet. 2. During a review of CNA 5's PAF, dated [DATE], the PAF indicated CNA 5 was hired to the facility on [DATE]. During a review of CNA 5's Notice of Certification, dated [DATE], the Notice of Certification indicated CNA 5's Nurse Assistant Certification was valid from [DATE] through [DATE]. During a review of CNA 5's Certification Verification, dated [DATE], the Certification Verification indicated CNA 4's Nurse Assistant Certification was valid from [DATE] through [DATE]. During a review of the facility's unnamed document containing the nursing staffing assignment for the day, dated [DATE] through [DATE], the document indicated CNA 5 had a resident work assignment for 29 shifts. During a phone interview on [DATE] at 12:28 p.m., with CNA 5, CNA 5 stated her Nurse Assistant Certification expired on [DATE] and there was an issue with processing her certification renewal. CNA 5 stated she did not perform direct care to the residents while her certification was expired. CNA 5 stated she assisted the other nursing staff and eventually assigned to assist the activity staff until her certification was renewed on [DATE]. During an interview on [DATE] at 7:59 a.m., with the ADSD, the ADSD stated CNA 5 was (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 555781	Facility ID: 555781 If continuation sheet Page 1 of 52

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	assigned a resident work assignment, however, CNA 5 was partnered with another CNA near CNA 5's assigned area. The ADSD stated CNA 5 was instructed not to perform any direct resident care and to assist the CNA she was partnered with. The ADSD stated the partnered CNA was assigned daily and not indicated on the staffing sheet. During an interview on [DATE] at 8:37 a.m., with the ADSD, the ADSD stated uncertified nursing assistants (NAs) could not perform direct resident care tasks, however, NAs were allowed to answer call lights to ask what the residents needed and relay the information to the CNA or other nursing staff. The ADSD stated NAs were assigned a resident work assignment, however, the NAs were partnered with the closest CNA. The ADSD stated the CNA would perform the direct care and the NA would assist. The ADSD stated the CNA was responsible for the direct care for two resident assignments, which meant the CNA had twice as many residents compared to the other CNAs. The ADSD stated having twice as many residents under the CNA's care would negatively affect the residents' quality of care and safety. During an interview on [DATE] at 10:13 a.m., with the Director of Nursing (DON), the DON stated the workload should be assigned equally between the CNAs. The DON stated one CNA should not be assigned two resident work assignments because two assignments could mean the CNA would be unable to attend to all the residents' needs. The DON stated having a double resident work assignment placed the residents at risk for falls and other safety issues. During a review of the facility's Nurse Assistant Job Description, undated, the Job Description indicated the NAs duties included but not limited to:- Providing supportive services to the CNAs and other staff as needed.- Assisting with distributing meal trays to residents who could feed themselves; NAs did not assist with feeding assistance.- Completing housekeeping duties while CNAs provide care. - Assisting with transporting residents within the facility once the resident was safely transferred to the wheelchair by certified staff.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to conduct the annual performance evaluation for one of one sampled licensed vocational nurse (LVN 9). This deficient practice had the potential to result in LVN 9 being unaware of any areas in their performance requiring improvement to better care for the residents in the facility. Findings: During a review of Licensed Vocational Nurse (LVN) 9's Personal Action Form (PAF), dated 3/29/2024, the PAF indicated LVN 9 was hired to the facility on 3/29/2024. During a review of LVN 9's Employee File, the Employee File did not contain documentation that LVN 9 received an annual performance evaluation in 2025 or 2026. During an interview on 7/16/2026 at 8:55 a.m. with the Assistant Director of Staff Development (ADSD), the ADSD stated when performance evaluations were completed, the performance evaluations should be in the employee's physical file or in a binder the Director of Staff Development (DSD) kept. The ADSD stated annual performance evaluations were necessary to determine areas for improvement to better the care for the residents. During an interview on 7/16/2026 at 10:16 a.m. with the Director of Nursing (DON), the DON stated she was responsible for conducting annual performance evaluations for the licensed nurses. The DON stated there was no documentation the performance evaluations were completed for the licensed nurses. The DON stated annual performance evaluations were a tool to ensure the licensed nurses were competent in their job and could provide safe care to the residents. During a review of the facility's Policy and Procedure (P&P) titled, Performance Evaluations, undated, the P&P indicated a performance evaluation would be completed for each employee at the conclusion of his/her 90-day probationary period, and at least annually thereafter.		

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review, the facility failed to ensure one of four staff members (Social Services Coordinator [SSC]), who worked as an uncertified nursing assistant (NA) from 5/1/2023 through 7/31/2024, did not exceed a 4-month employment as an NA and did not perform duties and tasks reserved for certified staff. This deficient practice had the potential for the SSC to provide incompetent care to the assigned residents, which could affect the residents' safety and well-being. Findings: During a review of the Social Services Coordinator's (SSC) Personnel Action Form (PAF), dated 11/8/2022, the PAF indicated the SSC was initially hired to the facility's housekeeping department on 11/8/2022. During a review of the SSC's PAF, dated 4/1/2023, the PAF indicated the SSC became an employee under the nursing department on 4/1/2023. During a review of the SSC's Timecard Report, dated 5/1/2023 through 7/31/2024, the Timecard Report indicated, from 5/1/2023 through 7/31/2024, the SSC worked as a certified nursing assistant (CNA) and an uncertified nursing assistant (NA). During a review of the facility's unnamed document containing the nursing staffing assignment for the day, dated 5/1/2023 through 12/30/2023, the document indicated the SSC had a resident work assignment (assigned residents for the staff member to provide care to) for 130 shifts. During a review of the SSC's Employee File, the Employee File did not indicate the SSC had a Nurse Assistant Certification from 5/1/2023 through 7/31/2024. During an interview on 7/15/2026 at 8:13 a.m., with the SSC, the SSC stated she was initially hired to the facility as a housekeeper and transitioned to working as an NA before her current position in the social services department. The SSC stated, on 4/16/2023, she completed her CNA program and began working in the facility as an NA shortly after. The SSC stated in 2023, she was notified she passed the nursing assistant certification exams and was waiting for her nursing assistant certification card to arrive in the mail, however, the certification never appeared. The SSC stated while she waited for her nursing assistant certification to process, she worked at the facility as an NA with another CNA. The SSC stated she was always partnered with another CNA and they would both have a resident work assignment, however, they would perform all resident care tasks together. The SSC stated with the other CNA, she would change residents' diapers and clothing, pass meal trays, assist the residents with feeding, assist with Hoyer lift (a mechanical device used to lift and/or transfer a person) transfers, and document in the residents' chart. During an interview on 7/15/2026 at 11:32 a.m. with the Assistant Director of Staff Development (ADSD), the ADSD stated the SSC worked as an NA prior to working in the social services department. The ADSD stated the SSC's nursing assistant certification was not properly processed. The ADSD stated the SSC should have only done NA tasks such as answering call lights to ask what the residents needed and relay the information to the CNA or other nursing staff. The ADSD stated NAs were allowed to pass meal trays, supervise smoking breaks, assist activity staff, answer phones, and obtain supplies for the nursing staff. During an interview on 7/16/2026 at 8:32 a.m. with the ADSD, the ADSD stated NAs were allowed to work at the facility for a four-month period until the NA received their nursing assistant certification. The ADSD stated the SSC worked as an NA for longer than four months and the SSC's nursing assistant certification was never processed and verified. The ADSD stated without the required nursing assistant certification, the SSC may not have been competent to work as an NA in the facility. During an interview on 7/16/2026 at 8:37 a.m., with the ADSD, the ADSD stated uncertified nursing assistants (NAs) could not perform direct resident care tasks. The ADSD stated NAs could assist with changing a resident, however, the NAs were allowed very limited participation, such as holding (continued on next page)		

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the resident in position while the CNA cleaned the resident. The ADSD stated NAs were not allowed to assist with feeding, perform transfers, or document in the residents' chart. The ADSD stated NAs were assigned a resident work assignment, however, the NAs were partnered with the closest CNA. The ADSD stated the CNA would perform the direct care and the NA would assist. During an interview on 7/16/2026 at 9:57 a.m., with the Director of Nursing (DON), the DON stated NAs were hired to the facility for a four-month period to transition into the CNA role after their nursing assistant certification was processed and verified. The DON stated without the nursing assistant certification, the NA should not be employed or assisting residents after the four-month period ended. The DON stated NAs were hired to the facility to assist the CNAs and other facility staff. The DON stated NAs were not allowed to perform direct resident care tasks because they did not have the nursing assistant certification to support the NA's competency and skills. The DON stated having an NA perform CNA tasks put the residents' at risk for quality of care and safety issues. During a review of the facility's Nurse Assistant Job Description, undated, the Job Description indicated the NAs duties included but not limited to:- Providing supportive services to the CNAs and other staff as needed.- Assisting with distributing meal trays to residents who could feed themselves; NAs did not assist with feeding assistance.- Completing housekeeping duties while CNAs provide care. - Assisting with transporting residents within the facility once the resident was safely transferred to the wheelchair by certified staff. During a review of the facility's Certified Nursing Assistant Job Description, undated, the Job Description indicated CNAs must be licensed in accordance with the laws of the state.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to conduct the annual performance evaluations for three of three sampled certified nursing assistants (CNAs 4, 5, and 6). This deficient practice had the potential to result in CNAs 4, 5 and 6 being unaware of areas in their performance requiring improvement to better care for the residents in the facility. Findings: 1. During a review of Certified Nursing Assistant (CNA) 4's Personal Action Form (PAF), dated 5/6/2022, the PAF indicated the facility hired CNA 4 on 5/6/2022. During a review of CNA 4's Employee File, the Employee File did not contain documentation indicating CNA 4 received an annual performance evaluation from 2023 through 2026. 2. During a review of CNA 5's PAF, dated 3/7/2022, the PAF indicated the facility hired CNA 5 on 3/7/2022. During a review of CNA 5's Employee File, the Employee File did not contain documentation indicating CNA 5 received an annual performance evaluation from 2023 through 2026. 3. During a review of CNA 6's PAF, dated 1/19/2018, the PAF indicated the facility hired CNA 6 on 1/19/2018. During a review of CNA 6's Employee File, the Employee File did not contain documentation indicating CNA 6 received an annual performance evaluation from 2018 through 2026. During an interview on 7/16/2026 at 8:55 a.m. with the Assistant Director of Staff Development (ADSD), the ADSD stated she recalled performance evaluations were completed, however, there was no documentation of their completion. The ADSD stated when performance evaluations were completed, the performance evaluations should be in the employee's physical file or in a binder the Director of Staff Development (DSD) kept. The ADSD stated annual performance evaluations were necessary to determine areas for improvement to better the residents' care. During an interview on 7/16/2026 at 10:16 a.m., with the Director of Nursing (DON), the DON stated the DSD was responsible for conducting annual performance evaluations for the CNAs. The DON stated there was no documentation indicating the performance evaluations were completed for the CNAs. The DON stated annual performance evaluations were a tool to ensure the CNAs were competent in their job and could provide safe care for the residents. During a review of the facility's Policy and Procedure (P&P) titled, Performance Evaluations, undated, the P&P indicated a performance evaluation would be completed for each employee at the conclusion of his/her 90-day probationary period, and at least annually thereafter.		

