STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555797	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gordon Lane Care Center	1821 E Chapman Ave Fullerton, CA 92831

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to show documented evidence one of one final sampled resident (Resident 2) reviewed for personal property was provided with an explanation of his rights regarding personal property. * The facility failed to show documentation Resident 2 was provided with an explanation to address the risks of having a razor and a blade at the bedside, and his right to access the razors he bought online. These failures resulted in Resident 2 feeling upset and frustrated about the facility controlling the use of his razors. Findings: Review of facility's P&P titled Resident Personal Belongings revised 12/18/22, showed the following:- All the residents' possessions, regardless of their apparent value to others, will be treated with respect;- The facility will support the resident's rights to retain and use personal possessions to promote a homelike environment and maintain their independence;- The facility may refuse to allow a resident to retain his or her personal possessions due to the following reasons: (a) insufficient space in resident's room, (b) as protection of health and safety, (c) the facility determines through observation that a resident may have access to illegal substances that they brought into the facility or secured from an outside source. The facility does not act as an arm of law enforcement. Rather, in accordance with state laws, the facility will determine if a referral to a local law enforcement is warranted. The facility may choose to provide additional monitoring and supervision determined on a case-by-case basis. If facility staff identify items or substances that pose risks to residents' health and safety and are in plain view, they may confiscate them. Facility staff will not conduct searches of a resident or their personal belongings, unless the resident or resident representative agrees to a voluntary search and understands the reason for the search, and (d) to maintain and prevent the infringement of other resident's rights; and- The social services designee, or another designated staff member, will encourage residents and their families to bring in personal belongings. On 7/29/25 at 0857 hours, during the initial tour of the facility, Resident 2 was observed awake and in bed. Resident 2 stated he bought a set of razors and blades online for his personal use, however, when the SSD brought the package into his room, the SSD told him he was not supposed to have sharp objects in the room. Resident 2 stated the SSD left a razor and a blade from the set of razors and blade he bought online. Resident 2 stated he felt frustrated because the SSD wanted to control the use of his razor blades. Medical record review for Resident 2 was initiated on 7/29/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's MDS assessment dated [DATE], showed Resident 2 was cognitively intact, and needed set-up or clean assistance with personal hygiene. On 7/30/25 at 0946 hours, a follow-up interview was conducted with Resident 2. When asked about his razor, Resident 2 stated the SSD told him he could not have a razor at the bedside because of the sharp blades and would give another back-up blades upon his request. Resident 2 stated the SSD gave him his razor and a blade, and the SSD kept the back-up blades. When asked if the SSD or another staff came to supervise him while he was shaving, Resident 2 answered no. When asked if the SSD or another staff came to get the razor back when he was done shaving, Resident 2 answered no, and stated he kept the used razor at the bedside. On 7/30/25 at 1051 hours, an interview was conducted (continued on next page)

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

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the SSD. The SSD stated when the facility received Resident 2's mail containing the set of razors with blades, she went to Resident 2's room and opened the mail with the resident's instructions. The SSD stated he explained to Resident 2 he could not keep the razor and blades at the bedside, but the social services department would keep them for him, because it was the facility's policy for the residents to not keep sharp objects at the bedside such as scissors or razors. When asked if she or any facility staff have supervised Resident 2 while shaving, the SSD answered no. When asked if she or another staff came to get the razor back when Resident 2 was done shaving, the SSD answered no, and stated Resident 2 did not want to give the razor back and he kept the used razor at the bedside. The SSD was not able to provide documented evidence Resident 2 was provided with an explanation to address the risks of having a razor and a blade at the bedside, and his right to access the razors he bought online. In addition, the SSD could not show any documented evidence she provided explanation to Resident 2 about safety using the razors and blade, and when Resident 2 kept the used razors at the bedside.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide reasonable accommodations to meet the needs of one nonsampled resident of 96 facility census (Resident 105). * The facility failed to ensure Resident 105's call light button was within the resident's reach. This failure posed the risk of delay in providing care to Resident 105, and the potential to negatively impact the resident's psychosocial well-being.Findings: Review of the facility's P&P titled Call Lights: Accessibility and Timely Response revised 12/19/22, showed the staff will be educated on the proper use of the resident's call system, including how the system works and ensuring resident access to the call light, the staff will ensure the call light is within reach of resident and secured, as needed, and the call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room. On 8/1/25 at 0547 and 0603 hours, Resident 105 was observed asleep in bed. The call light cord was observed routed through the right bed rail and tangled with the call light button, leaving the button hanging near the floor, and out of Resident 105's reach. CNA 7 was observed untangling the call light cord and placing the call light button on Resident 105's stomach area. On 8/1/25 at 0607 hours, an observation for Resident 105 and concurrent interview was conducted with CNA 7. CNA 7 was observed inside Resident 105's room. CNA 7 verified Resident 105's call light cord and button were tangled and hanging near the floor. CNA 7 also verified the call light button was not within Resident 105's reach. On 8/1/25 at 0620 hours, a follow-up interview was conducted with CNA 7. CNA 7 verified the above findings. CNA 7 stated Resident 105 was a newly admitted resident, and his call light did not have a clip. Medical record review for Resident 105 was initiated on 7/29/25. Resident 105 was admitted to the facility on [DATE]. Review of Resident 105's H&P examination dated 7/27/25, showed Resident 105 had the capacity to understand and make decisions. On 8/4/25 at 0812 hours, an interview was conducted with Resident 105. When asked about the call light use, Resident 105 stated he used his call light to ask for help from the staff. On 8/4/25 at 1038 hours, an interview was conducted with the DSD. The DSD stated the call light should be placed within the resident's reach, by clipping the call light on the side of the bed. The DSD further stated the CNAs and licensed nurses, and even managers, should be monitoring the call lights and to report to the maintenance staff if the call light did not have a clip on it.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to maintain a copy of the advance directive in the medical record readily accessible to the facility staff for one of six final sampled residents (Resident 1) reviewed for advance directives. This failure had the potential for Resident 1's decision regarding his healthcare and treatment options to not be honored.Findings: Review of facility P&P titled Residents' Rights Regarding Treatment and Advance Directives dated 12/19/22, showed upon admission, should the resident have an advance directive, copies will be made and placed on chart as well as communicated to the staff. Medical record review for Resident 1 was initiated on 7/29/25. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's POLST dated 4/10/25, showed Resident 1 had an Advance Directive dated 4/17/21, and it was available and reviewed. Under the section for health care agent if named in Advance Directive, did not show any entry. Further review of Resident 1's medical records failed to show the copy of the Advance Directive in resident's medical records and/or EHR. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 had a memory problem and had severe impaired cognitive skills for daily decision making. On 7/31/25 at 1058 hours, an interview and concurrent medical record review for Resident 1 was conducted with LVN 7. LVN 7 stated if a resident has an Advance Directive, then it should be available in the medical records and readily accessible to the facility staff. LVN 7 reviewed the resident's medical records and verified Resident 1's POLST showed Resident 1 had an Advance Directive. LVN 7 was not able to find a copy of the Advanced Directive in Resident 1's medical records and/or EHR. On 7/31/25 at 1256 hours, an interview was conducted with the DON. The DON stated the Advanced Directive for Resident 1 was available in the medical records department and not in Resident 1's chart and/or EHR. The DON acknowledged the copy of Resident 1's Advance Directive should have been placed in Resident 1's medical records for it to be easily accessible to the facility staff. On 7/31/25 at 1447 hours, an interview was conducted with the Medical Records Director. The Medical Records Director stated the facility's Medical Records Department was open every Monday to Friday from 0730 to 1800 hours. The Medical Records Director stated the staff will not be able to access any medical records from the department when it was closed. The Medical Record Director further stated the Advance Directive for the residents should be placed in the resident's medical record and/or EHR for it to be readily accessible to the facility staff not in the medical record department.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure two of five final sampled residents (Residents 17 and 68) were free from the unnecessary psychotropic drugs (any drug that affects brain activity associated with mental processes and behavior). * The facility failed to ensure Resident 17 was monitored for the specific behavior related to the use of the Seroquel (antipsychotic medication) medication. In addition, the facility failed to ensure Resident 17's orthostatic blood pressure (measure the blood pressure while laying down and sitting) was monitored for the use of the Seroquel medication. Furthermore, the facility failed to ensure the non-pharmacological interventions were identified and implemented for the psychosis behavior exhibited by Resident 17 related to the use of the Seroquel medication. * The facility failed to monitor and evaluate the number of behavioral episodes related to the use of quetiapine (antipsychotic medication) monthly for Resident 68. These failures had the potential to place the residents at risk for receiving the unnecessary medications and increased risk of serious medication adverse reactions.Findings: Review of the facility's P&P titled Use of Psychotropic Medication use dated 3/17/25, showed in part, a psychotropic drug is any drug that affects the brain activities associated with the mental processes and behavior, which includes the antipsychotics, anxiolytics, hypnotics, and antidepressants . Facility must attempt non-pharmacological approaches unless contraindicated to minimize the need for the psychotropic medication, permit the lowest possible dose, and allow for the discontinuation of the medications when possible.The resident's response to the medication(s) including progress towards the goal and presence/absence of adverse consequences, shall be documented in the residents' medical record. 1. Medical record review for Resident 17 was initiated on 7/29/25. Resident 17 was admitted to the facility on [DATE]. Review of Resident 17's H&P examination dated 2/17/25, showed Resident 17 had no capacity to understand and make decisions. Review of Resident 17's Order Summary Report showed a physician's order dated 6/6/25, to administer Seroquel (antipsychotic medication) oral tablet 12.5 mg by mouth in the evening for psychosis as manifested by mood disturbance. Review of Resident 17's MAR for June and July 2025 showed the Seroquel 12.5 mg medication was administered to Resident 17. Review of the Resident 17's plan of care showed a care plan problem revised 7/29/25, addressing the resident's use of the Seroquel medication. The interventions included to review the behaviors, interventions and alternate therapy attempted and their effectiveness as per facility policy. Further review of Resident 17's medical record 17 failed to show if the episodes of the specific behavior (i.e. mood disturbance) related to the use of Seroquel medication was monitored. In addition, Resident 17's medical record did not show a physician's order to monitor Resident 17 for orthostatic hypotension and/or if the facility monitored Resident 17 for orthostatic blood pressure related to the use of the Seroquel medication. Furthermore, the non-pharmacological interventions were not (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified and implemented for the use of the Seroquel medication. On 7/30/25 at 1050 hours, an interview and concurrent medical record review for Resident 17 was conducted with RN 1. RN 1 stated when the residents were prescribed antipsychotic mediations, the behavior related to the use of antipsychotic should be monitored and documented, the resident's orthostatic blood pressure should be monitored, and the non-pharmacological intervention to address the resident's behavior related to the use of the specific antipsychotic medication should be implemented and documented. RN 1 verified Resident 17's physician's order for the Seroquel medication and verified Resident 17 had been receiving the medication since it was ordered on 6/6/25. RN 1 verified the episodes of behavior (mood disturbance) related to the use of the Seroquel medication were not monitored for Resident 17. RN 1 also verified the orthostatic blood pressure related to the use of the Seroquel medication was not monitored for Resident 17. Furthermore, RN 1 verified the non-pharmacological interventions were not identified and implemented for the use of the Seroquel medication for Resident 17. On 8/1/25 at 1243 hours, an interview and concurrent medical record review for Resident 17 was conducted with the DON. The DON verified the above findings. 