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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 containers of ground rosemary, ground dill weed, ground oregano, ground chili powder, and a bag-in-box juice dispenser system were labeled with an open date. These failures had the potential for bacterial growth in potentially hazardous foods (PHFs, foods that require strict time and temperature control to prevent the growth of harmful bacteria or the formation of toxins) and increased the risk for food borne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) for 153 residents who consumed food prepared and served from the kitchen. Findings: During a concurrent observation and interview on 7/13/2026 at 8:33 a.m. with the Dietary Manager (DM) during the initial kitchen tour, there were open containers of ground rosemary, ground dill weed, ground oregano, ground chili powder, and an open bag-in-box juice dispenser system were not labeled with an open date. The DM stated unlabeled items may place residents at risk for foodborne illness and expired food products. During a concurrent interview and record review on 7/15/2026 at 10:11 a.m., with District Dietary Manager (DDM), the facility's P&P titled, Receiving, revised 2/2023, was reviewed. The P&P indicated, all food items will be appropriately labeled and dated. DDM stated these errors may place residents at risk for foodborne illness, cross-contamination, poor food quality, and unsafe meal service.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to honor three of ten sampled residents' (Residents 5, 34, and 150) right to be informed of and participate in their treatment by failing to: 1. Ensure an informed consent was obtained for Resident 5's use of Olanzapine (medication used to balance brain chemicals to treat mental health conditions such as schizophrenia) and Trazadone Hydrochloride (medication that works to increase serotonin [chemical messenger often associated with mood and happiness] sometimes used as a sleep aid).2. Ensure an informed consent was obtained for Resident 34's use of Celexa (an antidepressant).3. Ensure the name of medications and their indications (reason for the use of the medication) were provided to Resident 150 prior to the administration of the medications. These deficient practices resulted in Residents 5, 34, and 150 being unable to make an informed decision about their care. Findings:1. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 5's diagnoses included Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), schizophrenia (a mental illness that is characterized by disturbances in thought) and diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 5's History and Physical (H&P) dated 5/29/2026, the H&P indicated Resident 5 had fluctuating capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool) dated 5/29/2026, the MDS indicated Resident 5's cognition (ability to think and process) moderately impaired. The MDS indicated Resident 5 was dependent (helper does all of the effort) on staff for toileting, bathing and required supervision (helper provides verbal cues or steering or contact guard assistance as resident completes activity) for eating. During a review of Resident 5's physician orders dated 5/24/2026, the physician order indicated to administer Olanzapine 5 milligrams (mg-metric unit of measurement, used for medication dosage and/or amount) by mouth every 12 hours. During a review of Resident 5's physician orders dated 5/24/2026, the physician order indicated to administer Trazadone Hydrochloride 50 mg by mouth at bedtime for inability to sleep. During a concurrent interview and record review on 7/14/2026 at 12:37 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 5's medical records were reviewed. Resident 5's medical records indicated informed consents were not obtained for Olanzapine or Trazadone. LVN 2 stated informed consents should have been obtained for Resident 5's psychotropic medications and failure to obtain the consents placed resident at risk of being unable to make an informed decision about his care. During an interview on 7/14/2026 at 1:00 p.m. with Registered Nurse (RN) 2, RN 2 stated informed consents should have been obtained for Resident 5's psychotropic medications (medications that affect mood, thoughts, perceptions, and behavior) Trazadone and Olanzapine. RN 2 stated the (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	licensed nurses and physicians collaborate to ensure residents are fully informed and consent to psychotropic medications prior to administration. RN 2 stated informed consents were required for psychotropic medications because residents had the right to know what medications they were taking, the indication for the medication, and be involved in their own care. 2. During a review of Resident 34's admission Record, the admission Record indicated Resident 34 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 34's diagnoses included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and intracranial injury (any trauma or damage to the brain that occurred inside the skull). The admission Record indicated Resident 34 was self-responsible (able to make their own decisions). During a review of Resident 34's MDS, dated [DATE], the MDS indicated Resident 34's cognition was moderately impaired. The MDS indicated Resident 34 required substantial assistance (helper does more than half the effort) with eating, oral hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 34 took antidepressant medication (medication to treat depression). During a review of Resident 34's H&P, dated 9/13/2025, the H&P indicated Resident 34 could make needs known but could not make medical decisions. During a review of Resident 34's Physician Order, dated 9/13/2025, the Physician Order indicated to administer Celexa 10 mg by mouth once a day for major depressive disorder manifested by sad facial expression. During a review of Resident 34's Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 9/1/2025 through 9/30/2025, the MAR indicated Resident 34 received her first dose of Celexa 10mg on 9/14/2025. During a concurrent interview and record review on 7/15/2026 at 7:59 a.m. with the Social Services Director (SSD), Resident 34's Notice of Probate Referral (Request to appoint a legal guardian for an individual without decision-making capability), dated 4/30/2025, was reviewed. The Notice of Probate Referral indicated Resident 34 was denied an appointed legal guardian. The SSD stated Resident 34 did not have the capacity to make medical decisions and did not have family to appoint as her responsible party (RP, an individual appointed to make decisions for an individual without decision-making capabilities). The SSD stated because Resident 34's Probate Referral was denied, the interdisciplinary team (IDT, a group of healthcare professionals with various areas of expertise who work together towards the goals of the residents) made Resident 34's medical decisions for her. During an interview on 7/15/2026 at 9:24 a.m. with RN 2, RN 2 stated informed consent for psychotropic medications protected the resident and their RP's rights to approve or deny the medication treatment. RN 2 stated informed consent must be obtained from an individual with medical decision-making capability, whether from the resident or their RP. During a concurrent interview and record review on 7/15/2026 at 9:31 a.m. with RN 2, Resident 34's (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Verification of Resident Informed Consent, dated 9/13/2025, was reviewed. The Verification of Resident Informed Consent indicated informed consent for the use of Celexa 10 mg was obtained from Resident 34. RN 2 stated Resident 34 was not self-responsible and could not make an informed decision regarding her care. RN 2 stated informed consent should not have been obtained from Resident 34 because Resident 34 was unable to understand the risks and benefits of taking Celexa and could not make an informed decision. During an interview on 7/15/2026 at 2 p.m. with the Director of Nursing (DON), the DON stated obtaining informed consent for psychotropic medications meant the resident or their RP understood the risks and benefits of the medication and was able to make an informed decision to approve or deny the administration. The DON stated Resident 34's Celexa treatment should have been discussed with the IDT, who would determine whether Celexa was appropriate to treat Resident 34's behavior. The DON stated Resident 34 did not have the capacity to understand the risks associated with taking Celexa. 3. During a review of Resident 150's admission Record, the admission Record indicated Resident 150 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 150's with diagnosis included hypertensive heart disease (any heart condition caused by long-term, unmanaged high blood pressure) and hyperlipidemia (a medical condition where there is too much fat in the blood). During a review of Resident 150's MAR, dated 6/2026, the MAR indicated Resident 20 was prescribed amlodipine (a medication used to treat high blood pressure) 5 mg one tablet once a day, multivitamin with minerals one tablet once a day, and cholecalciferol (Vitamin D) 25 microgram (mcg, a unit of measurement) two tablets once a day. During an observation on 7/14/2026 at 8:40 a.m., licensed vocational nurse (LVN) 3 administered amlodipine, multivitamins with minerals, and vitamin D orally to Resident 150. LVN 3 did not inform Resident 150 the name of the medications administered or their indications. During an interview on 7/14/2026 at 8:43 a.m., with LVN 3, LVN 3 stated she administered amiodarone, multivitamins with minerals, and vitamin D orally to Resident 150 but failed to inform Resident 150 of the names and indications of the medications prior to Resident 150 swallowing them. LVN 3 stated according to the facility's policy and procedures (P&P), LVN 3 should have informed Resident 150 of the name and indication of all the medications administered because Resident 150 had the right to be involved in their care and treatment and make choices such as refusing a specific medication. LVN 3 stated not providing this information during medication administration restricted Resident 150's right to choose. During a review of the facility's P&P titled, Use of Psychotropic Medication(s) undated, the P&P indicated prior to initiating or increasing a psychotropic medication, the resident, family and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications (class of medications primarily used to manage psychosis [disconnection from reality]), in advance of such initiation or increase. The P&P indicated the resident had the right to accept or decline the initiation or increase of a psychotropic medication. (continued on next page)		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555781	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P, titled Resident Rights, dated 1/2026, the P&P indicated the resident had the right to be informed of, and participate in, his or her treatment, including the right to be informed in advance, of the care to be furnished and the right to request, refuse, and/or discontinue treatment.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for six of 12 sampled residents (Resident 15, 30, 48, 78, 89, and 133) by failing to ensure: A clock was present in Resident 15 and Resident 89's rooms. Resident 48 and Resident 133 did not sleep on a bare mattress. Resident 78 had a headboard attached to the resident's bed. The wall behind Resident 30's headboard was kept in good repair. This deficient practice had the potential to negatively impact Residents 15, 30, 48, 78, 89 and 133's well-being and contributed to an environment that did not promote a comfortable and homelike atmosphere for the residents. Findings: a. During a review of Resident 89's admission Record, the admission Record indicated Resident 89 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 89's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and anxiety (an overwhelming feeling of uneasiness). During a review of Resident 89's Minimum Data Set (MDS- a resident assessment tool), dated 5/14/2026, the MDS indicated Resident 89's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 89 required supervision for activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During an observation and interview on 7/13/2026 at 9:20 a.m., with Resident 89, in Resident 89's room, there was no clock observed in the resident's room. Resident 89 stated she was upset that the facility staff had purposely removed the clocks to prevent her from knowing the time for scheduled smoke breaks. During a concurrent observation and interview on 7/14/2026 at 1:57 p.m., with Licensed Vocational Nurse (LVN) 10, in Resident 89's room, there was no clock observed in the resident's room. LVN 10 stated Resident 89 smoked cigarettes and was depended on a clock to determine whether it was time for the designated smoke breaks. LVN 10 stated access to a clock was a resident's right, and enabled residents to be aware of their smoke break schedule. b. During a review of Resident 15's admission Record, the admission Record indicated Resident 15 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 15's diagnoses included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), dementia (a progressive state of decline in mental abilities), and schizoaffective disorder, During a review of Resident 15's MDS, dated [DATE], the MDS indicated Resident 15 had moderate cognitive impairment. The MDS indicated Resident 15 required setup or clean-up assistance from staff for ADLs such as eating, oral hygiene, toileting and dressing. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 7/13/2026 at 9:55 a.m., with Resident 15, there was no clock observed in the resident's room. Resident 15 stated a working wall clock would help him track the time during the day. During a concurrent observation and interview on 7/13/2026 at 10:01 a.m., with LVN 10 in Resident 15's room, there was no clock observed on the wall. LVN 10 stated residents should have a working clock on the wall to ensure they were provided with a homelike environment. During an interview on 7/14/2026 at 11:23 a.m., with LVN 10, the LVN 10 stated facility staff were responsible for ensuring requests were placed for missing wall clocks or repairs on maintenance communication logbook (a notebook where a person writes down important information and requests in order). LVN 10 stated ensuring residents had wall clock was important for resident rights to have a homelike environment. During an interview on 7/16/2026 at 11:20 a.m., with the Director of Nursing (DON), the DON stated maintaining a homelike environment helped residents feel safe, comfortable, respected and promote their dignity. c. During a review of Resident 48's admission Record, the admission Record indicated Resident 48 was initially admitted to the facility on [DATE] and readmitted [DATE]. Resident 48's diagnoses included encephalopathy (a broad term for any syndrome of overall brain dysfunction), epilepsy (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 48's MDS, dated [DATE], the MDS indicated Resident 48's cognitive skills for daily decision making were moderately impaired. During a review of Resident 48's MDS, dated [DATE], the MDS indicated Resident 48 required supervision for ADLs. During an observation on 7/14/2026 at 10:00 a.m., in Resident 48's room, Resident 48 slept on a mattress without a bed sheet. During an interview on 7/15/2026 at 8:40 a.m., with Resident 48, Resident 48 stated his bed did not have bed sheets yesterday and it made him feel cold. d. During a review of Resident 133's admission Record, the admission Record indicated Resident 133 was initially admitted to the facility on [DATE] with diagnoses including dementia, diabetes, and cataracts (a painless clouding of the eye's natural lens, which is typically clear). During a review of Resident 133's MDS, dated [DATE], the MDS indicated Resident 133's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 133 required partial to moderate assistance (helper does less than half the effort) for ADLs such as toileting, bathing, and lower body dressing. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/14/2026 at 10:02 a.m., in Resident 133's room, Resident 133 was observed sleeping on a mattress without a bed sheet. During an interview on 7/14/2026 at 2:36 p.m., with Certified Nursing Assistant (CNA) 9, CNA 9 stated she was assigned to Resident 48 and Resident 133, and he was responsible for changing the resident's bed linens. CNA 9 stated, earlier that morning, she removed the soiled bed linens from the residents' mattresses, cleaned the mattresses, and air-dried them. CNA 9 stated the bed linens should have been replaced immediately. Residents should not sleep directly on bare mattresses, as this practice does not support a dignified standard of care. e. During a review of Resident 78's admission Record, the admission Record indicated Resident 78 was admitted to the facility on [DATE] with diagnoses including DM, anemia (a condition where the body does not have enough healthy red blood cells), and schizophrenia. During a review of Resident 78's H&P dated 12/23/2025, the H&P indicated Resident 78 could make needs known but could not make medical decisions. During a review of Resident 78's MDS, dated [DATE], the MDS indicated Resident 78's cognitive function was intact. The MDS indicated Resident 78 required setup or clean-up assistance from staff for ADLs such as eating, oral hygiene, toileting and dressing. During a concurrent observation and interview on 7/13/2026 at 10:01 a.m., with LVN 6 in Resident 78's room, Resident 78 was observed lying in a bed without a headboard. LVN 6 stated residents should have headboards attached to their beds to ensure they were provided with a homelike environment. During an interview on 7/13/2026 at 1:23 p.m., with LVN 10, LVN 10 stated facility staff were responsible for ensuring maintenance requests were placed for missing or damaged equipment. LVN 10 stated ensuring residents had headboards was important for the residents' safety, comfort and to respect residents' rights to have a homelike environment. During an interview on 7/16/2026 at 8:50 a.m., with the DON, the DON stated residents had the right to a homelike environment. f. During a review of Resident 30's admission Record, the admission Record indicated Resident 30 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 30's diagnoses included chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in beathing), DM and dementia. During a review of Resident 30's H&P dated 9/29/2025, the H&P indicated Resident 30 did not have the capacity to understand and make decisions. During a review of Resident 30's MDS, dated [DATE], the MDS indicated Resident 30's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 30 required supervision or touching assistance from staff for all attempted mobility activities while in and out of (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bed. During an observation on 7/13/2026 at 9:34 a.m., inside Resident 30's room, the lower portion of the resident's wall, behind the resident's headboard was observed with damaged (cracked and crumbling) drywall, and exposed, peeling materials (the inside of the wall is visible due to holes or cracks). During a concurrent observation and interview on 7/14/2026 at 10:08 a.m., with CNA 3 in Resident 30's room, CNA 3 stated Resident 30's wall was damaged and could cause injury to the resident. The resident could come in contact with the broken area of the wall, if the wall was not repaired promptly. During an interview on 7/15/2026 at 3:38 p.m., with the Maintenance Supervisor (MS), the MS stated staff were expected to report damaged drywall using the communication book, which was reviewed daily to identify needed repairs. The MS stated if staff did not report damage to the walls promptly, it could increase the risk of injury, negatively affect the cleanliness and comfort of the resident's room, and undermine the resident's homelike environment During an interview on 7/15/2026 at 3:55 p.m., with the DON, the DON stated maintaining a safe, and functional environment was essential to resident care. The DON stated environmental concerns, including damaged walls, should be promptly reported and corrected to prevent potential hazards and to maintain a homelike environment. During a review of the facility's Policy and Procedure (P&P) titled, Safe and Homelike Environment dated 1/2025, the P&P indicated the facility will provide a safe, clean, comfortable and homelike environment. This includes ensuring that the residents can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. The P&P indicated the facility will maintain a clean environment and provide bed linens that are clean and in good condition. During a review of the facility's P&P titled, Resident Rooms dated 2026, the P&P indicated each resident would have bedding that was appropriate to the weather or climate and will be furnished with functional furniture according to the resident's needs and preferences.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to: 1). Ensure the rexulti (a medication used for depression) medication was available on 7/14/2026, 9 a.m. for one (1) of four (4) observed residents (Resident 482), medication administration. 2). Reconcile (the process of comparing transactions and activity to supporting documentation) two (2) medication-Ekits (emergency kit- a sealed container with supply of urgent prescription drugs kept stocked in nursing homes) containing controlled medications (CM, also known as Controlled Drug and Controlled Substance [CM, CD, CS]- medications which have a potential for abuse and may also lead to physical or psychological dependence) with an inventory count at each shift change for July 2026, in one (1) of one (1) inspected Medication Rooms (Medication room [ROOM NUMBER]), as indicated in its facility and procedure (P&P) titled, Controlled Substances. 3). Account for one (1) dose of CM for Resident 153 in one (1) of three (3) inspected medication carts (Medication Cart 2). These failures had the potential to result in Resident 482 receiving suboptimal (less than standard) care and the risk in experiencing adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have). These failures had the potential for increased opportunity for CM diversion (the transfer of a controlled medication or other medication from a lawful to an unlawful channel of distribution or use) and exposing residents in the facility to harmful medications, leading to physical and psychosocial harm, hospitalization and death. These failures had the potential for Resident 153 to have accidental overdose (administration of more than the prescribed dose) to CMs, resulting in Residents 153's and 482's health and well-being to be negatively impacted. Findings: During a concurrent observation and interview on 7/14/2026 at 8:50 a.m., in Medication Cart 3, Licensed Vocational Nurse (LVN) 5 was observed preparing docusate (a stool softener,) ascorbic acid (a supplement,) divalproex (a medication used for depression,) Eliquis (a medication used for thinning blood,) quetiapine (a medication used for schizophrenia,) senna (a laxative,) and multivitamin with minerals (a supplement) medications for administration to Resident 482. LVN 5 was not observed preparing rexulti for Resident 482. LVN 5 stated rexulti was not available in Medication Cart 3 or the facility to prepare for administration to Resident 482, as prescribed by Resident 482's physician for the 9 a.m. dose. LVN 5 stated medications should be readily available to ensure timely administration at the scheduled times. LVN 5 stated that medications should be ordered five (5) days in advance of last dose and followed up with pharmacy to prevent missing doses. LVN 5 stated rexulti was a medication used for depression and that missing a dose or failing to administer as prescribed, could increase Resident 482's risk of self-isolation. LVN 5 stated facility failed to ensure rexulti was readily available in Medication Cart 3 or facility, resulting in Resident 482 not having an available supply for administration of the 9 a.m. dose that day. LVN 5 stated LVN 5 will follow up with pharmacy to expedite the refill of rexulti. During a concurrent observation and interview on 7/14/2026 at 10:40 a.m., with Licensed Vocational Nurse (LVN) 3, in Medication Cart 2, a discrepancy in the count of Resident 153's lorazepam (a CM used for anxiety) between the Controlled Drug Record accountability log and the amount of medication remaining in the medication cart or medication bubble pack (medication packaging system that contains individual doses of medication per bubble) was observed. The Controlled Drug Record accountability log for Resident 153 indicated one (1) tablet of lorazepam was missing from the bubble pack. The medication bubble pack contained 11 lorazepam 1 mg tablets. The Controlled Drug Record accountability log for lorazepam indicated the bubble pack should have contained a total of 12 (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lorazepam 1 mg tablets, after the last administration of lorazepam 1 mg tablet documented/signed off, on 7/13/2026 at 9:57 p.m. The Controlled Drug Record accountability log contained no other documentation of subsequent administrations. LVN 3 stated LVN 3 administered one (1) lorazepam 1 mg tablet to Resident 153 on 7/14/2026 at 9:39 a.m. and forgot to sign the Controlled Drug Record accountability log. LVN 3 stated there was failure to follow the facility's policy to sign off each CM dose on the Controlled Drug Record accountability log after preparing the dose for the resident. LVN 3 stated it was important to sign out each dose once administered to ensure accountability, prevention of CM diversion, and accidental exposures of harmful substances to residents. LVN 3 stated if documentation was not accurate, it could lead to medication error and overdose (giving more than the prescribed amount), leading to stoppage of breathing, hospitalization and possibly death for Resident 153. During a concurrent observation and interview on 7/14/2026 at 11 a.m., with LVN 4, in Medication room [ROOM NUMBER]. The following were observed:1). One (1) medication Ekit was stored in the refrigerator containing CMs, labeled [NAME].REF-49, without an accountability log for the inventory reconciliation of CMs at every shift change for July 2026.2). One (1) medication Ekit was stored at room temperature containing CMs, labeled S20, without an accountability log for the inventory reconciliation of CMs at every shift change for July 2026.LVN 4 stated all CMs, including medication Ekits containing CMs, should be reconciled every shift. LVN 4 stated that the Ekit labeled [NAME].REF-49 in the refrigerator and S20 in the cabinet of Medication room [ROOM NUMBER] contained CMs and were not reconciled with an inventory count every shift in July 2026. LVN 4 stated it was important to account all CMs to ensure accountability, prevent CM diversion and residents' accidental exposure to harmful substances. During an interview on 7/14/2026 at 12:42 p.m., with the Director of Nursing (DON,) the DON stated per facility policies, medications should be ordered five (5) days in advance, Prescribed medications should be readily available to administer. The DON stated LVN's were expected to re-order medications timely and follow-up with pharmacy on the refills to ensure medications were available to the residents. The DON stated LVN 5 failed to administer Resident 482's rextulti medication on 7/14/2026 9 a.m. dose. This placed Resident 482 at risk for adverse consequences of exacerbating (making worse) the depression. The DON stated several licensed nurses failed to follow policy and procedures for medication reordering resulting in unavailability and interruption of medication administration and continuity of care for Resident 482. The DON stated LVN 3 failed to follow the facility's P&P in immediately documenting a CM on the Controlled Drug Record accountability log for Resident 153. The DON stated not documenting the Controlled Drug Record timely can lead to accountability failures, CM diversion, inaccurate clinical records, and accidental use and overdose of lorazepam for Resident 153. The DON stated medication Ekits containing CMs should be counted and reconciled at every shift change to ensure accountability and prevent CM diversion. The DON stated the Ekits containing CMs in Medication Room1 refrigerator labeled [NAME].REF-49 and in the cabinet labeled S20 were not accounted for with an inventory count on an accountability log at each shift change in July 2026. The DON stated that the facility will immediately implement an accountability log for reconciliation of EKIT inventory count at each shift change in Medication room [ROOM NUMBER]. During a review of Resident 153's admission Record (a document containing demographic and diagnostic information), the admission Record indicated Resident 153 was originally admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 153 had diagnoses that included depression, psychosis (a mental health state characterized by a disconnection from reality) and bipolar disorder (a mental health condition that causes extreme, uncontrollable shifts in mood, energy, and activity levels.) During a review of Resident 153's Order Summary Report (a report listing the physician order for the resident) dated 7/14/2026, the report (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated an order of Lorazepam one (1) milligram ([mg] - a unit of measure of mass) tablet, to give one (1) orally every 12 hours, for anxiety manifested by inability to relax, starting 9/25/2025. During a review of Resident 153's Medication Administration Record ([MAR] - a document of the medications administered to a resident that is part of the resident's permanent medical record) for July 2026, the MAR indicated Resident 153 was prescribed: 1). Lorazepam one (1) mg tablet orally every 12 hours for anxiety manifested by inability to relax, to give at 9 a.m. and 9 p.m. During a review of Resident 482's admission Record, the admission Record indicated Resident 482 was originally admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 482's diagnosis included depressive disorder. During a review of Resident 482's Order Summary Report dated 6/2/2026, the report indicated Resident 482 was prescribed rexulti 0.5 mg tablet, to give one (1) tablet orally once a day, for depressive disorder manifested by self-isolation, starting 4/16/2026. During a review of Resident 482's MAR for July 2026, the MAR indicated Resident 482 was prescribed: 1). Rexulti 0.5 mg tablet orally once a day for depressive disorder manifested by self-isolation, to give at 9 a.m. During a review of the facility's undated P&P titled Medication Administration -General Guidelines, the P&P indicated, medications should be administered in accordance with written orders of the prescriber. Medications should be administered within 60 minutes of scheduled. During a review of the facility's undated P&P titled Controlled Substances, the P&P indicated medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping at the nursing care center, in accordance with federal and state laws and regulations. The P&P indicated:When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record when removing dose from controlled storage.a). Date and time of administrationb). Amount administeredc). Signature of the nurse administering the dose2.) At each shift change, a physical inventory of controlled medications, as defined by state regulation, should be conducted by two (2) licensed clinicians and is documented on an audit record. During a review of the facility's undated P&P titled, Ordering and Receiving Non-controlled Medications, the P&P indicated medications and related products should be received from the dispensing pharmacy on a timely basis. The P&P indicated to reorder routine medications by the reorder date on the label to assure an adequate supply is on hand. All medications should be reordered in advance. Timely delivery of new orders is required so that medication administration is not delayed.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to: Label and store one (1) opened levalbuterol (a medication used to treat chronic obstruction pulmonary disorder [COPD - a condition with shortness of breath, cough and chest tightness]) inhalation (a form of a medication to be inhaled as a vapor or spray) foil pouch (package made of foil protecting the inhalation solution from light and degradation) with an open date for Resident 28, in accordance with the manufacturer's requirements and facility policies and procedures (P&P) in one (1) of three (3) inspected Medication Carts (Medication Cart 2.) 2. Remove and discard from use one (1) expired inhalation treatment for Residents 35 in accordance with manufacturer's requirements in one (1) of three (3) inspected Medication Carts (Medication Cart 2.) 3. Remove and discard 15 expired Afluria (an influenza [also known as flu] vaccine [a substance that provides immunity to an infectious disease] used to provide protection against the flu vaccine for the 2025 -2026 flu season) syringes, and sixteen expired loperamide (medication used for diarrhea) oral tablets from the facility stock, in accordance with manufacturer's requirements and facility P&P in one (1) of one (1) Medication Rooms (Medication room [ROOM NUMBER].) These deficient practices increased the risk for Residents 28, 35 and other residents in the facility to received medication that had become ineffective or toxic due to improper storage or labeling, possibly leading to health complications resulting in harm, hospitalization or death. Findings: During a concurrent observation and interview on 7/14/2026 at 10:40 a.m., of Medication Cart 2, with Licensed Vocational Nurse (LVN) 3, the following medications were found either stored in a manner contrary to their respective manufacturer's requirements, not labeled with an open date as required by their respective manufacturer's specifications, or stored and labeled contrary to facility policies: One (1) opened levalbuterol inhalation foil pouch containing unused vials (container filled with the medication) for Resident 28 was found stored at room temperature and not labeled with a date indicating when the foil pouch was opened. According to the manufacturer's product storage and labeling, levalbuterol inhalation vials should be stored at room temperature between 68 to 77 degrees Fahrenheit and once the foil pouch opened to use the vials within two (2) weeks. One (1) opened and expired fluticasone with salmeterol (a combination medication used to prevent and treat COPD) Diskus (a device used to deliver measured amount of medication in a powder form) inhalation powder for Resident 35 was found stored at room temperature without a foil pouch and labeled with a date indicating the device was opened on 6/3/2026. According to the manufacturer's product storage and labeling, fluticasone with salmeterol Diskus should be stored at room temperature between 68 to 77 degrees Fahrenheit and discarded one (1) month after opening the pouch.LVN 3 stated the Resident 28's levalbuterol inhalation pouch was opened and stored at room temperature and was not labeled with a date when the foil pouch was opened. LVN 3 stated she was unaware when Resident 28's levalbuterol inhalation pouch was opened. LVN 3 stated Resident 35's fluticasone with salmeterol Diskus was labeled with a date indicating the foil pouch was opened on 6/3/2026. According to the manufacturer guidelines, once the levalbuterol foil pouch was opened the vials should be used and discarded within two (2) weeks and considered expired after that timeframe. LVN 3 stated the fluticasone with salmeterol Diskus foil pouch for Resident 35 was opened on 6/3/2026 and according to the manufacturer guidelines the Diskus expired one (1) month later, on 7/3/2026. LVN 3 stated the unlabeled levalbuterol foil pouch for Resident 28 and the fluticasone with (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	salmeterol Diskus for Resident 35 were considered expired. LVN 3 stated expired medications have lost potency (strength) and will not be effective in treating Resident 28 and 35's COPD and could harm the residents by making their condition worse, cause shortness of breath, possibly leading to hospitalization and death. LVN 3 stated several licensed nurses failed to follow the facility's policy of labeling the inhalation treatments with a date when the foil was first opened and discarding expired medications. LVN 3 stated both medications for Residents 28 and 35 should be removed from Medication Cart 1, discarded and replaced with new ones from pharmacy. During a concurrent observation and interview on 7/14/2026 at 11 a.m., in Medication room [ROOM NUMBER], with LVN 4, the following medications were found either stored in a manner contrary to their respective manufacturer's requirements, expired and not discarded, or stored contrary to facility policies: Fifteen syringes of Afluria 2025-2026 formula vaccines for facility stock were found stored in the refrigerator. According to the manufacturer expiration dating, the Afluria syringes should be stored in the refrigerator and discarded by 6/30/2026. Sixteen loperamide oral tablets for facility stock were found stored at room temperature in the cabinet with other unexpired facility stock medications and labeled with an expiration date of 4/2026. According to the manufacturer date imprinted on the loperamide oral tablets, the medication should be used or discarded by 4/2026. LVN 4 stated the Afluria syringes, and loperamide tablets were expired, needed to be removed from use and placed in a designated area for disposal to prevent accidental use. LVN 4 stated administering expired vaccines and medications to residents in the facility would not provide protection for residents from the flu and not help treat diarrhea, because expired medications had lost potency and effectiveness. LVN 4 stated licensed nurses failed to remove expired medications from Medication room [ROOM NUMBER] and increased the risk of using expired medications and harming residents. During an interview on 7/14/2026 at 12:42 p.m., with the Director of Nursing (DON,) the DON stated expired medications should be removed from use and placed in the expired medication bin to be disposed of to prevent accidental use. The DON stated expired medications have lost potency, are ineffective and may not work properly when used in error for residents in the facility. The DON stated licensed nurses failed to remove fifteen expired Afluria syringes before 6/30/2026 and sixteen expired loperamide tablets before 4/2026 from use in Medication room [ROOM NUMBER], failed to remove fluticasone with salmeterol Diskus for Resident 35 from Medication Cart 2 by 7/3/2026, and place them in a designated area intended for disposal. The DON stated these failures increased the potential for use of expired loperamide, Afluria and fluticasone with salmeterol and could harm residents by not treating their condition or protecting their health and well-being. During the same interview, the DON stated licensed nurses failed to follow the facility's policy of labeling levalbuterol inhalation foil pouch with a date when the foil was first opened for Resident 28. The DON stated an opened levalbuterol foil pouch was good for two (2) weeks and beyond that, would be considered expired. The DON stated administering expired levalbuterol could potentially harm Resident 28 by not treating the resident's COPD and shortness of breath. During a review of the facility's P&P titled, Disposal of Medications, undated, the P&P indicated, Outdated medications, contaminated or deteriorated medications, and the contents of containers with no label shall be destroyed according to the above policy. During a review of the facility's P&P titled Storage of Medications, undated, the P&P indicated, Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal and reordered from the pharmacy, if a current order exists. During a review of the facility's P&P titled, Medication Administration General Guidelines, undated, the P&P indicated, no expired medication will be administered to a resident. 