2. Medical record review for Resident 68 was initiated on 7/29/25. Resident 68 was readmitted to the facility 6/9/25. Review of Resident 68's Order Summary Report showed the following physician's orders dated: - 6/9/25, to administer quetiapine 50 mg one tablet by mouth at bedtime. This physician's order was discontinued on 6/19/25; - 6/19/25, to administer quetiapine 50 mg two tablets by mouth at bedtime. This physician's order was discontinued on 6/30/25; - 6/30/25, to administer quetiapine 50 mg four tablets by mouth at bedtime. This physician's order was discontinued on 7/11/25; and - 7/11/25, to administer quetiapine 100 mg three tablets by mouth at bedtime for two weeks. This physician's order was discontinued on 7/25/25; and - 7/11/25, to administer quetiapine 100 mg four tablets by mouth at bedtime. This physician's order was started on 7/25/25. Review of Resident 68's MAR for June 2025 showed Resident 68 was administered the quetiapine 50 mg one tablet on 6/9, 6/10, 6/12 to 6/18/25 at 2100 hours, and quetiapine 50 mg two tablets on 6/19 to 6/29/25 at 2100 hours. Review of Resident 68's Monthly Behavior Summary form for June 2025 for the quetiapine medication showed the form was blank, and there was no monthly evaluation of the number of episodes exhibited and any side effects noted for Resident 68. On 8/1/25 at 1332 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified Resident 68's Monthly Behavior Summary form for June 2025 for the quetiapine medication was blank and not completed. When asked who completed the monthly behavior summary (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	form for the psychotropic medication use, LVN 2 was not able to provide an answer. On 8/4/25 at 0934 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified Resident 68's Monthly Behavior Summary form for June 2025 for the use of the quetiapine medication was blank and not completed. The DON stated the QA nurse should have completed the behavior summary form monthly for the psychotropic medication use at the beginning of the following month.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide the notice of discharge and notify the Ombudsman for two of three sampled residents (Residents 9 and 99) reviewed for the closed records. * The facility failed to provide the notice of discharge and notify the Ombudsman when Resident 9 was discharged from the facility AMA (against medical advice). * The facility failed to notify the Ombudsman of the resident's discharge from the facility when Resident 99 passed away. These failures had the potential for the residents and/or representatives and Ombudsman to not know the specific details/reason/basis of the residents' discharge from the facility.Findings: Review of the facility's P&P titled Transfer and Discharge (including AMA) revised on [DATE], showed the facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided:a. The specific reason and basis for transfer or discharge.b. The effective date of transfer or discharge.c. The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged .d. An explanation of the right to appeal the transfer or discharge to the State.e. The name, address (mailing and email) and telephone number of the State entity which receives such appeal hearing requests.f. Information on how to obtain an appeal form.g Information on obtaining assistance in completing and submitting the appeal hearing request.h. The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care Ombudsman.i. For nursing facility residents with intellectual and developmental disabilities (or related disabilities) or with mental illness (or related disabilities), the notice will include the name, mailing and e-mail addresses and phone number of the state agency responsible for the protection and advocacy of these populations. Further review of the facility's P&P showed generally the notice must be provided at least 30 days prior to a facility-initiated transfer or discharge of the resident. Exceptions to the 30-day requirement apply when the transfer or discharge is effected because:a. The health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident;b. The resident's health improves sufficiently to allow a more immediate transfer or discharge;c. An immediate transfer or discharge is required by the resident's urgent medical needs; ord. A resident has not resided in the facility for 30 days. In addition, in these exceptional cases, the notice must be provided to the resident, resident's representative if appropriate, and LTC Ombudsman as soon as practicable before the transfer or discharge. The facility will maintain evidence that the notice was sent to the Ombudsman. 1. Medical record review for Resident 9 was initiated on [DATE]. Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 9's H&P examination dated [DATE], showed Resident 9 had the capacity to make decisions. Review of Resident 9's Telephone Order showed a physician's order dated [DATE], to discharge Resident 9 against medical advice. Review of Resident 9's Progress note dated [DATE] at 1410 hours, showed Resident 9 had left the facility against medical advice and the physician was notified. Review of Resident 9's medical record failed to show if the notice of discharge was provided to Resident 9 when the resident was discharged against medical advice on [DATE]. Additionally, the medical record failed to show if the Ombudsman was notified of Resident 9's discharged against medical advice. On [DATE] at 1442 hours, an interview with the Nurse Consultant was conducted. The Nurse Consultant verified the findings and stated the Ombudsman should have been informed of the discharge against medical advice and the Notice of Transfer form should have been completed. On [DATE] at 1446 hours, the DON was informed and acknowledged the above findings. 2. Medical record review for Resident 99 was initiated on [DATE]. Resident 99 was admitted to the facility on [DATE]. Review of Resident 99's H&P examination dated (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE], showed Resident 99 had no capacity to understand and make decisions. Review of Resident 99's Telephone Order dated [DATE] at 2105 hours, showed a physician's order to release Resident 99's remains to the mortuary. Review of Resident 99's Record of Death showed Resident 99's date of death on [DATE] at 2100 hours. Review of Resident 99's medical record failed to show if the notice of discharge was provided to the Ombudsman when Resident 99 had expired on [DATE]. On [DATE] at 1442 hours, an interview with the Nurse Consultant was conducted. The Nurse Consultant verified the findings and stated the Ombudsman should have been informed of Resident 99's death and the Notice of Transfer form should have been completed. On [DATE] at 1446 hours, the DON was informed and acknowledged the above findings.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the PASRR screening for one of two final sampled residents (Resident 5) was accurately completed as per the facility's P&P. * The facility failed to accurately complete the PASRR screening to reflect Resident 5 was on a psychotropic medication and had history of developmental delay. This failure had the potential for the resident to not be screened for mental illness, intellectual disabilities or related conditions, and received any additional resources if needed.Findings: Review of the facility's P&P titled Resident Assessment - Coordination with PASRR Program revised 12/2023 showed the facility coordinates the assessments with the Preadmission Screening and Resident Review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. The P&P further showed all the applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. PASARR Level 1, initial pre-screening that is completed prior to admission. A negative Level 1 screen permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. A positive Level 1 screen necessitates a PASARR Level II evaluation prior to admission. Medical record review for Resident 5 was initiated on 7/29/25. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 5's Ortho H&P examination from the acute care hospital dated 11/5/24, showed Resident 5 had a past medical history of developmental delay. Review of Resident 5's PASARR Level 1 Screening dated 11/13/24, showed Resident 5 was not on the psychotropic medications and the section for suspected mental illness was incomplete. Review of Resident 5's Order Summary Report showed a physician's order dated 11/14/24, for risperidone 1 mg (an antipsychotic medication) by mouth at bedtime for schizophrenia m/b frequent mood swing. Review of Resident 5's MAR for November and December 2024, and January 2025 showed Resident 5 was administered with the risperidone medication on the following dates and time:- dated 11/14 to 11/30/24 at 2100 hours,- dated 12/1 to 12/31/24 at 2100 hours, and - dated 1/1 to 1/19/25 at 2100 hours. Review of Resident 5's H&P examination dated 7/24/25, showed Resident 5 had no capacity to make medical decisions. On 8/1/25 at 1021 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the above findings for Resident 5. The DON verified Resident 5 was administered with the risperidone medication in November and December 2024, and January 2025. The DON stated the facility used the acute care hospital PASARR; however, the facility did not update to reflect Resident 5 was taking a psychotropic medication and had history of developmental delay. The DON stated PASRRs should be accurately completed as it provide the recommendations for the facility on further resources and care for the residents with psychotropic medication and/or mental illness or developmental delays. On 8/4/25 at 1406 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to develop and implement a comprehensive person-centered care plan for two of 21 final sampled residents (Residents 2 and 63). * For Resident 2, there was no care plan developed for the resident's surgical wound. * For Resident 63, there was no care plan developed and implemented for the scabies and contact isolation. These failures had the potential of not providing the residents with person-centered plans of care.Findings: Review of the facility's P&P titled Comprehensive Care Plans revised on 12/2022, showed it is the policy of the facility to develop and implement a comprehensive person-centered plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The P&P further showed the care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility as outlined by the comprehensive care plan, shall be culturally-competent and trauma-informed. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 1. Medical record review for Resident 63 was initiated on 7/29/25. Resident 63 was admitted to the facility on [DATE], and readmitted back on 1/19/25. Review of Resident 63's Quarterly MDS assessment dated [DATE], showed the resident had a BIMS score of 3, indicating severe cognitive impairment. Review of Resident 63's Order Summary Report for August 2025 showed the following physician's orders: - order dated 6/19/25, for contact isolation for scabies. - order dated 7/3/25, for Ivermectin (medication to treat parasites) 6 mg give two tablets by mouth one time a day every Friday for scabies until 8/1/25. Further review of Resident 63's medical record failed to show documented evidence care plans were developed for the scabies and contact isolation. On 7/31/25 at 1335 hours, an interview and concurrent medical record review for Resident 63 was conducted with LVN 5. LVN 5 verified Resident 63 had a physician's order for the contact isolation precautions every shift for scabies from 6/19 to 6/21/25. LVN 5 further verified Resident 63's care plan failed to show documented evidence a care plan was completed for Resident 63 when the resident was in contact isolation and diagnosed with scabies. LVN 5 stated care plans were done when a resident has a change of condition and allows for nurses to follow an approach to care specific to the resident's needs and medical diagnosis. On 8/1/25 at 1021 hours, an interview and concurrent medical record review was conducted with the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON. The DON verified there was no documented evidence the facility created a care plan for Resident 63's positive diagnosis for scabies and contact isolation. The DON stated a care plan ensure the staff were aware of the plan of care for the resident and how to manage their care needs with the interventions. The DON further acknowledged there should have been care plans implemented for scabies and contact isolation. On 8/4/25 at 1406 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings. 2. Medical record review for Resident 2 was initiated on 7/29/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's N Adv – Skin Check dated 6/8/25, under Skin Issues Note section, showed Resident 2 was admitted with recent left metatarsal amputation. Review of Resident 2's plan of care did not show a care plan problem to address Resident 2's surgical wound from a left metatarsal amputation. On 8/1/25 at 0845 hours, an interview and concurrent medical record review was conducted with LVN 5. LVN 5 stated Resident 2 with a surgical wound on the left foot. LVN 5 verified a care plan problem was not developed to address Resident 2's surgical wound. On 8/1/25 at 0901 hours, an interview and concurrent medical record review was conducted with LVNs 5 and 6. LVNs 5 and 6 verified a care plan problem was not developed to address Resident 2's surgical wound. When asked who was responsible for initiating a care plan, LVN 6 stated any licensed nurse could initiate a care plan.