8b. the nurse shall place a date opened sticker on the medication of one (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	is not provided by the dispensing pharmacy and enter the date opened.8c. Certain products or package types.have specified shortened end-of-use dating, once opened, to ensure medication purity and potency.8d. The beyond use dating, which only lists month/year, falls to the last day of that month. During a review of the facility's P&P titled Abridged List of Medications with Shortened Expiration Dates undated, the P&P indicated: Once certain products are opened and in use, they must be used within a specific timeframe to avoid reduced stability, sterility and potentially reduced efficacy. Product-specific storage and expiration details can be found in the drug product's Package Insert under the How Supplied/Storage & Handling section. A drug product's Beyond Use Date is the manufacturer supplied expiration date or the shortened date after opening, whichever comes first. These In-Use medications should be labeled such that the Date opened is noted, clearly visible and securely attached to a part of the package to not be discarded. Fluticasone with Salmeterol - 30 days after removal from foil pouchLevalbuterol - if not used immediately, should be protected fromlight and used within one (1) week.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 maintain documentation of COVID-19 (a contagious respiratory illness) vaccination (a medicine that trains your body to fight off harmful germs or viruses) records and vaccine offerings for three of three sampled residents (Residents 47, 101 and 146). These failures had the potential to result in double dosing (taking or administering two amounts of medication close to the same time) and missed vaccinations for Residents 47, 101 and 146, and increased the risk of COVID-19 outbreaks in the facility. Findings:a. During a review of Resident 47's admission Record, the admission Record indicated Resident 47 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 47's diagnoses included schizophrenia (a mental illness that can affect thoughts, mood, and behavior) disorder, chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and anxiety (an overwhelming feeling of uneasiness).During a review of Resident 47's Immunization Report, dated 7/15/2026, the report did not indicate Resident 47's previous administrations or refusals of the COVID 19 vaccine were documented. b. During a review of Resident 101's admission Record, the admission Record indicated Resident 101 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 47's diagnoses included schizoaffective disorder, diabetes (poor blood sugar control) and anxiety.During a review of Resident 101's Immunization Report, dated 7/15/2026, the report did not indicate Resident 101's previous administrations or refusals of the COVID 19 vaccine were documented. c. During a review of Resident 146's admission Record, the admission Record indicated Resident 101 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 146's diagnoses included hypertension (high blood pressure), schizoaffective disorder, and anxiety.During a review of Resident 146's Immunization Report, dated 7/15/2026, the report did not indicate Resident 146's previous administrations or refusals of COVID 19 vaccine were documented. During an interview on 7/15/2026 at 1:56 p.m., with the Infection Prevention Nurse (IPN), the IPN stated it was not in his practice to maintain records of current and previous COVID-19 vaccine administrations in the resident's medical record because he did not have access to the California Immunization Registry (CAIR2, a secure, confidential, statewide computerized immunization information system for California residents). The IPN stated he recently (date unspecified) received access to CAIR since the start of his employment dating back to 11/2024. The IPN explained access to CAIR would have allowed him to extract and enter COVID 19 immunization data from the website to input into the residents' medical records. The IPN explained he held clinics for the administration of the COVID 19 vaccinations in the facility but did not maintain documentation. The IPN stated he provided the COVID 19 medication drug information sheets to residents and their responsible parties but did not maintain documentation of the specific education provided. The IPN stated it was important to maintain documentation of COVID-19 vaccine administration to determine if the resident already received the vaccine, and to avoid double dosing. The IPN stated documentation of COVID-19 vaccine offerings and education to residents was critical for continuity of care, disease prevention, and outbreak mitigation. The IPN stated the lack of documentation could possibly lead to double dosing, missed vaccinations, and potential COVID-19 outbreaks.During a review of the facility's Policy and Procedure (P&P) titled, COVID 19 Vaccination, dated 2026, the P&P indicated COVID-19 vaccinations will be offered to residents when supplies were available, as per Centers for Disease (continued on next page)		

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

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Control and Prevention (CDC) and, or Federal Drug Administration (FDA) guidelines unless such immunization is medically contraindicated, the individual has already been immunized during this time period, or refuses to receive the vaccine. The P&P indicated the resident's medical record will include documentation of the following:a. Education to the resident or resident representative regarding the risks, benefits, and potential side effects of the COVID-19 vaccine;b. Each dose of the vaccine administered to the resident, or;c. If the resident did not receive the COVID-19 vaccine due to medical contraindication or refusal.		

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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 privacy curtains were installed and privacy was maintained for one out of six sampled residents (Resident 14) when Resident 14's colostomy (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body) bag, which was filled with stool (bodily waste), was assessed by the licensed nursing staff. This deficient practice had the potential to result in Resident 14 experiencing a diminished sense of dignity and self-worth. Findings: During a review of Resident 14's admission Record, the admission Record indicated Resident 14 was initially admitted to the facility on [DATE] and readmitted [DATE]. Resident 14's diagnoses included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), aphasia (a disorder that makes it difficult to speak) following cerebral infarction (stroke, loss of blood flow to a part of the brain), and colostomy status (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body). During a review of Resident 14's Minimum Data Set (MDS, a resident assessment tool), dated 4/12/2026, the MDS indicated Resident 14's cognition (ability to think and process) was severely impaired. The MDS indicated Resident 14 required partial assistance (helper does less than half the effort) from staff for toileting hygiene and showering. During a review of Resident 15's admission Record, the admission Record indicated Resident 15 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 15's diagnoses included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), dementia (a progressive state of decline in mental abilities), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 15's MDS, dated [DATE], the MDS indicated Resident 15's cognition was intact. The MDS indicated Resident 15 required setup or clean-up assistance from staff for eating, oral hygiene, toileting and dressing. During a concurrent observation and interview on 7/14/2026 at 10:13 a.m. with Licensed Vocational Nurse (LVN) 9, in Resident 14 and Resident 15's room, Resident 15 (Bed A) and Resident 14 (Bed B) were lying in their beds. LVN 9 assessed Resident 14's colostomy bag, which contained stool, without utilizing a privacy curtain between the two residents. LVN 9 stated the room did not have a privacy curtain installed, which compromised Resident 14's privacy during the procedure. LVN 9 stated a privacy curtain should have been provided to maintain Resident 14's dignity and ensure proper privacy during the assessment. During a review of the facility's Policy and Procedure (P&P), titled, Resident Rooms, dated 2026, the P&P indicated all resident bedrooms would be equipped to assure full visual privacy for each resident. Including ceiling suspended curtains which extend around each bed in non-private bedrooms. During a review of the facility's P&P, titled, Resident Rights, dated 1/2026, the P&P indicated the residents had a right to personal privacy and confidentiality of his or her personal and medical records. The P&P indicated personal privacy included accommodations, medical treatment, and personal care.		

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to determine the responsible party (RP- an individual appointed to make decisions for an individual without decision-making capabilities) for one of two sampled residents' (Resident 9). This deficient practice resulted in Resident 9 not having an RP who could make medical decisions for her. Findings: During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 9's diagnoses included metabolic encephalopathy (a broad term for brain dysfunction caused by chemical imbalances, systemic illnesses, or organ failure), schizophrenia (a mental illness that is characterized by disturbances in thought) and heart failure (when the heart does not pump blood to the body as well). The Face Sheet listed two family members as Resident 9's emergency contacts. During a review of Resident 9's Minimum Data Set (MDS, a resident assessment tool), dated 5/29/2026, the MDS indicated Resident 9's cognition (ability to think and process) was severely impaired. The MDS indicated Resident 9 was dependent (helper does all of the effort) on staff for oral hygiene, toileting, bathing, upper/lower body dressing, and putting on/taking off footwear. During a review of Resident 9's History and Physical (H&P), dated 5/22/2026, the H&P indicated Resident 9 could make needs known but could not make medical decisions. During an interview on 7/14/2026 at 2:49 p.m. with the Social Services Director (SSD), the SSD stated when a resident was self-responsible, the resident was deemed capable of making their own medical decisions, consent to medications, and advocate for themselves. The SSD stated based on Resident 9's H&P, Resident 9 was unable to make medical decisions for herself. The SSD stated Resident 9 had a sister and a son listed as her emergency contacts. The SSD stated they should have been contacted and asked if one of them wanted to be appointed as Resident 9's RP. During an interview on 7/15/2026 at 1:55 p.m., with the Director of Nursing (DON), the DON stated Resident 9 was unable to make medical decisions for herself and required an RP. The DON stated her family members should have been asked to be Resident 9's RP to consent for medications and make other medical decisions for Resident 9. During review of the facility's Policy and Procedure (P&P) titled Advising Surrogate or Representative of Resident's Rights and Responsibilities, updated 2026, the P&P indicated should a resident be declared incompetent or incapable of understanding his or her rights, the resident's surrogate and/or representative would be advised of the resident's rights and their responsibilities as the resident's surrogate/representative.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to notify two of two sampled residents' (Residents 135 and 9) physician and responsible party (RP- appointed individual to make medical decisions) of changes in condition by failing to: 1. Ensure Resident 9 had hypotensive (blood pressure below 90 over 60 [90/60] millimeters of mercury [mmHg, a unit of measuring blood pressure]) blood pressure readings taken on 7/5/2026 and 7/14/2026.2. Notify the physician when Resident 135 had bleeding scabs on his forehead on 7/10/2025. This deficient practice had the potential to result in Resident 9 experiencing adverse side effects of hypotension, including dizziness, nausea, and fainting. This deficient practice had the potential to result in Resident 135's wound to go unmonitored, worsen and become infected. Findings: 1. During a review of Resident 9's admission Record (Face Sheet, front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 9 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 9's diagnoses included metabolic encephalopathy (a broad term for brain dysfunction caused by chemical imbalances, systemic illnesses, or organ failure), schizophrenia (a mental illness that is characterized by disturbances in thought) and hypertension (high blood pressure). During a review of Resident 9's History and Physical (H&P), dated 5/22/2026, the H&P indicated Resident 9 could make needs known but could not make medical decisions. During a review of Resident 9's Care Plan titled, Receiving Multiple Different Medications Daily, dated 5/27/2026, the Care Plan's interventions indicated to monitor vital signs, report results to the physician and follow-up if indicated. During a review of Resident 9's Care Plan titled, Risk for Complications Related to Diagnosis of Hypertension, dated 5/27/2026, the Care Plan's interventions indicated to monitor blood pressure and heart rate prior to administering medications, assess for signs and symptoms of hypotension, and notify the physician. During a review of Resident 9's Minimum Data Set (MDS, a resident assessment tool), dated 5/29/2026, indicated Resident 9's cognition (process of thinking) was severely impaired. The MDS indicated Resident 9 was dependent on staff's assistance with oral hygiene, toileting, bathing, upper/lower body dressing, and putting on/taking off footwear. During a review of Resident 9's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 7/1/2026 through 7/31/2026, the MAR indicated on 7/5/2026, Resident 9's blood pressure was 86 over 43 (86/43) millimeters of mercury (mm Hg, a unit of measuring blood pressure), and on 7/14/2026, Resident 9's blood pressure was 71/40 mm Hg. (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 9's electronic health record (eHR), dated 7/5/2026 to 7/14/2026, the eHR did not indicate Resident 9's physician was notified of Resident 9's hypotension (blood pressure below 90/60 mmHg) on 7/5/2026 or 7/14/2026. During an interview on 7/14/2026 at 11:45 a.m., with Licensed Vocational Nurse (LVN) 5, LVN 5 stated, on 7/14/2026, when she checked Resident 9's blood pressure reading it was 71/40 mm Hg. LVN 5 stated Resident 9's blood pressure of 71/40 mmHg was not Resident 9's usual blood pressure reading and she did not recheck Resident 9's blood pressure to confirm the reading. LVN 5 stated she did not notify Resident 9's physician of her hypotension. LVN 5 stated she should have notified Resident 9's physician right away because hypotension could be a sign of something more severe. During an interview on 7/14/2026 at 12:12 p.m., with the Director of Nursing (DON), the DON stated licensed nurses check the resident's vital signs routinely and prior to certain medication administration. The DON stated Resident 9's physician should have been notified of the two hypotensive readings to intervene if something more severe was occurring. During a review of the facility's Policy and Procedure (P&P) titled Change in a Resident's Condition or Status, update 2026, the P&P indicated the Nurse Supervisor or Charge Nurse was to notify the resident's Attending Physician or On-Call Physician when there had been a significant change in the resident's physical condition. During a review of the facility's undated P&P titled, Blood Pressure, Monitoring, the P&P indicated hypotension should be reported to the physician. During a review of the facility's P&P titled, Vital Signs, dated 2026, the P&P indicated, Licensed Nurses are responsible for knowing the usual range of a resident's vital signs, analyzing and interpreting vital signs, and notifying the physician of abnormal findings. 2. During a review of Resident 135's admission Record, the admission Record indicated Resident 135 was initially admitted to the facility on [DATE] and readmitted [DATE]. Resident 135's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), epilepsy (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) muscle weakness, muscle wasting (weakening, shrinking, and loss of muscle), and lack of coordination. During a review of Resident 135's Minimum Data Set ([MDS], a resident assessment tool), dated 5/4/2026, the MDS indicated Resident 1's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. During a review of Resident 135's MDS, dated [DATE], the MDS indicated Resident 135 required supervision for eating, dressing, personal hygiene, sitting to lying, sitting to standing, transferring from the bed to the chair, and walking ten feet to 150 feet. During a review of Resident 135's History and Physical (H&P), dated 6/25/2026, the H&P indicated Resident 135 lacked the capacity to understand and make decisions. (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of all of Resident 135's Progress Notes and Situation, Background, Assessment, Recommendation (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents) Notes, dated 6/2026 through 7/12/2026, there were no notes to indicate Resident 135 had developed scattered, circular scabs on his forehead. During an observation and interview on 7/13/2026 at 9:30 a.m. of Resident 135, in Resident 135's room, Resident 135 had a blue to purple discoloration noted under the left eye with several, round, small, scattered scabs across his forehead. During a phone interview on 7/14/2026 at 3:50 p.m. with Certified Nursing Assistant (CNA) 7, CNA 7 stated she was Resident 135's assigned CNA on 7/10/2026 for the 3 p.m. to 11 p.m. shift. CNA 7 recalled Resident 135 had scattered scabs to his forehead. CNA 7 stated one of Resident 135's scabs began bleeding during his shower, and this was reported to LVN 8. During an interview on 7/15/2026 at 7:39 a.m. with Licensed Vocational Nurse (LVN) 8, LVN 8 stated she was the assigned nurse for Resident 135 on 7/10/2026 for the 3 p.m. to 11 p.m. shift. LVN 8 stated she recalled CNA 7 informed her that Resident 135's forehead scabs were bleeding during a shower. LVN 8 stated she administered treatment to the affected areas but did not document her assessment or the interventions provided. LVN 8 stated a change of condition note should have been documented at that time to alert the physician, the responsible party, and licensed nursing staff, facilitate ongoing monitoring, and secure appropriate orders for managing the scabs. LVN 8 stated there was a risk for the scabs to worsen or become infected. During an interview on 7/15/2026 at 2:40 p.m. with the Director of Nursing (DON), the DON stated that if licensed nursing staff had assessed and treated Resident 135 for a bleeding scab, the responsible party should have been notified and the physician consulted to obtain appropriate treatment orders. During a review of the facility's Policy and Procedure (P&P), titled, Notification of Changes, dated 1/2026, the P&P indicated the facility was to ensure the facility promptly consulted the resident's physician; and notified, consistent with his or her authority, the resident's representative when there was a change requiring notification.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to verify the Notice of Medicare Non-Coverage Coverage (NOMNC, a form that notifies Medicare residents that their covered services are going to end) and Advance Beneficiary Notice (ABN, a notice notifying that Medicare may deny payment for specific treatments, and provides residents the opportunity to accept or refuse services if Medicare denies payment) forms were signed by someone with decision making capabilities when the Medicare Part A (insurance that primarily covers inpatient skilled nursing facility stays) coverage ended for two of three sampled residents (Resident 24 and Resident 157). This deficient practice resulted in Residents 24 and 157 being unable to make an informed decision about their care. Findings: a. During a review of Resident 24's admission Record, the admission Record indicated Resident 24 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 24's diagnoses included anemia (a condition where the body does not have enough healthy red blood cells), schizophrenia (a mental illness that is characterized by disturbances in thought) and hypertension (HTN-high blood pressure). The admission Record indicated Resident 24 was conserved (when a judge legally appoints someone to manage personal and financial affairs of someone who can no longer make decisions for themselves). During a review of Resident 24's History and Physical (H&P) dated 5/31/2026, the H&P indicated Resident 24 had fluctuating capacity to understand and make decisions. During a review of Resident 24's Minimum Data Set (MDS, a resident assessment tool) dated 6/20/2026, the MDS indicated Resident 24's cognition (ability to think and process) was moderately impaired. The MDS indicated Resident 24 required supervision from staff for toileting, bathing and personal hygiene. During a review of Resident 24's Skilled Nursing Facility (SNF) Beneficiary Notification Review form, indicated Resident 24's last covered date for Medicare Part A skilled services was 3/18/2026. During a review of Resident 24's NOMNC form dated 3/4/2026, the NOMNC form indicated Resident 24 signed and acknowledged coverage end date on 3/4/2026. During a review of Resident 24's ABN form dated 3/4/2026, the ABN form indicated Resident 24 chose to continue Inpatient Skilled Nursing services (24-hour medical, nursing and rehabilitative care provided in skilled nursing facilities) but not bill Medicare. The ABN form indicated Resident 24 signed the form on 3/4/2026. During a phone interview on 7/15/2026 at 3:55 p.m. with Responsible Party (RP) 1, RP 1 stated no one from the facility had contacted him to inform him of Resident 24's Medicare Part A coverage ending. RP 1 stated the facility should have notified him so he could review Resident 24's options for coverage. During an interview on 7/15/2026 at 2:36 p.m. with the Social Services Director (SSD), the SSD stated Resident 24 did not have the capacity to understand or make informed medical decisions, and he should have contacted Resident 24's conservator to fill out the NOMNC and ABN forms. The SSD stated conservators should be involved in the decision-making process for residents to ensure information was understood and informed decisions could be made. b. During a review of Resident 157's admission Record, the admission Record indicated Resident 157 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 157's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and chronic obstructive pulmonary disease (a chronic lung disease causing difficulty in breathing). The admission Record indicated Resident 157's responsible party was a public guardian (a court appointed professional authorized to make personal and financial decisions for someone who could no longer make decisions for themselves). During a review of Resident 157's History and Physical (H&P) dated 5/25/2026, the (continued on next page)		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	H&P indicated Resident 157 was able to make needs known but could not make medical decisions. During a review of Resident 157's Minimum Data Set (MDS-a resident assessment tool), dated 7/10/2026, the MDS indicated Resident 157's cognition was moderately impaired. The MDS indicated Resident 157 required supervision from staff for toileting, bathing and dressing. During a review of Resident 157's Skilled Nursing Facility (SNF) Beneficiary Notification Review form, the form indicated Resident 157's last covered date for Medicare Part A skilled services was 7/10/2026. During a review of Resident 157's NOMNC form dated 6/1/2026, the NOMNC form indicated Resident 157 refused to sign but made decision verbally on 6/1/2026. During a review of Resident 157's ABN form dated 6/1/2026, the ABN form indicated Resident 157 chose to continue Inpatient Skilled Nursing services (24-hour medical, nursing and rehabilitative care provided in skilled nursing facilities), but not to bill Medicare. The ABN form indicated Resident 157 refused to sign but made decision verbally on 6/1/2026. During a phone interview on 7/15/2026 at 2:48 p.m. with RP 2, RP 2 stated she had not been notified that Resident 157's Medicare Part A services ended. RP 2 stated the facility should have notified and included her in the decision-making process for Resident 157's Medicare coverage part A termination. During an interview on 7/15/2026 at 2:36 p.m. with the Social Services Director (SSD), the SSD stated he should have contacted Resident 157's RP 2 to fill out the NOMNC and ABN forms. The SSD stated involving a resident's RP 2 in the decision-making process was important to ensure all of the residents options were understood and an informed decision could be made. During an interview on 7/16/2026 at 8:58 a.m. with the Administrator (ADM), the ADM stated the NOMNC and ABN forms were important because they allow residents and their representatives to appeal Medicare part A termination and determine which services they want to continue to receive and take financial responsibility for. The ADM stated facility staff should notify and involve conservators and public guardians in the decision-making process once a residents Medicare Part A coverage ends, to ensure an informed decision was made. During a review of the facility's Policy and Procedure (P&P) titled, Advance Beneficiary Notices dated 2026, the P&P indicated a NOMNC form will be issued to the resident or representative when Medicare covered services were ending, and the NOMNC informs the resident on how to request an appeal. During a review of the facility's P&P titled, Advising Surrogate or Representative of Resident's Rights and Responsibilities dated 2026, the P&P indicated the facility will seek a health care decision from a representative when the resident is determined to be incompetent in accordance with state law.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the quarterly Minimum Data Set (MDS, a resident assessment tool) assessments were completed and submitted within the required federal timeframe for four of 24 sampled residents (Residents 44, 46, 47, and 75). The deficient practice had the potential to affect the accuracy and timeliness of resident assessments, care planning decisions, and the facility's compliance with federal Medicare and Medicaid requirements. Findings: During a review of Resident 44's admission Record, the admission Record indicated Resident 7 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 44's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), dementia (a progressive state of decline in mental abilities), chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and diabetes (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 44's MDS dated [DATE], the MDS indicated Resident 44's cognition (ability to think and process) was moderately impaired. During a review of Resident 46's admission Record, the admission Record indicated Resident 46 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 46's diagnoses included diabetes, schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) and hyperlipidemia (high cholesterol). During a review of Resident 46's MDS dated [DATE], the MDS indicated Resident 46's cognition was moderately impaired. During a review of Resident 47's admission Record, the admission Record indicated Resident 47 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 47's diagnoses included bipolar disorder, schizophrenia, COPD and insomnia (trouble falling asleep or staying asleep). During a review of Resident 47's MDS dated [DATE], the MDS indicated Resident 47's cognition was moderately impaired. During a review of Resident 75's admission Record, the admission Record indicated Resident 75 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 75's diagnoses included schizoaffective disorder, psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and hypertensive heart disease (heart conditions caused by long-term, unmanaged high blood pressure). During a review of Resident 75's MDS dated [DATE], the MDS indicated Resident 75's cognition was moderately impaired. During a concurrent interview and record review on 7/16/2026 at 9:38 a.m. with Minimum Data Set Nurse (MDSN) 2, the process for completing and submitting quarterly MDS assessments were reviewed. MDSN 2 stated the MDS was a federally required resident assessment that must be completed and electronically submitted within the required Assessment Reference Date (ARD, the specific endpoint for the observation or look-back period used when completing the MDS) completion timeframe. MDSN 2 stated in accordance with federal requirements, quarterly MDS assessments must be submitted on or before 14 days from the assessment start date to ensure compliance with Medicare and Medicaid regulations and to maintain an accurate, timely assessment of each resident's clinical status. During a concurrent interview and record review on 7/16/2026 at 9:38 a.m. with MDSN 2, the quarterly MDS assessments for Residents 44, 46, 47, and 75 were reviewed. The quarterly MDS assessment for Resident 44 was initiated on 5/17/2026 but was not submitted until 7/15/2026. MDSN 2 stated the assessment should have been submitted on or before 5/31/2026 and not 45 days late. The quarterly (continued on next page)		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDS assessment for Resident 46 was initiated on 5/14/2026 but was not submitted until 7/13/2026. MDSN 2 stated the assessment should have been submitted on or before 5/28/2026 and not 46 days late. The quarterly MDS assessment for Resident 47 was initiated on 3/12/2026 but was not submitted until 4/27/2026. MDSN 2 stated the assessment should have been submitted on or before 3/26/2026 and not 32 days late. The quarterly MDS assessment for Resident 75 was initiated on 5/18/2026 but was not submitted until 7/10/2026. MDSN 2 stated the assessment should have been submitted on or before 6/1/2026 and not 39 days late. MDSN 2 stated that there was no documented explanation or justification in the medical records for the delayed submissions of the quarterly MDS assessments for Residents 44, 46, 47, and 75. MDSN 2 stated the timely completion and submission of MDS assessments was essential to ensure compliance with federal Medicare and Medicaid requirements, accurately reflect each resident's current clinical condition, support appropriate care planning and reimbursement, and maintain the facility's compliance with regulatory requirements. MDSN 2 stated these quarterly MDS assessments were not submitted within the required timeframe. During an interview on 7/16/2026 at 10:40 a.m. with the Director of Nursing (DON), the facility's process for monitoring completion and submission of MDS assessments was reviewed. The DON stated failure to submit MDS assessments within the required timeframe may result in noncompliance with Medicare and Medicaid requirements and the facility should have identified and addressed the delays to prevent recurrence. During a review of the facility's policy and procedure (P&P) titled, MDS 3.0 Completion dated 2026, the P&P indicated the facility would initially and periodically conduct a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State. The P&P indicated Quarterly Assessment would be completed using an Assessment Reference Date [ARD] no greater than 92 days from the most recent prior quarterly or comprehensive assessment counting ARD to ARD and Care Area Assessment [CAA's] were completed no later than 14 days after admission and each time a comprehensive MDS was completed.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a fall care plan was revised after a fall for one out of two sampled residents (Resident 135). This deficient practice placed Resident 135 at risk for bodily injury from another fall. Findings: During a review of Resident 135's admission Record, the admission Record indicated Resident 135 was initially admitted to the facility on [DATE] and readmitted [DATE]. Resident 135's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), epilepsy (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) muscle weakness, muscle wasting (weakening, shrinking, and loss of muscle), and lack of coordination. During a review of Resident 135's Minimum Data Set (MDS, a resident assessment tool), dated 5/4/2026, the MDS indicated Resident 1's cognition (ability to think and process) was moderately impaired. During a review of Resident 135's MDS, dated [DATE], the MDS indicated Resident 135 required supervision from staff for eating, dressing, personal hygiene, sitting to lying, sitting to standing, transferring from the bed to the chair, and walking ten feet to 150 feet. During a review of Resident 135's History and Physical (H&P), dated 6/25/2026, the H&P indicated Resident 135 lacked the capacity to understand and make decisions. During a review of Resident 135's Fall Risk Evaluation, dated 6/22/2026 and 6/30/2026, the Fall Risk Evaluation indicated Resident 135 was at risk for falls. During a record review of Resident 135's Situation, Background, Assessment, Recommendation (SBAR, a communication tool used by healthcare workers when there is a change of condition among the residents), dated 6/30/2026, the SBAR indicated Resident 135 fell, hit the back of his head, and was bleeding. During a review of Resident 1's care plan titled, Risk for falls and, or Injuries Related to [incomplete], dated 7/1/2026, the care plan indicated the interventions included conduct visual checks and monitoring every shift, provide assistance with bed mobility and transfer as indicated, and provide the resident with a safe environment. During a record review of Resident 135's SBAR, dated 7/13/2026 at 10:42 a.m., the SBAR indicated Resident 135 leaned forward in his wheelchair and hit his face against the wall. During a concurrent interview and record review, on 7/14/2026 at 3:09 p.m., with Registered Nurse (RN) 1, Resident 135's care plans, titled Actual Fall, dated 6/30/2026 and 7/1/2026, were reviewed. Both care plans indicated Resident 135 fell backwards while ambulating and both care plans had interventions that remained unchanged. RN 1 stated the facility's practice was to ensure fall care plans were updated to implement alternative fall interventions. RN 1 stated she developed both care plans but did not ensure different interventions were implemented after Resident 135's second fall on 7/1/2026. RN 1 stated this placed Resident 135 at risk for subsequent falls. During an interview on 7/15/2026 at 8:13 a.m. with the Minimum Data Set Nurse (MDSN) 1, MDSN 1 stated a post fall Interdisciplinary Team (IDT) Meeting was important to allow the representative party, resident, and the IDT to collaborate on a plan of care and modify existing fall interventions. MDSN 1 stated the post fall IDT should be conducted within 72 hours post fall so that interventions could be implemented. MDSN 1 stated that because a post fall IDT has not occurred after Resident 135's falls on 6/30/2026 and 7/1/2026, Resident 135 was at risk for another fall. During a review of the facility's Policy and Procedure (P&P), titled, Care Plan Revision Upon Status Change, dated 2018, the P&P indicated the following: Upon identification of a change in status, the nurse would notify the MDS Coordinator, the physician, and the resident representative, if applicable. The MOS Coordinator and the Interdisciplinary Team would discuss the resident condition (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and collaborate on intervention options. The team meeting discussion would be documented in the nursing progress notes. The care plan would be updated with the new or modified interventions. Care plans would be modified as needed by the MDS Coordinator or other designated staff member. During a review of the facility's P&P, titled, Resident-Oriented Approach to Safety, dated 1/2025, the P&P indicated the following: The facility-oriented and resident-oriented approaches to safety were used together to implement a systems approach to safety, which considered the hazards identified in the environment and individual resident risk factors, and adjusts interventions accordingly. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for that resident. The care team shall target interventions to reduce the potential for accidents.		