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to ensure three of 21 final sampled residents (Residents 2, 4, and 63) attained and maintained their highest practicable well-being. * The facility failed to ensure Resident 2 was monitored post removal of staples from a wound on the resident's left foot. Additionally, there was no care plan developed to address the removal of the staples. * The facility failed to monitor Resident 4's vital signs every shift as per plan of care when the resident had a change in condition for weight gain of 3 (three) pounds related to edema (swelling that occurs when fluid builds up in the body's tissues). * The facility failed to ensure Resident 63's primary physician was notified of the Wound Physician's recommendation. Additionally, there was no further wound physician or dermatology follow up after 6/17/25. These failures had the potential for not providing the necessary care and services if the residents had a change in condition or requiring treatments.Findings: 1. Review of the facility's P&P titled Vital Signs revised 12/19/22, showed the vital signs indicators of health status, including temperature, pulse, blood pressure, respiratory rate, oxygen saturation, and pain. Vital signs shall be obtained at least in the following circumstances like when the resident's general condition changes. Review of the facility's P&P titled Comprehensive Care Plans revised 12/19/22, showed a qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. On 7/29/25 at 0901 hours, during the initial tour of the facility, Resident 4 was observed awake and lying in bed. Resident 4 was observed with edema in both legs. Resident 4 stated she would have swelling and it would sometimes resolve. Medical record review for Resident 4 was initiated on 7/29/25. Resident 4 was readmitted to the facility on [DATE]. Review of Resident 4's H&P examination dated 7/11/25, showed Resident 4 was able to make decisions. Review of Resident 4's eINTERACT Change in Condition Evaluation dated 7/28/25 at 1345 hours, showed Resident 4 was noted with three pounds weight gain for one week related to edema. Review of Resident 4's plan of care revised on 7/28/25, showed a care plan problem addressing Resident 4's weight gain of 3 pounds. The interventions included monitoring of the signs and symptoms of the bilateral lower extremity edema, monitoring of vital signs every shift, and to notify the physician for any significant changes. Further review of Resident 4's medical record did not show documented evidence Resident 4's vitals signs were being monitored every shift. On 7/31/25 at 1319 hours, an interview and concurrent medical record review for Resident 4 was conducted with LVN 6. LVN 6 stated any new issues concerning the resident should be addressed in the plan of care and the interventions should be implemented to address the specific needs of the resident and to promote healing. LVN 6 verified Resident 4's vital signs were not monitored every (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shift. LVN 6 stated the vital signs monitoring was important to help to identify the potential health issues, no significant changes, if the resident was doing well, and ensured safety of the resident. On 8/4/25 at 1300 hours, an interview was conducted with the DON. The DON stated the interventions in the resident's plan of care should be implemented because if not, the facility might not meet the goals intended for the resident for the specific problem. The DON was informed and acknowledged the above findings. 2. On 7/29/25 at 0857 hours, during the initial tour of the facility, Resident 2 was observed lying in bed with a bandage on his left foot. Resident 2 showed a photograph of his left wound with staples, following a left metatarsal amputation. Medical record review for Resident 2 was initiated on 7/29/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's medical records failed to show any documentation of the removal of the staples on Resident 2's left foot wound and failed to show any monitoring of Resident 2's left foot wound after staple removal. In addition, review of Resident 2's plan of care did not show a care plan problem was developed to address the removal of the staples on Resident 2's left foot wound. On 7/30/25 at 0946 hours, an observation and concurrent follow-up interview was conducted with Resident 2. Resident 2 was observed lying in bed with a bandage on his left foot. Resident 2 stated the physician came by and the physician told him about the staples on his left foot wound were gone. Resident 2 stated he did not know when the staples were removed, and the nurses could not tell him either. On 8/1/25 at 0809 hours, a wound care treatment observation for Resident 2 was conducted with LVN 5. LVN 5 verified Resident 2's left foot wound did not have staples. On 8/1/25 at 0901 hours, an interview and concurrent medical record review was conducted with LVNs 5 and 6. LVN 5 stated Resident 2 was admitted with a left surgical wound, and it was covered with dressing upon admission. The dressing was only changed after Resident 2 came back from his appointment. LVN 5 stated they counted the staples on the left foot wound. LVN 5 stated the staples on Resident 2's left foot wound were removed when Resident 2 went to his follow-up appointment. When asked to show documentation to show the number of staples on the left foot wound when the staples were removed, and the monitoring for Resident 2 when the staples were removed, LVNs 5 and 6 showed Resident 2's Progress Notes. Review of Resident 2's Progress Notes showed the following: - Under N Adv Skilled Evaluation dated 6/25/25 at 0915 hours, showed left toes amputated.noted closed with staples; - Under N Adv Skilled Evaluation dated 7/28/25 at 1019 hours, showed skin issue has not been evaluated; and - Under Orders – Administration Note dated 7/28/25 at 1033 hours, showed appointment; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVNs 5 and 6 verified there was no documented evidence to show the number of staples on the left foot wound when the staples were removed, and any monitoring conducted for Resident 2 when the staples were removed on the left foot wound. LVN 5 stated Resident 2 informed him the staples were removed on 7/28/25. LVN 6 verified Resident 2's Progress Note dated 7/28/25, showed appointment but there was no documentation to show when the resident went to the appointment and when Resident 2 came back from his appointment. LVN 6 stated the nurses should have initiated a change of condition monitoring when the staples on the resident's left foot wound were removed. 3. Review of the facility's P&P titled Medication Orders revised on 12/2022, showed documentation of medications orders included: - Each medication order should be documented with the date, time, and signature of the person receiving the order. The order should be recorded on the physician order sheet, and the MAR. - Clarify the order - Enter the order on the medication order and receipt record - If using electronic medication records, input the medication order according to the electronic health record instructions and facility policy - Call or fax the medication order to the provider pharmacy. The P&P further showed the charge nurse on duty at the time the order is received should note the order and enter it on the physician order sheet or electronic order format, if not written by the physician. Medical record review for Resident 63 was initiated on 7/29/25. Resident 63 was admitted to the facility on [DATE], and readmitted back on 1/19/25. Review of Resident 63's Quarterly MDS assessment dated [DATE], showed the resident had a BIMS score of 3, indicating severe cognitive impairment. Review of Resident 63's Wound assessment dated [DATE], showed the wound physician's plan medication management included Ivermectin 20 mcg/kg (medication to treat parasites orally on days one, two, eight, nine, and 15 for crusted or resistant scabies. Further review of Resident 63's physician's orders and progress notes in June 2025 failed to show documentation Resident 63's primary physician was notified of the wound physician's medication recommendation for the treatment of the resident's scabies. On 8/4/25 at 1057 hours, an interview and concurrent medical record review for Resident 63 was conducted with LVN 6. LVN 6 stated the wound physician makes round weekly on Wednesdays. LVN 6 verified the Wound Physician's wound notes showed an Ivermectin order was recommended. LVN 6 further verified Ivermectin was not ordered in June and there were no documented evidence Resident 63's primary physician was notified of the Wound Physician's recommendation. LVN 6 stated Resident 63's primary physician should have been notified and if the physician declined the wound physician's recommendation, then it should have been documented. LVN 6 also verified there were no further wound physician or dermatology follow up after 6/17/25. LVN 6 stated a wound physician or (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dermatology follow up could help identify Resident 63's rashes as new lesions and the type of strain. On 8/4/25 at 1122 hours, an interview and concurrent medical record review for Resident 63 was conducted with the MRD. The MRD verified the Wound Assessment for Resident 63 was received on 6/19/25. When asked if the Wound Assessment notes were given to the nursing staff, the MRD stated she did not give it to the nursing staff; however, they placed the copy in the resident's chart. On 8/4/25 at 1406 hours, an interview and concurrent medical record review was conducted with the DON, with the Administrator and the Nurse Consultant present. The DON verified the above findings and stated the Plan Medication Management from the Wound Assessment were the wound physician's order recommendations and stated she expected the nursing staff to follow up with the resident's primary physician and document. The DON further verified the facility failed to show Resident 63's primary physician was notified of the Wound Physician's recommendation regarding the resident's treatment for scabies. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings. On 8/5/25 at 1206 hours, a telephone interview with the wound physician was conducted. The Wound Physician stated he was returning a call back from 8/4/25. When asked if the Plan Medication Management on his Wound Assessment notes were orders he recommended, he stated they were. The Wound Physician further stated he wrote his ordered medication recommendations and expected the staff to contact the residents' primary physician if they would like to continue with his recommendations. The Wound Physician verified understanding and further stated there should be a documentation if the primary physician refuses the treatment recommendation. Cross Reference to F880.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility P&P review, and facility document review, the facility failed to ensure two final sampled residents (Residents 4 and 7) were provided with the necessary care and services when: * The facility failed to monitor Resident 4 when the resident developed a MASD (moisture-associated skin damage caused by prolonged or repeated exposure to moisture) in the sacral area, per the facility's Change of Condition protocols. The facility failed to provide documented evidence Resident 4 was monitored every shift for 72 after the identification of a MASD in the sacral area. In addition, the facility failed to initiate a care plan for Resident 4's non-compliance with the interventions to address the sacral wound. The MASD was classified as an unstageable pressure injury eight days later. * The facility failed to ensure Resident 7's alternating pressure mattress was not in static mode while the resident was in bed. This posed the risk of defeating the mattress' purpose and may cause skin breakdown for Resident 7. These failures had the potential for the residents not to receive the appropriate care and services to promote skin healing.Findings: 1. Review of the facility's P&P titled Skin Assessment revised 12/19/22, showed under the Policy Explanation and Compliance Guidelines section, a full body or head to toe skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury. On 7/29/25 at 0901 hours, during the initial tour of the facility, Resident 4 was observed awake and lying in bed with LAL mattress set to alternating pressure mode. Resident 4 stated she had developed a bedsore in her buttock. Resident 4 stated the staff informed her it was open and red. Resident 4 stated she could reposition herself in bed; however, most of the time she wanted to stay on her back. Resident 4 admitted she needed to be repositioned because of the wound on her buttock. Resident 4 stated the staff reminded her to turn every two hours or more often, and if she needed help, the staff assisted her with repositioning. Resident 4 further stated she liked the bed mattress set at static mode at times because she did not like the mattress to be moving a lot. Medical record review for Resident 4 was initiated on 7/29/25. Resident 4 was readmitted to the facility on [DATE]. Review of Resident 4's H&P examination dated 7/11/25, showed Resident 4 was able to make decisions. Review of Resident 4's MDS assessment dated [DATE], showed Resident 4 needed partial/moderate assistance with mobility. Review of the Order Summary Report showed the following physician's orders: - dated 7/17/25, to cleanse the sacrum MASD with normal saline, pat dry, apply Medihoney (used in wound care to promote healing by creating a moist environment, combating bacteria, and aiding in the removal of dead tissue) and calcium alginate (used in wound care dressings due to its ability to absorb wound exudate and form a gel that promotes a moist healing environment), then apply zinc oxide (topical cream to protect the skin from being irritated and wet), and leave open to air every day shift; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 7/23/25, to administer Juven Oral Packet (nutritional supplements) one packet by mouth one time a day with six to eight ounces of water for supplements; - dated 7/23/25, to administer Pro-Stat Oral Liquid (amino acids-protein hydrolysate) 30 ml by mouth three times a day for supplements; - dated 7/25/25, to cleanse the sacral pressure injury with 1/4 strength Dakin's solution (used to clean or care for cuts, scrapes, burns, or other skin wounds to prevent or treat skin infection), pat dry, apply Medihoney, apply foam dressing, and cover with dry dressing every day shift; and - dated 7/25/25, for LAL mattress for wound management every shift. Review of Resident 4's Skin Check record dated 7/16/25 at 1626 hours, showed a new skin issue was identified and classified as MASD in the sacral area. Review of Resident 4's Skin Check record dated 7/21/25 at 1151 hours, showed the MASD at the sacral area got worsened with purplish & bluish skin, shiny texture with slight elevation in the peri area. Review of Resident 4's plan of care initiated on 7/21/25, showed a care plan problem addressing Resident 4's sacral area pressure injury. The interventions included the IDT recommended treatment as per the physician's order, RD consult/ follow up, LAL mattress, and turning/repositioning the resident every two hours as or as needed, wound consult/follow up, and to inform the physician if the treatment was not effective. Review of Resident's 4 Nutritional assessment dated [DATE], showed the RD recommended adding Pro-Stat and Juven as supplements for wound healing as well as high potassium fruits three times a day. Review of Resident 4's Skin Check record dated 7/24/25 at 1401 hours, showed Resident 4 was evaluated by the wound care specialist and classified the new wound in the left sacrum as unstageable pressure injury. Resident 4 was educated on the importance of turning and repositioning every two hours and as needed, as well as avoiding pressure on any pressure points. Resident 4 verbalized understanding of the information provided. Further review of Resident 4's medical record failed to show documented evidence of continued monitoring/assessment by the licensed nurses for Resident 4's newly developed MASD in the sacral area, which was classified eight days later by the wound care specialist as unstageable pressure injury in the left sacrum. In addition, Resident 4's medical record failed there was a plan of care initiated to address the resident's noncompliance with repositioning. On 7/30/25 at 1013 hours, an observation and concurrent interview for Resident 4 was conducted with CNA 8. CNA 8 was observed inside Resident 4's room and informed the resident she needed to be turned. Resident 4 refused at this time but would do it later and informed CNA 8 she would want to be in the wheelchair in preparation for lunch and after she would join some activities. CNA 8 stated Resident 4 could turn by herself but needed the staff to clean her. CNA 8 stated he would always remind Resident 4 to turn every two hours, but the resident would refuse at times. CNA 8 further stated Resident 4 liked to go to activities in the dining area so the resident would be sitting in the wheelchair for a long time. CNA 8 stated they put a pillow underneath the sacrum. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/25 at 1319 hours, an interview and concurrent medical record review for Resident 4 was conducted with LVN 6. LVN 6 stated he was familiar with Resident 4 as he had been doing wound care for the resident during the past admission. LVN 6 stated Resident 4 was alert and oriented, and noncompliant with turning/repositioning. LVN 6 stated the staff would always remind Resident 4 to turn every two hours and more often, and the importance of turning and repositioning. LVN 6 stated Resident 4 at times wanted the LAL mattress to be set in static mode and they reminded the resident the alternating pressure setting was better especially the resident was a high risk of developing skin impairment. LVN 6 stated the wound rounds with the wound specialist happened either on Wednesday or Thursday weekly. LVN 6 stated the wound specialist just changed the sacral pressure injury's wound treatment. LVN 6 stated if a resident had a change of condition, the licensed nurses should monitor or assess, and document to address the specific change of condition every shift for 72 hours or might extend more as needed. LVN 6 stated the monitoring was important to evaluate if the change of condition was worsening or if the resident was responding well with the treatment. LVN 6 further stated it would assist the licensed nurses to report to the physician immediately if any worsening condition was identified immediately. LVN 6 verified Resident 4 was not continuously monitored or assessed when the resident had a change of condition specific to the development of MASD in the sacral area on 7/16, 7/17, 7/18, and 7/19/25, and unstageable pressure injury in left sacrum on 7/21 and 7/22/25. LVN 6 further stated for any issues encountered concerning the resident's care should have a plan of care. LVN 6 verified they should have initiated a plan of care for Resident 4's noncompliance with the repositioning every two hours or more often but it was discussed during IDT meeting. On 8/4/25 at 1300 hours, an interview was conducted with the DON. The DON stated she was aware of Resident 4's development of unstageable pressure injury in the sacrum. The DON stated Resident 4's wound was improving. The DON stated they had conducted an IDT meeting to address the pressure injury problem and noncompliance of the resident with the treatment/intervention, and they would continue to do so. The DON stated the RD continued to follow up with Resident 4 and recommended supplements to help with the wound healing which the resident was already taking. The DON stated Resident 4 was continuously being followed up by the wound specialist and the treatment/wound nurses continued to assess the effectiveness of the treatment being provided. The DON stated the staff continuously reminding Resident 4 of the importance of repositioning every two hours or as often as possible and the use of LAL mattress. The DON stated for any change of condition identified in the resident, the licensed nurses had to monitor the change of condition every shift for 72 hours and reevaluate if there was a need to be monitored more. The DON stated it was important to do this to evaluate if all the interventions were helping to resolve the issue or if the facility was meeting the goal for the resident. The DON further stated if worsening conditions were assessed immediately, then the physician would be notified and new orders or interventions would have been provided, and they would be able to update the plan of care of the resident. The DON verified Resident 4 was not consistently monitored every shift for 72, when the resident was identified with a change of condition related to MASD in the sacrum; and verified there was no care plan initiated to address the resident's noncompliance with the interventions and the risks for delayed wound healing. The DON acknowledged the above findings. 2. Review of the manufacturer's User Manual for Satin-Air MER-SAPM2 (Meridian – SatinAir Alternating Pressure Mattress) showed the following: - The MER-SAPM2 is a high quality and affordable air support surface system suitable for pressure ulcer prevention and treatment. It has been specially designed for the prevention of bedsores and offers an affordable 24-hour pressure care area (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Under Installation Section, in static mode, the mattress provides a firm surface that makes it easier for the patient to transfer or reposition. The static mode prevents the patient from bottoming out when in a sitting position. On 7/29/25 at 1012 hours, 7/30/25 at 1131 hours, 7/31/25 at 0805 hours, and 8/1/25 at 0920 hours, Resident 7 was observed asleep in bed with an alternating pressure mattress. The machine connected to the mattress showed it was in static mode. Medical record review for Resident 7 was initiated on 7/29/25. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's Order Summary Report showed a physician's orders dated on: - 5/2/25, to cleanse the coccyx area with normal saline, pat dry and apply zinc oxide. Leave open to air every shift for skin maintenance; and - 6/23/26, to provide LAL mattress every shift for wound management. On 8/1/25 at 0925 hours, an observation for Resident 7 and concurrent interviews were conducted with LVNs 5 and 6. LVNs 5 and 6 verified Resident 7 was asleep in bed with an alternating pressure mattress. The machine connected to the mattress showed it was in static mode. LVN 6 stated the mattress should be in an alternating pressure mode, and not in static mode. LVN 6 further stated the static mode was used when transferring or repositioning a resident, or also used per the resident's comfort level, when the resident complained about the pressure of the mattress.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the appropriate care and services for the use of the GT for two of three final sampled residents (Residents 1 and 8) reviewed for the GT feeding. * The facility failed to ensure the HOB was elevated at a minimum 30-degree angle when the enteral feeding was infusing via GT, to reduce the risk of aspiration (entry of food, liquid or foreign material into the airway) for Residents 1 and 8. This failure posed the risk for complications related to use of GT for Residents 1 and 8. Findings: Review of the facility's P&P titled Care and Treatment of Feeding Tubes revised 12/19/22, showed it was the policy of the facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complication to the extent possible. Further review of the P&P showed the resident's plan of care would direct staff regarding proper positioning of the resident consistent with the resident's individual needs. Medical record review for Resident 1 was initiated on 7/29/25. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's Order Summary Report showed a physician's order dated 7/27/25, for continuous enteral feeding with Novasource Renal (type of enteral feeding) at the rate of 50 ml per hour for 20 hours and total volume of 1000 ml, providing 2000 kcal, 183 gm of carbohydrate, 91 gm of protein, 100 gm of fat, and 717 ml of free water. Start at 2000 hours until the total volume completed. Review of Resident 1's plan of care showed a care plan dated 7/2/25, addressing the resident's enteral feeding. The interventions showed the resident needed the HOB elevated at least 30-45 degrees during and thirty minutes after the tube feedings. On 7/30/25 at 1452 hours, an observation was conducted with Resident 1. Resident 1 was observed lying in bed and receiving the enteral feeding Novasource Renal at the rate of 50 ml per hour via the GT. Resident 1's HOB was observed at less than 30-degree angle and measured to be at a 20-degree angle. On 7/30/25 at 1555 hours, an observation and concurrent interview was conducted with LVN 8. LVN 8 verified the observation of Resident 1's HOB elevated at 20-degree angle, while Resident 1 was receiving the enteral feeding via the GT. LVN 8 stated since Resident 1 was receiving the enteral feeding, the HOB for the resident should have been elevated at a 30–45-degree angle. On 8/1/25 at 1243 hours, an interview with the DON was conducted. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 8 was initiated on 7/30/25. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's MDS assessment dated [DATE], under Section I, showed Resident 8 had a medical history of dysphagia (difficulty swallowing). (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 8's plan of care showed a care plan dated 5/9/24, addressing Resident 8's dysphagia diagnosis. The interventions included to elevate the HOB at least 30 to 45 degrees during and thirty minutes after tube feedings. Review of Resident 8's Order Summary Report dated 6/24/25, showed to administer DiabetiSource AC 1.2 (type of enteral feeding) at 75 cc per hour for 20 hours, to provide 1500 ml, 1800 kcals. To start administration at 1300 hours and to continue until the total volume was completed. Review of Resident 8's H&P examination dated 7/25/25, showed Resident 8 had a GT. On 8/1/25 at 0614 hours, Resident 8 was observed lying in bed and was receiving the enteral feeding with the HOB elevated less than 30 degrees. On 8/1/25 at 0625 hours, an observation and concurrent interview was conducted with LVN 3. Resident 8's HOB elevation was measured with an measurement tool application. LVN 3 verified the measurement tool application showed Resident 8's HOB was elevated to 24 degrees while the resident was receiving the enteral feeding. LVN 3 stated Resident 8's HOB should be elevated at least 30 to 45 degrees while receiving the enteral feeding to prevent aspiration. LVN 3 stated the licensed nursing staff determined the HOB elevation by doing a visual check. LVN 3 was observed increasing the elevation of Resident 8's HOB. However, LVN 3 asked for further verification of the accuracy of the Surveyor's measurement tool used to assess the resident's HOB angle. On 8/1/25 at 0703 hours, an interview was conducted with the Maintenance Director. The Maintenance Director stated the facility did not have a device to check the angle of the resident's HOB. However, he would consult the rehabilitation department for a tool to measure the angle of the residents' HOB. On 8/1/25 at 0715 hours, an interview and concurrent observation was conducted with the Maintenance Director and Director of Rehabilitation in Resident 8's room. The Director of Rehabilitation used a goniometer (instrument used to measure angle motion at a joint) to measure the angle of Resident 8's HOB. Resident 8's HOB was angled at 35 degrees. The Director of Rehabilitation stated the goniometer was used to measure the angle of joints. The Maintenance Director stated the resident beds technically have a mechanical joint. The Director of Rehabilitation and Maintenance Director compared and verified the result of the measurement tool application on the Surveyor's cellular phone showed Resident 8's HOB was elevated at 34 degrees. The Director of Rehabilitation stated he would rather use the phone leveler (measurement tool application) to check the resident's bed angle because it was easier to use, and the results were still accurate. On 8/4/25 at 1345 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, medical record reviews, and facility P&P review, the facility failed to provide the necessary care and services to maintain the IV access for four final sampled residents (Residents 4, 7, 68, and 102) reviewed for the IV care. * The facility failed to ensure Resident 2's peripheral IV was inserted with an ultrasound by an outside vascular access provider as per the physician's order. * For Resident 4, the facility failed to ensure the midline catheter dressing change, external catheter and arm circumference measurement, the injection cap of the midline lumen and securement device were change upon admission and as per the physician's order. * The facility failed to monitor Resident 68's Port-A-Cath site for the signs and symptoms of infection and bleeding every shift as per the physician's order. * The facility failed to ensure Resident 102's PIV was correctly labeled. These failures had the potential to delay the identification of catheter-related complications for these residents.Findings: 1. Review of the facility's P&P titled PICC/Midline/CVAD Dressing Change revised 12/19/22, showed it is the policy of the facility to change the peripherally inserted central catheter (PICC), midline or central venous access device (CVAD) dressing, weekly or if soiled, in a manner to decrease potential for infection and/or cross-contamination. The Policy Explanation and Compliance Guidelines section showed the nurses to: - Inspect the catheter-skin junction and surrounding area, palpating through the intact dressing for redness, tenderness, swelling and drainage. Be attentive to any reports of pain, paresthesia, numbness, or tingling; - Inspect the catheter and hub for any defects such as cracks or splits; and - Use sterile measuring tape