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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 interview and record review, the facility failed to conduct the assessments for one of three sampled residents (Resident 38) in accordance with the physician's orders on 6/13/2026. This deficient practice had the potential to result in Resident 38 experiencing undetected adverse reactions of medications, changes of conditions, and abnormal vital signs requiring intervention. Findings: During a review of Resident 38's admission Record, the admission Record indicated Resident 38 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 38's diagnoses included hypertension (high blood pressure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a mental health condition characterized by excessive, persistent fear or worry), schizophrenia (a mental illness that is characterized by disturbances in thought), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 38's Minimum Data Set (MDS, a resident assessment tool), dated 6/9/2026, the MDS indicated Resident 38's cognition (ability to think and process) was moderately impaired. The MDS indicated Resident 38 required substantial assistance (helper does more than half the effort) from staff with toileting, bathing, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 38 took antipsychotic (medication that affects mood and behavior), antianxiety (medication to treat anxiety), and antiplatelet (blood thinner) medication. During a review of Resident 38's History and Physical (H&P), dated 6/2/2026, the H&P indicated Resident 38 had the capacity to understand and make decisions. During a review of Resident 38's Physician Orders, dated 6/2/2026, the Physician Orders indicated to: 1. Auscultate (listen to) lung sounds every shift. 2. Monitor behavior episodes of anxiety manifested by the inability to relax every shift. 3. Monitor behavior episodes of depression manifested by sad facial expression every shift. 4. Monitor behavior episodes of schizoaffective disorder manifested by labile mood every shift. 5. Monitor behavior episodes of schizophrenia manifested by delusions (misconceptions or beliefs firmly held, contrary to reality) that someone is stealing from her every shift. 6. Monitor for central nervous system (CNS) adverse effects such as cognitive changes and drowsiness every shift. 7. Monitor signs and symptoms of dehydration, hypotension (low blood pressure), dizziness, increased confusion, and muscle cramps every shift. 8. Monitor for signs and symptoms of bleeding every shift. 9. Monitor oxygen saturation (O2 sat, measurement of oxygen in the blood) every shift. 10. Monitor pain every shift. 11. Monitor signs and symptoms of tardive dyskinesia (abnormal facial and tongue movement), cognitive impairment, akathisia (inability to sit still), and parkinsonism (abnormal movements such as tremors, drooling, and rigidity) every shift. 12. Monitor Patient 38's orthostatic blood pressure (a measurement of the change in blood pressure between lying down and standing up) every Saturday in a lying and sitting position. During a concurrent interview and record review, on 7/15/2026 at 2:02 p.m., with the Director of Nursing (DON), Resident 38's Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 6/1/2026 through 6/30/2026, was reviewed. The MAR indicated on 6/13/2026, the following assessments were not done: 1. Auscultate lung sounds. 2. Monitor behavior episodes of anxiety manifested by the inability to relax. 3. Monitor behavior episodes of depression manifested by sad facial expression. 4. Monitor behavior episodes of schizoaffective disorder manifested by labile mood ever. 5. Monitor behavior episodes of schizophrenia manifested by delusions that someone is stealing from her. 6. Monitor for CNS adverse effects such as cognitive changes and drowsiness. 7. Monitor signs and symptoms of dehydration, hypotension, dizziness, increased confusion, and muscle (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cramps.8. Monitor for signs and symptoms of bleeding.9. Monitor oxygen saturation.10. Monitor pain.11. Monitor signs and symptoms of tardive dyskinesia, cognitive impairment, akathisia, and parkinsonism.12. Monitor Patient 38's orthostatic blood pressure in a lying and sitting position.The DON stated the empty areas on Resident 38's MAR indicated the assessments were not done. The DON stated the purpose of the assessments was to monitor the occurrences of Resident 38's behaviors and any adverse effects of medications. The DON stated without the ordered monitoring done, Resident 38 could have experienced an undetected adverse reaction of medications, changes of conditions, and abnormal vital signs requiring intervention.During a review of the facility's Policy and Procedure (P&P) titled, Vital Signs, dated 2026, the P&P indicated vital signs would be obtained by the nurse, as indicated.During a review of the facility's P&P titled, Use of Psychotropic Medications, undated, the P&P indicated the resident's response to the medications, including progress towards the goal and presence/absence of adverse consequences, shall be documented in the resident's medical record.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure three of four sampled residents (Residents 135, 12, and 9) were free of accidents and hazards by failing to: 1. Ensure adequate supervision and visual checks were rendered and documented for Resident 135. 2. Ensure orthostatic blood pressure (a measurement of the change in blood pressure between lying down and sitting up) orders were followed for Resident 12 for May 2026, June 2026, and July 2026. 3. Ensure Resident 9's orthostatic blood pressure was monitored on 6/13/2026. These deficient practices resulted in Resident 135 falling and sustaining a bruise under his left eye and scattered scabs across his forehead with the potential for Resident 135 to sustain more falls and had the potential to result in Residents 12 and 9 experiencing adverse effects of hypotension (low blood pressure), including dizziness, lightheadedness, fatigue, nausea, blurred vision, and fainting. Cross reference F657 Findings: 1. During a review of Resident 135's admission Record, the admission Record indicated Resident 135 was initially admitted to the facility on [DATE] and readmitted [DATE]. Resident 135's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), epilepsy (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) muscle weakness, muscle wasting (weakening, shrinking, and loss of muscle), and lack of coordination. During a review of Resident 135's Minimum Data Set (MDS, a resident assessment tool), dated 5/4/2026, the MDS indicated Resident 1's cognition (ability to think and process) was moderately impaired. During a review of Resident 135's MDS, dated [DATE], the MDS indicated Resident 135 required supervision from staff for eating, dressing, personal hygiene, sitting to lying, sitting to standing, transferring from the bed to the chair, and walking ten feet to 150 feet. During a review of Resident 135's History and Physical (H&P), dated 6/25/2026, the H&P indicated Resident 135 lacked the capacity to understand and make decisions. During a review of Resident 135's Fall Risk Evaluation, dated 6/22/2026 and 6/30/2026, the Fall Risk Evaluation indicated Resident 135 was at risk for falls. During a review of Resident 135's Situation, Background, Assessment, Recommendation (SBAR, a communication tool used by healthcare workers when there is a change of condition among the residents), dated 6/30/2026, the SBAR indicated Resident 135 was witnessed falling and hitting the back of his head, and was bleeding. During a review of Resident 135's SBAR, dated 7/1/2026, the SBAR indicated Resident 135 had an unwitnessed fall and was found lying down on the ground on his back with bleeding noted to the back of his head. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 135's care plan titled, Risk for falls and, or Injuries Related to [incomplete], dated 7/1/2026, the care plan indicated the interventions included to conduct visual checks and monitoring every shift, provide assistance with bed mobility and transfer as indicated, and provide the resident with a safe environment. During a review of Resident 135's SBAR, dated 7/13/2026, timed at 10:42 a.m., the SBAR indicated Resident 135 had a change in skin color and after speaking to the resident with an interpreter, Resident 135 leaned forward in his wheelchair and hit his face against the wall. During an observation and interview on 7/13/2026 at 9:30 a.m. in Resident 135's room, Resident 135 had a blue to purple discoloration noted to the area under his left eye and several, round, small scabs scattered scabs across his forehead. During a concurrent record review on 7/15/2026 at 8:20 a.m. with Minimum Data Set Nurse (MDSN) 1, Resident 135's nursing progress notes, dated 7/5/2026 through 7/12/2026, were reviewed. The nursing progress notes indicated, from 7/5/2026 through 7/12/2026, there was no documentation indicating visual monitoring was performed for Resident 135 prior to the identification of the discoloration to his left eye and scattered scabs on his forehead on 7/13/2026. MDSN 1 stated Resident 1 required visual monitoring every 15 minutes because he was more prone to falls. During an interview on 7/15/2026 at 2:40 p.m. with the Director of Nursing (DON), the DON stated nursing staff usually conducted head count rounds every two hours; however, supervisory checks should have been performed and documented more frequently for Resident 135. The DON stated Resident 135 was at risk for falls and had poor safety awareness. The DON stated adequate supervision could not be verified without proper documentation and insufficient supervision increased the risk of falls or altercations for Resident 135. 2. During a review of Resident 12's admission Record, the admission Record indicated Resident 12 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 12's diagnoses included atrial fibrillation (an irregular and often very rapid heart rhythm), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), dysphagia (difficulty swallowing) and schizoaffective disorder. During a review of Resident 12's H&P, dated 1/3/2026, the H&P indicated Resident 12 could make needs known but could not make medical decisions. During a review of Resident 12's physician order, dated 3/14/2026, the physician order indicated to obtain orthostatic blood pressure monitoring weekly and notify the medical doctor if the systolic blood pressure's difference was 20 millimeters of mercury (mmHg, a unit for measuring blood pressure) or greater, every Saturday evening with Resident 12 lying down. During a review of Resident 12's physician order, dated 3/14/2026, the physician order indicated to obtain orthostatic blood pressure monitoring weekly and notify the medical doctor if the systolic blood pressure's difference was 20 mmHg or greater, every Saturday evening with Resident 12 sitting down. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 12's Weights and Vitals Summary record for the months of May, June, and July 2026, the records did not indicate Resident 12's orthostatic blood pressures were monitored on Saturday's 5/2/2026, 5/9/2026, 5/16/2026, 5/23/2026, 5/30/2026, 6/6/2026, 6/13/2026, 6/20/2026, 6/27/2026, 7/4/2026 and 7/11/2026. During a concurrent record review and interview on 7/15/26 at 10:55 a.m., with the Licensed Vocational Nurse (LVN) 12, Resident 12's physician orders, dated 3/14/2026 and Resident 12's Weights and Vital summary for the months of May, June, and July were reviewed. LVN 12 stated the physician order directed staff to obtain and document Resident 12's orthostatic blood pressure every Saturday evening by measuring the resident's blood pressure while lying down and while sitting. LVN 12 stated there was no documentation indicating the orthostatic blood pressure assessments had been obtained or recorded during the months of May, June, or July 2026. During an interview on 7/15/2026 at 1:30pm with the DON, the DON stated nursing staff were expected to carry out all physician orders as written and accurately document the completion of ordered assessments in the resident's medical record. The DON stated orthostatic blood pressure monitoring was used to assess postural blood pressure changes, evaluate the effectiveness and safety of prescribed medications, identify residents at risk for dizziness, falls, or syncope, and promptly notify the physician of any abnormal findings. The DON stated the lack of documentation indicated the physician's order had not been followed as prescribed and the ordered monitoring should have been performed and documented each Saturday. 3. During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 9's diagnoses included metabolic encephalopathy (a broad term for brain dysfunction caused by chemical imbalances, systemic illnesses, or organ failure), schizophrenia (a mental illness that is characterized by disturbances in thought) and heart failure (when the heart does not pump blood to the body as well). During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9's cognition was severely impaired. The MDS indicated Resident 9 was dependent on staff for oral hygiene, toileting, bathing, upper/lower body dressing, and putting on/taking off footwear. During a review of Resident 9's H&P, dated 5/22/2026, the H&P indicated Resident 9 could make needs known but could not make medical decisions. During a review of Resident 9's Physician Order, dated 5/22/2026, the Physician Order indicated to monitor Resident 9's orthostatic blood pressure every Saturday in a lying and sitting position and to notify the physician for blood pressure differences of 20 mmHg or greater. During a review of Resident 9's Care Plan titled, Risk for Complications Related to Orthostatic Hypotension, dated 5/27/2026, the Care Plan's interventions indicated to monitor Resident 9's blood pressure as ordered. During a review of Resident 9's MAR, dated 6/1/2026 through 6/30/2026, the MAR indicated on (continued on next page)		