to measure external length of the catheter from hub to skin entry to ensure that it has not migrated. On 7/29/25 at 0901 hours, during the initial tour of the facility, Resident 4 was observed awake and lying in bed. Resident 4 was observed with a midline catheter in the left upper arm. Resident 4's midline catheter dressing was observed dated 7/19/25 at 1210 hours, without a staff's initials. Resident 4 stated the midline catheter was inserted in the acute care hospital and she was getting the intravenous antibiotics. Resident 4 stated the nurses had not changed the midline catheter dressing and she had been telling them the dressing was due for a change. Resident 4 further stated the nurses should change the dressing every week. Medical record review for Resident 4 was initiated on 7/29/25. Resident 4 was readmitted to the facility on [DATE]. Review of Resident 4's H&P examination dated 7/11/25, showed Resident 4 was able to make decisions. Review of the Order Summary Report showed the following physician's orders dated 7/9/25: - for the PICC/midline transparent dressing change per sterile technique upon admission and on the day shift every Sunday for site maintenance; (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- to measure the external catheter length of the PICC/midline and measure arm circumference upon admission and on the day shift every Sunday for site maintenance and as needed; - to change the injection cap to each lumen upon admission and as needed for after blood draws; - to change the securement device upon admission and as needed for site maintenance. Review of Resident 4's IV Administration Report for July 2025 showed Resident 4's midline dressing was changed on 7/13, 7/20, and 7/27/25. The IV Administration Report on 7/13/25, showed NA documentation for the measurement of the midline's external catheter and arm circumference. Furthermore, the report showed the injection cap to each lumen and securement device were changed on 7/13, 7/20, and 7/27/25. Further review of Resident 4's medical record failed to show documented evidence if Resident 4's midline external catheter and arm circumference were measured, the injection cap of each lumen and securement device were changed, and if the midline dressing was changed upon admission. On 7/29/25 at 1504 hours, an interview and concurrent medical record review for Resident 4 was conducted with LVN 1. LVN 1 stated the IV dressing change was being done every seven days or as needed. LVN 1 stated the RN was responsible for the management of all the IV access. LVN 1 verified Resident 4's midline catheter dressing was dated 7/19/25 at 1210 hours, and had no staff's initials who did the dressing change. On 7/29/25 at 1516 hours, an interview and concurrent medical record review for Resident 4 was conducted with RN 2. RN 2 stated the RNs were primarily responsible for the management or care of the resident's IV access like the dressing changes, measuring the external catheter and arm circumference, and changing the lumen and securement device weekly. RN 2 verified there was no documentation if the midline catheter care, including the measurement of the external catheter and arm circumference were provided to Resident 4 upon admission as per the physician's order dated 7/9/25. RN 2 also verified the NA entered on 7/13/25, for the measurement of the external catheter and arm circumference possibly meant not applicable. RN 2 stated the nurse should have measured and recorded the midline catheter length and arm circumference measurement to help identify any changes in the catheter length or arm circumference. RN2 acknowledged the catheter dressing changes were necessary, if not done regularly posed a risk of infection and delay in the identification and treatment of any external catheter complications. On 8/4/25 at 1300 hours, an interview was conducted with the DON. The DON was informed of and acknowledged the above findings. 2. Review of the facility's P&P titled Peripheral Catheter Dressing Change dated 6/2018 showed apply transparent dressing so that the insertion site is in the center of dressing. Label the dressing with date, time, and nurse's initials. Medical record review for Resident 102 was initiated on 7/29/25. Resident 102 was admitted to the facility on [DATE]. Review of Resident 102's H&P examination dated 7/27/25, showed Resident 102 had the capacity to make decisions. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 102's Order Summary Report dated 7/30/25, showed a physician's order dated 7/28/25, to administer vancomycin 750 mg (antibiotic) intravenously every 12 hours for bacteremia (presence of bacteria on the bloodstream) for five days. On 7/29/25 at 0906 hours, during the initial tour of the facility, an observation for Resident 102 was conducted. Resident 102 was observed lying in bed with PIV line to the left wrist. The PIV site was not observed labeled. On 7/29/25 at 0941 hours, a concurrent observation and interview was conducted with the MDS Coordinator. The MDS Coordinator verified the above findings. The MDS Coordinator stated the IV site should have been labeled with the date when it was inserted and initials of the nurse. On 8/4/25 at 0822 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated the PIV site should be labeled with the date of the insertion and initials of the staff that started the IV line. 3. Medical record review for Resident 68 was initiated on 7/29/25. Resident 68 was readmitted to the facility on [DATE]. Review of Resident 68's IV Administration Report for June 2025 showed a physician's order dated 6/10/25, to monitor the Port-a-Cath site for infection and bleeding every shift and administer TPN at 65 ml/hr, to start from 0800 to 2300 hours. Further review of Resident 68's IV Administration Report for June, July, and August 2025 showed Resident 68 was administered the TPN from 6/10 to 8/4/25 via the Port-a-Cath. However, review of the reports showed Resident 68's Port-a-Cath site was not monitored for the signs and symptoms of infection and bleeding on 6/13, 6/20, and 6/27/25; and 7/4, 7/8, 7/11, 7/12, 7/13, 7/18, 7/19, 7/25, 7/26, and 7/29/25 at the night shift as per the physician's order. Further review of Resident 68's medical records failed to show documented evidence Resident 68's Port-a-Cath site was monitored for the signs and symptoms of infection and bleeding every shift as per the physician's order on the above dates and shift. On 8/4/25 at 0851 hours, an interview and concurrent medical record for Resident 68 was conducted with the MDS Coordinator. The MDS Coordinator verified the above findings. The MDS Coordinator verified Resident 68's IV Administration Reports failed to show if Resident 68's Port-a-Cath site was monitored for the signs and symptoms of infection and bleeding every shift. The MDS Coordinator stated the RNs should have monitored and documented the monitoring. 4. On 7/29/25 at 0857 hours, during the initial tour of the facility, Resident 2 was observed awake in bed. Resident 2 stated the nurses in the facility had a difficult time inserting his peripheral IV, and the physician had ordered an ultrasound to insert his peripheral IV. Medical record review for Resident 2 was initiated on 7/29/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 6/9/25, showed Resident 2 had the capacity to understand and make decisions. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's Order Summary Report showed a physician's order dated 7/3/25, for an ultrasound guided IV through an outside vascular access provider. Review of Resident 2's Skilled Nursing Visit Documentation Form from the outside vascular access provider dated 7/3/25, showed the procedure was for PIV. The Note/Assessment portion of the form showed stuck the resident one time with a 22 gauge and the skin was tough and it bent the catheter. The note further showed the resident refused any further sticks, and he wants an ultrasound only, said the doctor ordered ultrasound. Discussed with RN Supervisor and still insists on ultrasound only. On 8/4/25 at 0823 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. The MDS Coordinator stated the licensed nurses had attempted several times to insert a peripheral IV to Resident 2, and the physician had ordered Resident 2 to have an ultrasound guided peripheral IV. The MDS Coordinator reviewed the Skilled Nursing Visit Documentation Form dated 7/3/25, and verified the documentation did not show an ultrasound was used when the RN attempted to insert a peripheral IV to Resident 2 on 7/3/25. On 8/4/25 at 1003 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified there was a physician's order for an ultrasound guided peripheral IV for Resident 2. The DON stated she was not informed of the incident when the RN from the IV company inserted the peripheral IV to Resident 2 without an ultrasound. The DON acknowledge the physician's order for Resident 2's peripheral IV insertion was not followed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services for suctioning for two of two final sampled residents (Residents 1 and 7) reviewed for respiratory care. * The facility failed to ensure the Yankauer suction tip was stored in a bag when not in use, and the suction canister and tubing were dated and changed weekly for Resident 1, per the facility's P&P. * The facility failed to ensure a physician's order was obtained prior to suctioning Resident 7. In addition, the facility failed to ensure the Yankauer suction tip was stored in a bag when not in use, and the suction canister and tubing were dated and changed weekly for Resident 7, per the facility's P&P. These failures posed the risk for complications related to suctioning and affect the residents' wellbeing.Findings: Review of the facility's P&P titled Changing Suction Canisters revised 7/8/24, showed the following: - To minimize the risk of infection to the resident, the resident's suction canister and tubing shall be changed once a week and PRN; - To gather needed items, and label with the date; and - To dispose of items contaminated with secretions according to facility infection control policies. 1. On 7/29/25 at 1012 and 1230 hours, Resident 7 was observed asleep in bed. An undated and unlabeled Yankauer suction tip and a suction canister was observed on top of the nightstand. In addition, the Yankauer suction tip was not observed inside a set-up bag while not in use. Medical record review for Resident 7 was initiated on 7/29/25. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's Order Summary Report failed to show a physician's order to suction Resident 7. On 7/29/25 at 1237 hours, an observation for Resident 7, interview and concurrent medical record review was conducted with LVN 9. When asked about suctioning Resident 7, LVN 9 stated she suctioned Resident 7 before, and LVN 9 further stated Resident 7 had a physician's order to suction as needed. LVN 9 verified there was no physician's order to suction Resident 7 in the PCC. LVN 9 verified the suction canister and Yankauer suction tip were not labeled and dated. LVN 9 verified the suction canister had a whitish fluid, and the Yankauer suction was not in a set-up bag when not in use. When asked who was supposed to discard the used suction canister, and how often should the suction canister and Yankauer suction tip be changed, LVN 9 stated any of the nurses could replace or change the canister and Yankauer suction tip as needed. LVN 9 could not answer how often the canister and Yankauer suction tip would replaced but she stated, we changed frequently. On 8/4/25 at 0817 hours, an interview was conducted with LVN 10. When asked who was supposed to discard the used suction canister, and how often the suction canister and Yankauer suction tip be changed, LVN 10 stated the charge nurses were responsible for changing the Yankauer suction tip and suction canister, every Tuesday and as needed. LVN 10 stated the Yankauer suction tip should be unopened from the packaging, and inside a labeled bag with the name and date. LVN 10 further stated when the Yankauer suction tip was opened, the packaging should be dated when it was opened. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/4/25 at 0946 hours, an interview and concurrent medical record review for Resident 7 was conducted with the DON. The DON stated there should be a physician's order before suctioning the resident. The DON further stated the Yankauer suction tip should be inside a bag when not in use, and the suction canister should be changed after use, and about 1/3 full. 2. Medical record review for Resident 1 was initiated on 7/29/25. Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 1's Order Summary Report showed the following orders: - dated 7/29/25, for suctioning as needed for increased secretions. - dated 7/22/25, for suctioning every four hours four times a day for increased secretions. On 7/29/25 at 1120 hours, Resident 1 was observed lying in bed. There was an open Yankauer connected to the suction canister with the tubing stored on the night stand and not in a set up bag. The suction canister was observed with whitish liquid. The Yankauer, suction tubing, and suction canister were not labeled with the date indicating when it was last changed. On 7/29/25 at 1249 hours, an observation and concurrent interview was conducted with LVN 4. LVN 4 verified the Yankauer, suction tubing, and suction canister were not labeled with the date. LVN 4 also verified Yankauer and suction tubing was stored on the night stand and not in a set up bag. LVN 4 was not able to verify when the Yankauer, suction tubing, and the suction canister was last changed. LVN 4 stated Yankauer and suction tubing should have been stored in a set up bag and labeled. On 8/4/25 at 1253 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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Gordon Lane Care Center	1821 E Chapman Ave Fullerton, CA 92831

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the appropriate pain management was provided to four of four final sampled residents (Residents 2, 11, 40, and 96) reviewed for pain management. * The facility failed to ensure Resident 2 was administered the oxycodone (controlled pain medication) medication according to the physician's orders. * The facility failed to ensure Resident 11 was administered with the hydrocodone-acetaminophen (a controlled pain medication) medication according to the physician's order . * The facility failed to ensure Resident 40 was administered with the tramadol (a controlled pain medication) and acetaminophen (a pain medication) medication according to the physician's order. * The facility failed to ensure the non-pharmacological intervention was provided to Resident 96 before the administration of the oxycodone pain medication. These failures had the potential to put the residents at risk for ineffective pain management and receive the unnecessary pain medication.Findings: Review of the facility's P&P titled Pain Management revised 3/2025 showed the pain management included appropriate assessment and treatment of pain based on the professional standards of practice and utilized the appropriate pain assessment tool based on the resident's cognitive status. Review of the facility's P&P titled Medication Administration dated 12/2022 showed the medications should be administered by the licensed staff as ordered by the physician. 1. Medical record review for Resident 11 was initiated on 7/30/25. Resident 11 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 11's MDS assessment dated [DATE], showed Resident 11 had a BIMS Summary Score of 14 (cognitively intact). Review of Resident 11's H&P examination dated 5/30/25, showed Resident 11 had the capacity to understand and make decisions. Review of Resident 11's Order Summary Report for July 2025 showed the following physician's orders dated 5/25/25: - to monitor the pain level on a scale of 0 to 10 (0 = no pain, 1-4 = mild pain, 5-7 = moderate pain, 8-9= severe pain, and 10 = very severe pain) every shift prior to treatment, and - to administer one hydrocodone-acetaminophen 10-325mg tablet by mouth every four hours as needed for moderate pain (4-6, on the pain scale of 0 to 10 with 0 = no pain and 10 = worst pain). Review of Resident 11's MAR for 7/2025 showed Resident 11 was administered with one hydrocodone-acetaminophen 10-325 mg tablet by mouth on the following dates, times, and pain levels: - dated 7/4 and 7/12/25 at 1600 and 2000 hours, for a pain level of 0; - dated 7/5, 7/10, and 7/22/25 at 0000, 1600, and 2000 hours, for a pain level of 0; - dated 7/13 and 7/29/25 at 0000 hours, for a pain level of 0; (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 7/14 and 7/15/25 at 0000 hours, for a pain level of 3; and 0400 hours, for a pain level of 0; - dated 7/16, 7/20, 7/23, and 7/28/25 at 0000 and 0400 hours, for a pain level of 0; - dated 7/19 and 7/26/25 at 0800 and 1200 hours, for a pain level of 0; - dated 7/21/25 at 0400, 1600, and 2000 hours, for a pain level of 0; and - dated 7/27/25 at 0630 hours, for a pain level of 0. On 7/31/25 at 1110 hours, an interview and concurrent medical record review for Resident 11 was conducted with LVN 7. LVN 7 reviewed Resident 11's MAR for July 2025 and verified the above findings. LVN 7 stated the numerical pain level scale were 1 to 4 for mild pain, 5 to 7 for moderate pain, 8 to 9 for severe pain, and 10 for very severe pain. LVN 7 stated prior to pain medication administration, the licensed staff should assess the resident's location and severity of pain, implement non-pharmacological interventions and administer the pain medications according to the severity of resident's pain. LVN 7 stated the PRN hydrocodone-acetaminophen medication should not have been administered when Resident 11 had no pain. On 7/31/25 at 1300 hours, an interview and concurrent medical record review for Resident 11 was conducted with the DON. The DON reviewed Resident 11's MAR for 7/2025 and verified the hydrocodone-acetaminophen medication was not administered according to the physician's prescribed parameters. The DON stated her licensed staff did not document Resident 11's pain level correctly and should have followed the prescribed parameters before the pain medication administration. On 8/4/25 at 1345 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings. 2. Medical record review for Resident 40 was initiated on 7/31/25. Resident 40 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 40's MDS assessment dated [DATE], showed a BIMS Summary Score of 12 (moderate cognitive impairment) Review of Resident 40's H&P examination dated 7/28/25, showed Resident 40 had the capacity to understand and make decisions. Review of Resident 40's Order Summary Report dated 7/31/25, showed the following physician orders: - dated 7/11/25, to monitor for the pain level on a scale of 0 to 10 (0 = no pain, 1-4 = mild pain, 5-7 = moderate pain, 8-9= severe pain, and 10 = very severe pain) every shift, and administer two acetaminophen 325mg tablets by mouth every four hours as needed for mild pain (1-4); and - dated 7/12/25, to administer one tramadol 50mg tablet by mouth every twelve hours as needed for moderate to severe pain (5-10). Review of Resident 40's MAR for July 2025 showed Resident 40 was administered with the pain medication administration for the following date, times and pain levels: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 7/14/25 at 0741 hours, the acetaminophen medication was administered for a pain level of 5; - dated 7/20/25 at 0700 hours, the tramadol medication was administered for a pain level of 3; - dated 7/22/25 at 2041 hours, the tramadol medication was administered for a pain level of 0; and - dated 7/28/25 at 0222 hours, the tramadol medication was administered for a pain level of 0. On 8/1/25 at 1320 hours, an interview and concurrent medical record review for Resident 40 was conducted with LVN 2. LVN 2 reviewed Resident 40's MAR for July 2025 and verified the above findings. LVN 2 stated the PRN pain medications should not have been administered because the resident's pain level was not within the parameters the medication was prescribed for. On 8/4/25 at 1345 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings. 3. On 7/29/25 at 0857 hours, during the initial tour of the facility, Resident 2 was observed lying in bed with a bandage on his left foot. Resident 2 showed a photo of his left wound with staples, following a left metatarsal amputation. Medical record review for Resident 2 was initiated on 7/29/25. Resident 2 was admitted to the facility on [DATE], with a diagnosis of acute osteomyelitis (bone infection). Review of Resident 2's H&P examination dated 6/9/25, showed Resident 2 had the capacity to understand and make decisions. Review of Resident 2's Order Summary Report showed the following physician's order: - dated 6/7/25, to administer acetaminophen 325 mg two tablets by mouth every four hours as needed for mild pain (pain level of 1-4 pain rating scale), administer ibuprofen (NSAID, nonsteroidal anti-inflammatory drug) 400 mg one tablet by mouth every six hours as needed for moderate pain (pain level of 5-7 pain rating scale), and administer oxycodone 5 mg one tablet by mouth every four hours as needed for severe pain (pain level of 7-10 pain rating scale); and - dated 7/22/25, to monitor for pain every shift with the following pain rating on a pain scale 0 to10: zero for no pain; 1-4 for mild pain; 5-7 for moderate pain; 8 -9 for severe pain; and 10 for very severe pain. Review of Resident 2's MAR for June and July 2025 showed the oxycodone pain medication was administered when Resident 2 had a documented pain level of zero (no pain) on the following dates and times: - dated 6/8/25 at 2130 hours, - dated 6/11/25 at 1800 hours, - dated 6/13/25 at 2050 hours, - dated 6/14/25 at 2029 hours, (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 6/18/25 at 0555 and 1944 hours, - dated 6/19/25 at 0000 and 1710 hours, - dated 6/20, 6/23, and 6/28/25 at 1600 and 2000 hours, - dated 6/22/25 at 2000 hours, - dated 6/24/25 at 0150 hours, - dated 6/27/25 at 1800 and 2200 hours, - dated 6/29/25 at 0800 hours, - dated 7/1/25 at 0620 hours, - dated 7/10/25 at 1549 hours, - dated 7/10/25 at 2000 hours, - dated 7/10/25 at 0000 hours, and - dated 7/20/25 at 0845. On 7/31/25 at 1450 hours, an interview was conducted with CNA 6. CNA 6 stated Resident 2 complained of pain on his left foot, and the resident had pain all the time. On 8/4/25 at 1003 hours, an interview and concurrent medical record review was conducted with the DON. The DON was informed Resident 2 was provided with the oxycodone pain medication when the resident's pain level was zero. The DON verified and acknowledged the above findings. 4. Review of the facility's P&P titled Pain Management revised 3/17/25, showed the facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goal and preferences. Under the section for pain management and treatment showed the non-pharmacological intervention will include but are not limited to: - Environmental comfort measures (e.g., adjusting room temperature, smoothing linens, comfortable seating, assistive devices or pressure redistributing mattress and positioning). - Loosening any constrictive bandage, clothing or device. - Applying splinting (e.g., pillow or folded blanket.) - Physical modalities (e.g., cold compress, warm sour bath, massage, turning and repositioning). - Exercises to address stiffness and prevent contracture as well as restorative nursing programs to maintain joint mobility. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Cognitive behavioral interventions (e.g., music, relaxation techniques, activities, diversion, spiritual and comfort support, teaching the resident coping techniques and education about pain) Medical record review for Resident 96 was initiated on 7/29/25. Resident 96 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 96's H&P examination dated 5/31/25, showed Resident 96 had the capacity to understand and make decisions. Review of Resident 96's MDS assessment dated [DATE], showed Resident 96 was cognitively intact. Review of Resident 96's Care Plan dated 6/5/25, showed a care plan problem addressing Resident 96's pain. The intervention included to provide non-pharmacological intervention to alleviate pain. Further review of the care plan showed to provide warm blanket when cold, to provide cool drinks when hot, to provide extra snack when hungry, to provide a quiet environment to sleep when tired, to provide different pain-relieving methods (i.e. positioning, relaxation therapy, progressive relaxation, bathing, heat and cold application, muscle stimulation, and ultra-sound). Review of Resident 96's Order Summary Report showed a physician's order dated 7/30/25, for oxycodone HCL to give one tablet by mouth every six hours as needed for severe pain (7-10, on a pain scale of 0 to 10, with 0 = no pain and 10 = severe pain) for 60 days. Review of Resident 96's MAR for July 2025 showed Resident 96 was administered with the oxycodone HCL pain medication on the following dates, times and pain levels: - dated 7/15/25 at 2025 hours, for a pain level of 8; - dated 7/17/25 at 2107 hours, for a pain level of 8; - dated 7/19/25 at 2020 hours, for a pain level of 9; - dated 7/20/25 at 2030 hours, for a pain level of 7; - dated 7/21/25 at 2018 hours, for a pain level of 8; - dated 7/22/25 at 2000 hours, for a pain level of 8; - dated 7/23/25 at 2018 hours, for a pain level of 8; - dated 7/24/25 at 2038 hours, for a pain level of 8; - dated 7/25/25 at 2013 hours, for a pain level of 8; - dated 7/26/25 at 2023 hours, for a pain level of 8; - dated 7/27/25 at 2010 hours, for a pain level of 8; - dated 7/28/25 at 2008 hours, for a pain level on 7; and, (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 7/29/25 at 2014 hours, for a pain level of 8; Review of Resident 96's MAR for August 2025 showed Resident 96 was administered with the oxycodone HCL pain medication on the following dates, times and pain levels: - dated 8/1/25 at 2053 hours, for a pain level of 8; and - dated 8/3/25 at 2005 hours, for a pain level of 7. Further review of Resident 96's medical records failed to show if a non-pharmacological intervention was provided before the administration of the PRN oxycodone pain medication for severe pain on the above dates and times. On 8/4/25 at 0918 hours, an interview and concurrent medical record review for Resident 96 was conducted with LVN 2. LVN 2 stated the non-pharmacological interventions should be provided before administration of the pain medication. LVN 2 verified Resident 96 received the oxycodone pain medication oxycodone on the above dates and times for severe pain (7-10). When asked if the non-pharmacological intervention was provided, LVN 2 verified there was no documented evidence the non-pharmacological intervention was provided before administering Resident 96's oxycodone pain medication. On 8/4/25 at 1252 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the dialysis communication forms were completed for one of two sampled residents (Resident 5) reviewed for hemodialysis. * The facility failed to ensure the necessary information in Resident 5's dialysis communication forms between the facility and dialysis center were completed. This failure had the potential for not identifying the changes in resident condition and/or complications prior to, during, and after the hemodialysis.Findings: Review of the facility's P&P titled Hemodialysis revised 6/2023 showed the facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis. The P&P further showed the facility will assure that each resident receives care and services for the provision of hemodialysis and/or peritoneal dialysis consistent with professional standards of practice. This will included:- The ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility.- Ongoing assessment and oversight of the resident before, during, and after dialysis treatments, including monitoring of the resident's condition during treatments, monitoring for complications, implementation of appropriate interventions, and using appropriate infection control practices, and- Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. Medical record review for Resident 5 was initiated on 7/29/25. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 5's H&P examination dated 7/24/25, showed Resident 5 had no capacity to make medical decisions. Review of Resident 5's Order Summary Report for August 2025 showed the following physician's orders:- dated 1/19/25, for hemodialysis access site monitoring of the AVF LUA every shift, monitoring the access site for redness, swelling, bleeding, and pain.