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/13/2026, Resident 9 had a lying and sitting position blood pressure of 128 over 78 (128/78) mmHg. During a phone interview on 7/13/2026 at 3:42 p.m., with LVN 11, LVN 11 stated he was a registry nurse (temporary employee) and worked one shift at the facility. LVN 11 stated he recalled checking the vital signs of his assigned residents but did not do any orthostatic blood pressure monitoring. LVN 11 stated on 6/13/2026, he must have overlooked Resident 9's order for orthostatic blood pressure and documented the same blood pressure for both positions. LVN 11 stated monitoring orthostatic blood pressures was necessary to understand how Resident 9's blood pressures varied from lying to sitting position. LVN 11 stated a change in orthostatic blood pressures could cause dizziness which could cause a fall. During an interview on 7/14/2026 at 12:21 p.m. with the DON, the DON stated orthostatic blood pressure monitoring was different from regular blood pressure readings because during orthostatic blood pressure monitoring, blood pressures were checked in different positions. The DON stated if the blood pressures were not monitored, the resident could have a missed change of condition requiring intervention. During a review of the facility's Policy and Procedure (P&P), titled, Resident-Oriented Approach to Safety, dated 1/2025, the P&P indicated the facility strived to make the environment as free from accident hazards as possible. The P&P indicated implementing interventions to reduce accident risks and hazards shall include ensuring interventions were implemented and documented. The P&P indicated resident supervision was a core component of the systems approach to safety and the type and frequency of resident supervision was determined by the individual resident's assessed needs and identified hazards in the environment. The P&P indicated the type and frequency of resident supervision may vary among residents and over time for the same resident. During a review of the facility's P&P, titled, Fall Prevention Program, dated 1/2026, the P&P indicated each resident would receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. During a review of the facility's P&P titled, Vital Signs, dated 1/2026, the P&P indicated vital signs would be obtained by the nurse, as indicated.		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform the responsible party for one of seven sampled residents (Resident 30) when Resident 30's initial podiatry appointment (a specialized medical visit to diagnose and treat conditions affecting the feet, ankles) was canceled due to lack of transportation. This deficient practice had the potential to place Resident 30 at risk for delayed diagnosis, treatment and delivery of care. Findings: During a review of Resident 30's admission Record, the admission Record indicated Resident 30 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 30's diagnoses included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and dementia (a progressive state of decline in mental abilities). During a review of Resident 30's History and Physical (H&P), dated 9/29/2025, the H&P indicated Resident 30 did not have the capacity to understand and make decisions. During a review of Resident 30's Minimum Data Set (MDS, a resident assessment tool), dated 5/3/2026, the MDS indicated Resident 30's cognition (ability to think and process) was severely impaired. The MDS indicated Resident 30 required supervision or touching assistance (helper provides verbal cues or steadying or contact guard assistance as resident completes activity) from staff for all attempted mobility activities while in and out of bed. During a telephone interview on 7/14/2026 at 9:16 a.m. with Resident 30's Responsible Party (RP) 3, RP 3 stated the Social Services Coordinator (SSC) did not notify her about Resident 30's missed podiatry appointment or provided updates. RP 3 stated after a week, RP 3 contacted the facility and learned from Licensed Vocational Nurse (LVN 10) that transportation was not scheduled, which led to concerns about delayed notification. During an interview on 7/14/2026 at 1:32 p.m. with Licensed Vocational Nurse (LVN) 10, LVN 10 stated failure to notify the RP and document the canceled appointment could result in delays in necessary medical care, and unmet healthcare needs. During a review of Resident 30's Social Services Notes, dated 5/18/2026 to 6/18/2026, the Social Services Notes indicated there was no entry made indicating the appointment scheduled for 5/18/2026 was canceled and RP 3 was informed about the cancellation because transportation was unavailable. During an interview on 7/16/2026 at 10:26 a.m. with the Social Services Director (SSD), the SSD stated it was important to document the residents' appointments, along with follow-up measures to maintain consistent care and clear communication with staff, residents, and the RP in the social services progress notes. During a review of the facility's Policy and Procedure (P&P) titled, Resident Medical Appointment and Scheduling, undated, the P&P indicated social services staff would schedule, coordinate, and document all resident medical appointments and missed or delayed appointments must be recorded with the reason and care coordination details involving the attending physician and RP.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to follow the physician-ordered medication parameters for two of two residents (Resident 12 and 9) by failing to: 1. Ensure Lisinopril and metoprolol were not administered outside of the physician-ordered heart rate parameter for Resident 12.2. Ensure Lantus and losartan were not administered outside of the physician-ordered parameters for insulin and blood pressure for Resident 9. These deficient practice had the potential to result in adverse outcomes, including hypotension, bradycardia, and hypoglycemia. Findings: 1). During a review of Resident 12's admission Record, the admission Record indicated Resident 12 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 12's diagnoses included atrial fibrillation (an irregular and often very rapid heart rhythm), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), dysphagia (difficulty swallowing) and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 12's History and Physical (H&P), dated 1/3/2026, the H&P indicated Resident 12 can make needs known but cannot make medical decisions. During a review of Resident 10's physician order, dated 3/14/2026, the physician order indicated to administer lisinopril (high blood pressure medication) 20 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) 1 tablet per day for hypertension (HTN- high blood pressure). Hold medication for systolic (SBP- top number of blood pressure reading) blood pressure less than (<) 110 millimeters of mercury (mmHg) or heart rate < 60 beats per minute. During a review of Resident 12's physician order, dated 3/14/2026, the physician order indicated to administer metoprolol (high blood pressure medication) 25 mg. Give 1 tablet per day for hypertension. Hold medication for systolic blood pressure < 120 mmHg or heart rate < 60 beats per minute. During a record review of Residents 12's Medication administration record (MAR) for the month of June 2026, the MAR indicated the following: a. On 6/13/2026, Resident 12's heart rate was 51 beats per minute. The MAR indicated a dose of lisinopril was administered at 9:00 a.m. On 6/13/2026, Resident 12's heart rate was 51 beats per minute. The MAR indicated a dose of metoprolol was administered at 9:00 a.m. During a concurrent interview and record review on 7/15/2026 at 10:55 a.m., with Licensed Vocational Nurse (LVN) 2, Resident 12's physician orders and MAR were reviewed. LVN 2 stated that it is the licensed nurse's responsibility to review the physician's orders and follow all prescribed blood pressure and heart rate parameters before administering antihypertensive or cardiac medications. LVN 2 stated that if a resident's blood pressure or heart rate falls outside the physician-ordered parameters, the medication should be held. LVN 2 stated that administering a medication when the resident's vital signs are outside the ordered parameters could place the resident at risk for adverse outcomes. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/15/26 at 1:30 p.m., with the Director of Nursing (DON), Resident 12's physician orders and MAR were reviewed. The DON stated that licensed nurses are expected to assess and document the resident's blood pressure and heart rate prior to administering medications with physician-ordered vital sign parameters. The DON stated that if either the blood pressure or heart rate is outside the ordered parameters, the medication should be withheld. The DON stated that administering a medication without following the ordered parameters constitutes a failure to follow the physician's orders and the facility's medication administration standards, which could place the resident at risk for adverse events such as hypotension (low blood pressure), bradycardia ([NAME] heart rate), dizziness, falls, syncope (fainting), or other serious complications, and that nurses are expected to consistently follow physician orders to ensure resident safety. During a review of the facility's policy and procedure (P&P) titled Medication Administration dated 1/2021, the P&P indicated, Medications are administered in accordance with written orders of the prescriber. 2. During a review of Resident 9's admission Record (Face Sheet, front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 9 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 9's diagnoses included hypertension (high blood pressure) and type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 9's History and Physical (H&P), dated 5/22/2026, the H&P indicated Resident 9 could make needs known but could not make medical decisions. During a review of Resident 9's Physician Orders, dated 5/22/206, the Physician Orders indicated to administer: 1. Lantus (a medication for DM) 12 units, subcutaneously (into the fatty tissue), once a day, hold the medication if Resident 9's blood sugar was less than 120 milligrams per deciliter (mg/dl, a unit for measuring blood glucose). 2. Losartan potassium (a blood pressure medication) 25 milligrams (mg, a unit of measurement), by mouth once a day, hold the medication if Resident 9's systolic blood pressure (SBP, the top number in a blood pressure reading) was less than 120 millimeters of mercury (mm Hg, a unit of measuring blood pressure). During a review of Resident 9's Care Plan titled, Risk for Complications Related to Diagnosis of Hypertension, dated 5/27/2026, the Care Plan's interventions indicated to administer losartan potassium as ordered. During a review of Resident 9's Care Plan titled, Potential for Hypo- or Hyperglycemic (low or high blood sugar) Reaction, dated 5/27/2026, the Care Plan's interventions indicated to administer insulin as ordered. During a review of Resident 9's Minimum Data Set (MDS, a resident assessment tool), dated (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/29/2026, indicated Resident 9's cognition (process of thinking) was severely impaired. The MDS indicated Resident 9 was dependent on staff's assistance with oral hygiene, toileting, bathing, upper/lower body dressing, and putting on/taking off footwear. During a concurrent interview and record review on 7/14/2026 at 12:07 p.m., with the Director of Nursing (DON), Resident 9's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 6/1/2026 to 6/30/2026, indicated on 6/13/2026, Resident 9's blood glucose was 112 mg/dl. The MAR indicated on 6/20/2026, Resident 9's blood glucose was 113 mg/dl. The MAR indicated on 6/13/2026 and 6/20/2026, the licensed nurse administered Lantus to Resident 9. The DON stated Resident 9's Lantus had hold parameters if Resident 9's blood glucose was less than 120 mg/dL. The DON stated the licensed nurses should not have administered Resident 9's Lantus on 6/13/2026 and 6/20/2026. The DON stated the administration of Lantus placed Resident 9 at risk for low blood sugar, which could cause associated complications such as a fall. During a concurrent interview and record review on 7/14/2026 at 12:07 p.m., with the DON, Resident 9's MAR, dated 6/1/2026 to 6/30/2026, indicated on, 6/24/2026, Resident 9's SBP was 119 mm Hg. The MAR indicated the licensed nurse administered losartan potassium to Resident 9. The DON stated Resident 9's losartan potassium had hold parameters to hold if Resident 9's SBP was less than 120 mmHg. The DON stated the licensed nurse should not have administered Resident 9's losartan potassium on 6/24/2026. The DON stated the administration of losartan potassium placed Resident 9 at risk for low blood pressure, which could cause associated complications such as dizziness and falls. During a review of the facility's Policy and Procedure (P&P) titled, Medication Administration, dated 1/2023, the P&P indicated medications were to be administered in accordance with the physician orders.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the medical records were accurate for three of twelve sampled residents (Resident 3, 34, and 135) by failing to: Ensure Licensed vocational nursing staff documented an assessment, monitoring, and treatment for Resident 135's bleeding scab on his forehead. Ensure Resident 34's admission Sheet (Face Sheet, front page of the chart that contains a summary of basic information about the resident) was kept accurate and indicated Resident 34 was self-responsible (able to make his or her own independent medical and lifestyle decisions). Ensure Resident 3 was assigned to the correct room in the electronic health record and physical chart. These deficiencies had the potential to result in unmonitored and unassessed injuries for Resident 135, inaccurate informed consent for Resident 34, and possible medical errors related to misidentification for Resident 3. Cross Reference F552 and F580. Findings: 1. During a review of Resident 135's admission Record, the admission Record indicated Resident 135 was initially admitted to the facility on [DATE] and readmitted [DATE]. Resident 135's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), epilepsy (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) muscle weakness, muscle wasting (weakening, shrinking, and loss of muscle), and lack of coordination. During a review of Resident 135's Minimum Data Set ([MDS], a resident assessment tool), dated 5/4/2026, the MDS indicated Resident 1's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. During a review of Resident 135's MDS, dated [DATE], the MDS indicated Resident 135 required supervision for eating, dressing, personal hygiene, sitting to lying, sitting to standing, transferring from the bed to the chair, and walking ten feet to 150 feet. During a review of Resident 135's History and Physical (H&P), dated 6/25/2026, the H&P indicated Resident 135 lacked the capacity to understand and make decisions. During a review of all of Resident 135's Progress Notes and Situation, Background, Assessment, Recommendation (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents) Notes, dated 6/2026 through 7/12/2026, there were no notes to indicate Resident 135 had developed scattered, circular scabs on his forehead. During an observation and interview on 7/13/2026 at 9:30 a.m. of Resident 135, in Resident 135's room, Resident 135 had a blue to purple discoloration noted under the left eye with several, round, small scabs scattered across his forehead. During a phone interview on 7/14/2026 at 3:50 p.m. with Certified Nursing Assistant (CNA) 7, CNA 7 (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she was Resident 135's assigned CNA on 7/10/2026 for the 3 p.m. to 11 p.m. shift. CNA 7 recalled Resident 135 had scattered scabs to his forehead. CNA 7 stated one of Resident 135's scabs began bleeding during his shower, and this was reported to LVN 8. During an interview on 7/15/2026 at 7:39 a.m. with Licensed Vocational Nurse (LVN) 8, LVN 8 stated she was the assigned nurse for Resident 135 on 7/10/2026 for the 3 p.m. to 11 p.m. shift. LVN 8 stated she recalled CNA 7 informed her that Resident 135's forehead scabs were bleeding during a shower. LVN 8 stated she administered treatment to the affected areas but LVN 8 stated a change of condition note should have been documented at that time to alert the physician and licensed nursing staff, facilitate ongoing monitoring, and secure appropriate orders for managing the scabs. LVN 8 stated there was a risk for the scabs to worsen or become infected. During a review of the facility's Policy and Procedure (P&P), titled, Documentation in Medical Record, reviewed in 2026, the P&P indicated each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. 2. During a review of Resident 34's admission Record (Face Sheet, front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 34 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 34's diagnoses included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and intracranial injury (any trauma or damage to the brain that occurred inside the skull). During a review of Resident 34's H&P, dated 9/13/2025, the H&P indicated Resident 34 could make her needs known but could not make medical decisions. During a review of Resident 34's MDS, dated [DATE], the MDS indicated Resident 34's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 34 required substantial assistance (helper does more than half the effort) with eating, oral hygiene, upper body dressing, and personal hygiene). The MDS indicated Resident 34 took antidepressant medication (medication to treat depression). During a concurrent interview and record review on 7/15/2026 at 7:59 a.m., with the Social Services Director (SSD), Resident 34's Notice of Probate Referral (Request to appoint a legal guardian for an individual without decision-making capability), dated 4/30/2025, was reviewed. The Notice of Probate Referral indicated Resident 34 was denied an appointed legal guardian. The SSD stated Resident 34 did not have the capacity to make medical decisions and did not have family to appoint as her responsible party (RP- an individual appointed to make decisions for an individual without decision-making capabilities). The SSD stated Resident 34's Probate Referral was denied, therefore, the interdisciplinary team (IDT- a group of healthcare professionals with various areas of expertise who work together towards the goals of the residents) made Resident 34's medical decisions for her. During a concurrent interview and record review on 7/15/2026 at 8:01 a.m., with the SSD, Resident 34's Face Sheet, was reviewed. The Face Sheet indicated Resident 34 was self-responsible (able to (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	make their own decisions). The SSD stated Resident 34's Face Sheet was not accurate and Resident 34 should not have been indicated as self-responsible. The SSD stated the IDT should have been indicated as Resident 34's RP to prevent any confusion. During a review of the facility's Policy and Procedure (P&P) titled Advising Surrogate or Representative of Resident's Rights and Responsibilities, updated 2026, the policy and procedure indicated should a resident be declared incompetent or incapable of understanding his or her rights, the resident's surrogate and/or representative would be advised of the resident's rights and their responsibilities as the resident's surrogate/representative. 3. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), anemia (a condition where the body does not have enough healthy red blood cells) and hypertension (HTN-high blood pressure). During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had moderate cognitive (ability to think and understand) impairment. The MDS indicated Resident 3 was dependent on staff for personal hygiene, toileting and bathing. During a review of Resident 3's H&P dated 7/13/2026, the H&P indicated Resident 3 was able to make decisions for activities of daily living. During an observation on 7/13/2026 at 2:07 p.m. with LVN 1 in room [ROOM NUMBER], Resident 3 was observed in room [ROOM NUMBER] bed C. During a concurrent interview and record review on 7/13/2026 at 2:10 PM with LVN 1, Resident 3's admission Record and physical chart were reviewed. Resident 3's admission Record indicated Resident 3 was assigned to room [ROOM NUMBER]-B. Resident 3's physical chart indicated a label that Resident 3 was assigned to room [ROOM NUMBER]-B. LVN 1 stated Resident 3's room assignment was incorrect in his admission record and physical chart. LVN 1 stated licensed nurses use room numbers as an identifier during medication pass, and incorrect room assignments placed residents at risk for medication errors. During an interview on 7/14/2026 at 12:37 p.m. with LVN 2, LVN 2 stated when Resident 3 was readmitted she accidentally assigned him to the wrong bed since both B and C bed were empty in room [ROOM NUMBER]. LVN 2 stated she should have assigned Resident 3 to room [ROOM NUMBER]-C. LVN 2 stated incorrect resident room assignments were a safety concern and placed residents at risk for medication errors. During an interview on 7/16/2026 at 8:50 a.m. with the Director of Nursing (DON), the DON stated nursing staff should ensure their documentation, including the assigning of resident rooms, were accurate. The DON stated the facility uses registry nurses (licensed nurses provided by a temporary staffing agency on a short-term basis to fill staffing shortages at facilities), who are unfamiliar with residents, and incorrect room assignments could place residents at risk for errors in care, such as (continued on next page)		

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Centers for Medicare & Medicaid Services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication errors. During a review of the facility's Policy and Procedure (P&P), titled, Documentation in Medical Record last reviewed 2026, the P&P indicated, Documentation shall be accurate, relevant, and complete.		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the Arbitration Agreement (is a contract where parties agree to resolve disputes out of a court room) document was executed through an appropriate and informed decision-making process by obtaining the signature of a resident with impaired cognitive status without involving or consulting the resident's daughter, who was identified by the facility as the emergency point of contact, for one of three residents sample residents (Resident 32). This deficient practice had the potential to result in the resident signing a legally significant document without fully understanding its contents, purpose, or implications, thereby compromising the resident's ability to make an informed decision and placing the resident's rights and interests at risk. Findings: During a review of Resident 32's admission Record, the admission Record indicated Resident 32 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 32's diagnoses included chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), encephalopathy (a disease or malfunction of the brain that alters mental state), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 32's History and Physical (H&P), dated 5/21/2024, the H&P indicated Resident 32 had fluctuating capacity to understand and make decisions. During a review of Resident 32's Minimum Data Set (MDS - a resident assessment tool), dated 9/27/2024, the MDS indicated Resident 32's mental capacity was severely impaired. The MDS indicated that Resident 32 was partially dependent (helper does less than half the effort) on staff to complete activities of daily living. During a review of Resident 32's arbitration agreement document, dated 10/14/2024, the arbitration agreement indicated an X in the resident's signature areas and in the resident's initial areas next to the date of 10/14/2024. The arbitration agreement document indicated two signatures from the business office manager (BOM) on the facility representative's signature area. During an interview on 7/16/2026 at 8:04 a.m., Resident 32 stated that he did not remember signing any documents. Resident 32 stated that he did not know what an arbitration agreement was. During a phone interview on 7/16/2026 at 8:13 a.m., with Resident 32's daughter (family) 1, Family 1 stated that she was present when Resident 32 was originally admitted on [DATE] and did not remember signing or being informed about an arbitration agreement document. Family 1 stated that she was not present and not aware that an arbitration document was signed by her father, Resident 32, on 10/14/2024. Family 1 stated that Resident 32 did not have the mental capacity to sign legal documents and Family 1 should have been informed and/or present during this discussion. During an interview on 7/16/2026 at 8:47 a.m., with the business office manager (BOM), the BOM stated that the arbitration agreement had been explained to Resident 32 by the BOM and translated in Spanish by the Social Services Designee (SSD) prior to Resident 32 signing the document on 10/14/2024. The BOM stated that no legal documents from the original admission date of 3/28/2023 were able to be located for Resident 32 and therefore admission documents and legal documents had to be re-discussed with Resident 32 on 10/14/2024. The BOM stated that Resident 32 indicated agreement with the arbitration document and signed it by placing an X because the resident was unable to write a signature. The BOM stated the unawareness of Resident 32's cognitive impairment. During a concurrent interview and record review on 7/16/2026 at 9:40 a.m., with the Director of Nursing (DON), Resident 32's admission record, MDS, and arbitration (continued on next page)		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	agreement dated 10/14/2024, was reviewed. The DON stated that residents are expected to have the mental capacity to understand the purpose and legal implications of documents before signing them. The DON stated that when a resident has impaired cognition or lacks the capacity to make informed decisions, legal documents, including arbitration agreements, should be reviewed with and signed by the resident's legally authorized representative or responsible party. The DON stated that the facility should verify a resident's decision-making capacity before obtaining signatures on legal documents. The DON stated that if the resident lacked the capacity to understand the arbitration agreement, the document should have been presented to and signed by the resident's legally authorized representative or responsible party or Family 1, rather than the resident. The DON stated that legal documents should not be executed by a resident who lacks the capacity to provide informed consent. During a review of the facility's policy and procedure (P&P) titled, Resident Rights dated 1/2026, the P&P indicated, Prior to or upon admission, designated staff member, will inform the resident and/or the resident's representative of the resident's rights and responsibilities. During a review of the facility's P&P titled, Advising Surrogate or Representative of Resident's Rights and Responsibilities dated 2026, the P&P indicated, Should a resident be declared incompetent or determined to be medically incapable of understanding his or her rights, the resident's surrogate and/or representative will be advised of the resident's rights and responsibilities. The surrogate or representative (sponsor) must acknowledge, in writing, that an oral explanation of the resident's rights and responsibilities has been made and that he or she also received a written copy of such material. During a review of the facility's P&P titled, Binding Arbitration Agreements dated 2023, the P&P indicated, When explaining the arbitration agreement, the facility shall: Explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, this facility. Explain to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands. Ensure the resident or his or her representative acknowledges that he or she understands the agreement.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 follow its Infection Prevention and Control measures for one of three sampled residents (Resident 7) by failing to identify, clean, and disinfect urine contamination in Resident 7's room. This deficient practice had the potential to create unsanitary living conditions, attract pests, increase the risk of infection, produce offensive odors, and negatively affect the resident's comfort, dignity, and quality of life. Findings: Findings: During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 7's diagnoses included end stage renal disease (ESRD, irreversible kidney failure) schizophrenia (a mental illness that is characterized by disturbances in thought), overactive bladder (causes a sudden, uncontrollable urge to urinate), dementia (a progressive state of decline in mental abilities), and nodular prostate (enlarged prostate). During a review of Resident 7's History and Physical (H&P), dated 6/21/2026, the H&P indicated Resident 7 did not have the capacity to understand and make decisions. During a review of Resident 7's Minimum Data Set (MDS - a resident assessment tool), dated 5/26/2026, the MDS indicated Resident 7 required supervision from staff for toileting hygiene and cleaning assistance for eating. During an observation on 7/13/2026 at 9:41 a.m., in Resident 7's room, the room was noted to have a very strong smell of urine with flying insects observed around Resident 7's bedside table and nightstand. During a concurrent observation and interview on 7/13/2026 at 9:42 a.m., with housekeeping staff (HS) 1, inside Resident 7's room, a flying insect was observed around the resident's bedside table. HS 1 stated she noticed a strong odor of urine coming from Resident 7's side of the room. HS 1 stated she completed cleaning and mopping Resident 7's room, but the urine odor remained persistent. During a concurrent observation and interview on 7/15/2026 at 12:25 a.m., with Certified Nurse Assistant (CNA) 8, inside Resident 7's room, CNA 8 stated the room smelled of urine. CNA 8 stated, Resident 7 sometimes peed on the floor or knocked over the urinal (a handheld plastic bottle used to collect urine) and would lead to urine seeping underneath the nightstand and bed. CNA 8 stated the flying insects in the room could have been attributed to the strong smell of urine. During a concurrent observation and interview on 7/15/2026 at 12:23 p.m., with the Housekeeping and Laundry Supervisor (HLS), inside Resident 7's room, the HLS stated there was a strong urine odor present in Resident 7's room. The HLS moved the resident's nightstand, and a puddle of yellow-colored fluid was observed on the floor underneath the resident's nightstand. The HLS stated the fluid was old urine that had not been removed during routine room cleaning and the nightstand had absorbed the urine due to prolonged exposure. HLS stated the flying insects could have been attributed to the strong smell of urine and wetness of the floor. Housekeeping staff were responsible for maintaining a clean and sanitary resident environment. The HLS stated Resident 7's room required more frequent and thorough cleaning due to the resident's known history of urinating on the floor. The HLS also stated the condition observed should have been identified and addressed during routine cleaning. Additional monitoring and cleaning interventions were needed to ensure the resident's room remained clean, odor-free, and sanitary. During an interview on 7/15/2026 at 1:08 p.m., with the Infection Preventionist Nurse (IP), the IP stated maintaining a clean, sanitary, and homelike environment for all residents was essential to preventing the spread of infection and promoting dignity and quality of life for residents. The IP stated staff should always keep residents' rooms clean. Any visible urine, feces, blood, or other bodily fluids should be cleaned immediately upon discovery. The IP stated, while housekeeping staff were responsible for routine environmental (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cleaning and disinfection, nursing staff were responsible for promptly cleaning bodily fluids when identified and notifying housekeeping so the affected area could be thoroughly cleaned and disinfected, using the appropriate disinfectant. The IP stated no staff member should leave urine or other bodily fluids on the floor with the expectation that another department would clean it later. All staff shared the responsibility for identifying and reporting environmental concerns to ensure that the resident rooms remained clean, safe, odor-free, and free of potential infection control hazard. During a review of the facility's Policy and Procedure (P&P) titled, Infection Prevention and Control Program, undated, the P&P indicated It is a policy of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.		