- dated 1/20/25, for hemodialysis days on Monday, Wednesday, and Friday. Review of Resident 5's Dialysis Communication Forms under the section for Pre-Dialysis Information showed the following: - no documentation of the medications administered prior to hemodialysis on 7/4, 7/18, and 7/21/25, and- no documentation of the medications administered prior to hemodialysis and shunt/catheter location/status on 7/7, 7/11, 7/14, 7/23, and 7/28/25. Review of Resident 5's Dialysis Communication Forms under the section for Dialysis Center Information showed the following:- no documentation of the vital signs, pre and post weight, shunt/catheter location/status, fluid removed, meal/snack intake, new physician orders or recommendations and nurse's signature on 7/18/25,- no documentation of the fluid removed, new physician orders or recommendations, and meal and snack intake on 7/21/25, and- no documentation of the shunt/catheter location/status on 7/23/25. Review of Resident 5's Dialysis Communication Form under the section for Post-Dialysis Information showed the following:- no documentation of the vital signs, shunt/catheter location/status, catheter dressing intact, presence of bruit, thrill or bleeding, general condition of the resident, and nurse's signature on 7/14/25, and- no documentation of the shunt/catheter location/status, catheter dressing intact, presence of bruit, thrill or bleeding, and general condition of the resident on 7/16/25. On 7/31/25 at 1436 hours, an interview and concurrent medical record review was conducted with LVN 5. LVN 5 verified Resident 5 receives hemodialysis on Mondays, Wednesdays, and Fridays. LVN 5 verified the above findings and stated the Dialysis Communication Forms were completed by the charge nurse assigned to the resident when the resident leaves for hemodialysis and upon return from the dialysis center. LVN 5 stated the residents on hemodialysis were monitored when they leave and return from the hemodialysis to assess for any changes in condition and obtain a baseline status for the resident. LVN 5 further stated the Dialysis Center Information section of the communication form should be completed by the hemodialysis nurses and if the resident returns with the information incomplete, the (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility staff were expected to call and have the dialysis center fax the updated information. On 8/1/25 at 1021 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the above findings for Resident 5. The DON stated she expected the charge nurses to complete the Dialysis Communication Form, check the resident's vital signs, and monitor the residents on hemodialysis. The DON stated the residents returning from hemodialysis needed their vital signs to be checked and be monitored to ensure the resident was stable upon return. On 8/4/25 at 1406 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the pharmaceutical services to ensure the accurate administration of the medications as evidenced by: * The facility failed to ensure Resident 102's vancomycin medication was administered timely. This failure had the potential to negatively impact the resident's health outcomes. * The facility failed to ensure the Controlled Substance Shift Count Log (a form where the nurses sign when the controlled medications were reconciled before and after each shift) for Medication Carts A and B were signed by the incoming and/or outgoing nurses. This failure posed the risk for loss or diversion of the controlled medication in the facility.Findings: 1. Review of the facility's P&P titled Medication Administration dated 12/19/22, showed administer the medications within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. Review of the facility's document titled Medication Administration Times (undated) showed the following medications frequencies and schedule of the times to be administered: - daily, administer at 0900 hours; - twice a day, administer at 0900 and 1700 hours; - three times a day, administer at 0900, 1300, and 1700 hours; - bedtime, administer at 2100 hours; - four times a day, administer at 0900, 1300, 1700, and 2100 hours; - every eight hours, administer at 0600, 1400 and 2200 hours; - every six hours, administer at 0600, 1200, 1800, and 0000 hours; - every twelve hours, administer at 0900 and 2100 hours; - three times a day with meals, administer at 0700, 1130, and 1630 hours; and - every four hours, administer at 0000, 0400, 0800, 1200, 1600, and 2000 hours; Medical record review for Resident 102 was initiated on 7/29/25. Resident 102 was admitted to the facility on [DATE]. Review of Resident 102's H&P examination dated 7/27/25, showed Resident 102 had the capacity to make decisions. Review of Resident 102's Order Summary Report dated 7/30/25, showed a physician's order dated 7/28/25, for vancomycin 750 mg (antibiotic) intravenously every 12 hours for bacteremia (presence of bacteria on the bloodstream) for 5 days. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/29/25 at 0906 hours, during the initial tour of the facility, an observation for Resident 102 was conducted. Resident 102 was observed lying in bed with PIV line to the left wrist and receiving a course of the IV antibiotic therapy via the PIV line. On 7/30/25 at 1021 hours, a concurrent interview and medical record review for Resident 102 was conducted with RN 1. RN 1 verified Resident 102 was on IV the antibiotic medication for bacteremia every 12 hours to be given at 0900 and 2100 hours. When asked if she had administered Resident 102's IV antibiotic, RN 1 stated she has not administered the IV antibiotic as scheduled for 0900 hours. On 8/4/25 at 0822 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated she expected the IV antibiotic should have been administered timely. 2. Review of the facility's P&P titled Controlled Substance Administration & Accountability revised on 6/5/23, by the Policy and Procedure Committee showed it is the policy of this facility to promote safe, high-quality care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure. Under Policy Explanation and Compliance Guidelines General Protocols showed all controlled substances are accounted for in one of the following ways, all controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage for, the written documentation must be clearly legible with all applicable information provided. For the Storage and Security, areas without automated dispensing systems utilize a substantially constructed storage unit with two locks and a paper system for 24-hour recording of the controlled substance use. For patient care areas which do not utilize automated dispensing systems, daily orders for stock narcotics are filled out by the charge nurse according to the following procedure: The amount on hand is checked against the amount used daily from the documentation records. Two licensed staff must witness any disposal or destruction of a controlled substance and document same on the Drug Disposition Record. Under Inventory and Verifications, for areas without automated dispensing system, two licensed nurses account for all controlled substances and access keys at the end of each shift. a. Review of Medication Cart A's Controlled Substance Shift Count Log for March 2025 showed the multiple missing signatures for the incoming and/or outgoing licensed nurses on the following shifts and dates: - morning shift on 3/23, 3/24, 3/26, 3/27, 3/30, and 3/31/25, and - afternoon shift on 3/26/25. On 7/30/25 at 1050 hours, an interview and concurrent facility document review was conducted with LVN 1. LVN 1 verified multiple licensed nurses' signatures were missing in the Controlled Substance Shift Count Log on different days and shifts. LVN 1 stated it should have been signed by the incoming and outgoing nurses to make sure the narcotics were accounted for when they come and leave from work and there was no missing medication. b. Review of Medication Cart B's Controlled Substance Shift Count Log for March 2025 showed the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	multiple missing incoming and/or outgoing licensed nurses' signatures on the following shifts and dates: - morning shift on 3/4 and 3/10/25, - afternoon shift on 3/4, 3/6, and 3/12/25, and - night shift on 3/14, 3/15, 3/26, and 3/29/25. On 7/30/25 at 1107 hours, an interview and concurrent facility document review was conducted with LVN 4. LVN 4 verified the findings and stated the Controlled Substance Shift Count Log should have been signed by the nurses who worked on those days and shifts to account for the narcotic medications. On 8/4/25 at 1410 hours, an interview and concurrent facility document review was conducted with the DON. The DON verified the findings and stated it should have been signed by the nurses. The DON further stated she did not know why the nurses missed to sign the Controlled Substance Shift Count Log for March 2025.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of 21 final sampled residents (Residents 4 and 40) was free from the unnecessary medications. * The facility failed to monitor Resident 4 for the signs and symptoms of bleeding related to the use of Eliquis medication (an anticoagulant used to prevent blood clots). * The facility failed to assess, monitor, and provide the insulin medication to Resident 40 as per the physician's order. These failures had the potential for the residents to receive unnecessary medications and develop significant adverse effects. Findings: 1. According to the FDA approved Highlights of Prescribing Information for Eliquis issued on 04/2025 showed the most common adverse reaction in adult patients are related to bleeding. Review of the facility's P&P titled High Risk Medications – Anticoagulants revised on 12/19/22, showed the facility recognizes that some medications, including anticoagulants, are associated with greater risks of adverse consequences than other medications. The policy addresses the facility's collaborative, systematic approach to managing anticoagulant therapy for efficacy and safety. The Policy Explanation and Compliance Guidelines section showed the resident's plan of care should alert staff to monitor for adverse consequences. Risks associated with anticoagulants include bleeding and hemorrhage (bleeding gums, nosebleed, unusual bruising, blood in urine or stool). Review of the facility's P&P titled Comprehensive Care Plans revised 12/19/22, showed qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. On 7/29/25 at 0901 hours, during the initial tour of the facility, Resident 4 was observed awake and lying in bed. Resident 4 stated she was taking a blood thinner medication twice a day. Resident 4 stated she had not had any episodes of bleeding while in the facility. Medical record review for Resident 4 was initiated on 7/29/25. Resident 4 was readmitted to the facility on [DATE]. Review of Resident 4's Order Summary Report showed a physician's order dated 7/9/25, to administer Eliquis oral tablet 2.5 mg one tablet by mouth two times a day for DVT prophylaxis. Review of Resident 4's H&P examination dated 7/11/25, showed Resident 4 was able to make decisions. Review of Resident 4's plan of care revised on 7/11/25, showed a care plan problem addressing Resident 4's use of the anticoagulant medication. The interventions included the monitoring, documenting and reporting as needed the adverse reactions of anticoagulant therapy such as blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools. Further review of Resident 4's medical record did not show documented evidence Resident 4 was observed or monitored for the signs and symptoms of bleeding. On 7/30/25 at 0825 hours, an interview and concurrent medical record review for Resident 4 was conducted with LVN 1. LVN 1 verified the above findings for Resident 4. LVN 1 stated the facility's (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	protocol when the resident was taking anticoagulant medication was to monitor the resident every shift for the signs and symptoms of bleeding and document the findings in the Monitor Record in the PCC. LVN 1 stated if the resident was not monitored for the signs and symptoms of bleeding, the resident could have critical consequences like internal (inside of the body) bleeding. LVN 1 further stated if the signs and symptoms of bleeding were observed, the nurses would be able to report the findings to the physician immediately and interventions could be implemented right away. On 8/4/25 at 1300 hours, an interview was conducted with the DON. The DON stated it was very important to assess and monitor the resident who was taking an anticoagulant medication for the signs and symptoms of bleeding to prevent any complications. The DON was informed of and acknowledged the above findings. 2. Review of the facility's P&P titled Blood Glucose Monitoring revised 1/2024 showed the facility would perform blood glucose monitoring as per the physician's orders. Review of the facility's P&P titled Medication Administration dated 12/2022 showed the medications should be administered by a licensed staff as ordered by the physician and in accordance with the professional standards of practice. Medical record review for Resident 40 was initiated on 7/31/25. Resident 40 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 40's H&P examination dated 7/28/25, showed Resident 40 had the capacity to understand and make decisions. Review of Resident 40's MDS assessment dated [DATE], showed Resident 40 had a medical diagnosis of diabetes. a. Review of Resident 40's Order Summary Report dated 7/13/25, showed to administer insulin lispro injection (medication to lower blood sugar) per sliding scale subcutaneously before meals for diabetes with the following medication parameters: - inject 0 units of insulin for the blood glucose level of 71 to 150 mg/dL, - inject 1 unit of insulin for the blood glucose level of 151 to 200 mg/dL, - inject 2 units of insulin for the blood glucose level of 201 to 250 mg/dL, - inject 3 units of insulin for the blood glucose level of 251 to 300 mg/dL, - inject 4 units of insulin for the blood glucose level of 301 to 350 mg/dL, - inject 5 units of insulin for the blood glucose level of 351 to 400 mg/dL, and - inject 6 units of insulin for the blood glucose level above 400 mg/dL, and to call the physician. Review of Resident 40's MAR for July 2025 showed the following: - dated 7/16/25 at 0630 hours, Resident 40 was not administered with the insulin lispro when (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 40's blood glucose level was 158 mg/dL. The code documented was 5 which indicated no insulin required. - dated 7/18/25 at 0630 hours, there was no documentation of blood glucose level and no insulin administration. On 8/4/25 at 1034 hours, an interview and concurrent medical record review for Resident 40 was conducted with LVN 4. LVN 4 reviewed Resident 40's MAR and verified the above findings. LVN 4 stated before the medication administration, the licensed staff should check the resident 's blood sugar level, then provide the resident with the insulin medication based on the sliding scale parameters as ordered by the physician. LVN 4 further stated if a resident's blood glucose level was not checked or the insulin medication was withheld when indicated, this could potentially lead to a hyperglycemic (too much sugar in the blood that can lead to serious complications) event. On 8/4/25 at 1341 hours, an interview and concurrent medical record review for Resident 40 was conducted with the DON. The DON reviewed Resident 40's MAR and verified the above findings. The DON stated the licensed staff were expected to check the resident's blood glucose level and administer the insulin medication according to the sliding scale as per the physician's order. b. Review of Resident 40's Order Summary Report showed a physician's order dated 7/12/25, to administer 15 units of insulin glargine (a medication used to lowed blood sugar) injection subcutaneously at bedtime for diabetes. Review of Resident 40's MAR for 7/27/25 at 2100 hours, showed 15 units of insulin glargine was administered to Resident 40. Review of Resident's Blood Sugar Summary for July 2025 showed the following: - dated 7/27/25 at 1624 hours, a blood sugar level of 94 mg/dL. - dated 7/28/25 at 0630 hours, a blood sugar level of 55 mg/dL. Review of Resident 40's progress notes did not show a documentation regarding insulin glargine administration or if Resident 40's blood sugar was re-check for the insulin administration on 7/27/25 at 2100. Review of Resident 40's Tasks, Section for Nutrition – Amount Eaten dated 7/27/25 at 1749 hours, showed Resident 40 had eaten 26-50% of his meal. The section for Nourishments and Snacks failed to show documentation if Resident 40 had consumed additional nourishment or snack after dinner. On 8/4/25 at 1116 hours, an interview and concurrent medical record review for Resident 40 was conducted with LVN 2. LVN 2 stated prior to the insulin glargine administration, the licensed staff should check the blood glucose level of the resident. LVN 2 further stated the resident would be at risk for a hypoglycemic (the blood sugar level falls below normal) event if the resident received the insulin medication without a blood glucose check. LVN 2 verified the above findings. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/4/25 at 1341 hours, an interview and concurrent medical record review for Resident 40 was conducted with the DON. The DON verified the above findings. The DON stated a blood glucose level check was not necessarily indicated prior to the administration of the insulin glargine medication, unless there was a physician's order. The DON further stated the best practice for the licensed staff was to verify whether the resident had eaten dinner and assessed the amount eaten. If the resident had not eaten or had eaten a small portion of their meal, the licensed staff were expected to check the resident's blood glucose level prior to insulin administration to prevent a hypoglycemic event.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility P&P review, facility failed to provide the necessary pharmacy services to ensure proper storage, labeling and disposal of the medications. * The facility failed to ensure the open vial of a PPD test (Purified Protein Derivative, test to diagnose tuberculosis infection) and Humulin N (insulin medication used to lower down blood sugar level) had a written date on when it was opened. This failure has the potential for the medication to lose its stability and effectiveness when the medication was administered beyond the required time. * The facility failed to ensure the expired medication was removed from the medication cart. This failure had the potential for the expired medication to be accidentally administered to the residents. Findings: Review of the facility's P&P titled Labeling of Medications and Biologicals revised on [DATE], showed that all the medications and biologicals used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of the medications. Biologicals are made from a variety of natural sources and are used to treat, prevent, and diagnose disease and medical conditions. They may include a wide range of products such as vaccines, blood and blood components, allergenics, somatic cell gene therapy, tissues and recombinant therapeutic proteins. Under the section for Policy Explanations and Compliance Guidelines showed all the medications and biologicals will be labeled in accordance with applicable federal and state requirements and current accepted pharmaceutical principles and practices. Medication labels must be legible at all times. Labels for the individual drug containers must include the expiration date when applicable. Label for the multi-use vials must include the date the vial was initially opened or accessed (needle -punctured). All the opened or accessed vials should be discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. 1. On [DATE] at 0820 hours, an observation of Medication Room A refrigerator and concurrent interview was conducted with LVN 3. One open PPD vial that was found inside Medication Room A refrigerator with no date label on when it was opened. LVN 3 verified the findings. On [DATE] at 0921 hours, an interview was conducted with DON. The DON was made aware and acknowledged the findings. 2. On [DATE] at 1058 hours, an interview and concurrent observation of Medication Cart B was conducted with LVN 4. The medication cart was observed with one used vial of Humulin N with no date label on when it was opened. LVN 4 verified the findings and stated it was important because the medication may lose effectiveness or potency when used beyond the required date. 3. On [DATE] at 1013 hours, an observation of Medication Cart A and concurrent interview was conducted with LVN 1. The medication cart was observed with one bottle of Arthritis Pain tablets (medication used to treat pain and joint inflammation) with the date open label of [DATE]. However, the bottle of the Arthritis Pain tablets had an expiration date of [DATE]. LVN 1 verified the findings and stated the medication should have been discarded and removed from the medication cart. On [DATE] at 1158 hours, an observation and concurrent interview was conducted with the DON. The DON verified the expired bottle of the Arthritis Pain medication. The DON stated it should have been removed from the medication cart.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility P&P review, the facility failed to ensure the food brought in from the outside was safely stored for one final sample resident (Resident 96). * The facility failed to safely store the food brought in from the outside for Resident 96. Additionally, the facility failed to ensure Resident 96 was educated on the safe food handling guidelines. These failures had the potential to expose the residents who received food brought in by the family/visitors to food borne illnesses.Findings: Review of the facility's P&P titled Outside Food Brought in by Family or Visitors dated 1/25/24, showed it was the right of the resident of the facility to have food brought in by family or other visitors, however, the food must be handled in a way to ensure the safety of the resident. Further review of the P&P showed all the food items that are already prepared by the family or visitor brought in must be approved per nursing to ensure it is accordance with the diet order and eaten within two hours of receiving and all remaining food must be discarded. All the food items brought in that are manufactured and do not require refrigeration may be kept in the resident room inside a sealed tight container that is provided by the resident and consumed prior to expiration date. Any expired food must be discarded. Medical record review for Resident 96 was initiated on 7/29/25. Resident 96 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 96's H&P examination dated 5/31/25, showed Resident 96 had the capacity to understand and make decisions. Review of Resident 96's MDS assessment dated [DATE], showed Resident 96 was cognitively intact. On 7/29/25 at 1019 hours, an observation and concurrent interview was conducted with Resident 96. Resident 96 was observed sitting on her bed. The following unlabeled/undated food items were observed on top of Resident 96's bedside table:- two containers of fried chicken,- one container of scalloped potatoes,- one container of cereal, and- one bag of Hawaiian rolls. Resident 96 stated the two containers of the fried chicken were ordered and delivered through a mobile application food delivery service the day before. Resident 96 further stated the facility had no refrigerator to store her food. On 7/30/25 at 1202 hours, a follow-up observation and concurrent interview was conducted with Resident 96 in her room. Resident 96 was observed sitting on her bed. Two undated plastic containers were observed on top of Resident 96's bedside table. One plastic container contained fried chicken and the other container contained chicken wings. Resident 96 stated the fried chicken and chicken wings were ordered and delivered through a mobile application food delivery service. Resident 96 further stated the facility did not store the food and had no refrigerator to store the food brought in by the family and visitors. Resident 96 further stated she stored the food brought in from the outside that required refrigeration at her bedside until it was spoiled. When asked if the facility provided her an education on safe food handling guidelines, Resident 96 stated the facility did not educate her on the safe food handling guidelines. Further review of the medical records for Resident 96 did not show if Resident 96 was provided with an education on safe food handling guidelines. On 7/30/25 at 1205 hours, an observation in Resident 96's room and concurrent interview was conducted with RN 1. RN 1 verified the two undated containers of the fried chicken and chicken wings on top of Resident 96's bedside table. RN 1 stated she did not know if the facility stored the food for the residents in the facility. On 7/30/25 at 1220 hours, an interview was conducted with CNA 10. CNA 10 stated the facility stored the food for the residents in the refrigerator located in Medication Room A. On 7/30/25 at 1227 hours, an interview was conducted with LVN 1. LVN 1 stated the facility stopped storing the food for the residents in the refrigerator located in Medication Room A. LVN 1 further stated the residents were allowed to bring food from outside; however, it has to be consumed immediately or discarded if the food required refrigeration. On 7/30/25 at 1532 hours, a follow-up interview and medical record review for Resident 96 was conducted with RN 1. RN 1 verified there was no documented evidence if the facility provided education on safe food handling guidelines to Resident 96. On 8/1/25 at 1243 hours, an interview was conducted with the DON. The DON was informed and acknowledged above findings.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and facility document review, the facility failed to ensure the Facility Assessment addressed or included the following: 1. Active involvement of required individuals in developing the Facility Assessment; and2. A plan to maximize recruitment and retention of direct care staff. These failures had the potential to not meet the residents' care needs if the assessed population needs and resources were not comprehensively identified and addressed. Findings: According to the CMS QSO-24-13-NH dated 6/18/24, with an implementation date of 8/8/24, CMS had issued a revised guidance for long-term care facility assessment requirement. The Facility Assessment should address and included the active involvement of the direct care staff in developing the Facility Assessment. The guidance also included the staffing resources necessary to care for the residents, including the weekends; a plan to maximize recruitment and retention of direct care staff member, and a contingency plan for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to the availability of direct care nurse staffing or other resources needed for resident care. Review of the Facility's assessment dated [DATE], failed to show the direct care staff member, direct care representatives, residents, residents' representatives, and residents' family members were actively involved in developing the Facility Assessment and in planning to maximize recruitment and retention of the direct care staff. On 8/4/25 at 1445 hours, an interview and concurrent facility document review of the Facility Assessment was conducted with the Administrator. The Administrator reviewed the Facility assessment dated [DATE], and verified there were no direct care staff, direct care representatives, residents' representatives, and family members actively involved in developing the Facility Assessment. The Administrator further verified there was no documentation of a plan to maximize recruitment in the Facility Assessment. The Administrator stated she was not aware of the current guidance. The Administrator verified and acknowledged the Facility Assessment was not updated based on the latest guidance from the CMS.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medical record was complete and accurate for one final sampled resident (Resident 102), one nonsampled resident (Resident 18) and one closed record sampled resident (Resident 99) when: * The facility failed to ensure Resident 18's blood pressure measurement site was accurately documented in the resident's medical record. * The facility failed to ensure Resident 102's H&P was accurately documented. * The facility failed to ensure the facility staff were not documenting in a deceased resident's medical record (Resident 99). These failures had the potential for the residents' care needs not being met as their medical information was inaccurate.Findings: 1. Review of the facility's P&P titled Hemodialysis dated [DATE], showed the resident will not receive blood pressures or laboratory sticks on the arm where the dialysis access device is located. Medical Record Review for Resident 18 was initiated on [DATE]. Resident 18 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Residents 18's H&P examination dated [DATE], showed Resident 18 had the capacity to understand and make decisions. Review of Resident 18's Order Summary Report dated [DATE], showed a physician's order dated [DATE], for AV Fistula on the left upper arm. Review of Resident 18's plan of care showed a care plan problem dated [DATE], addressing the resident's need for a hemodialysis related to end stage renal disease. The interventions included to not draw blood, no IM injections or take blood pressure on the resident's left arm with the fistula. Review of Resident 18's Blood Pressure Summary showed the documentation for the resident's BP reading was obtained on the left arm on the following dates and times: - On [DATE] at 0909 hours, the resident's blood pressure was 158/72 mmHg; - On [DATE] at 0850 hours, the resident's blood pressure was 128/66 mmHg; - On [DATE] at 1733 hours, the resident's blood pressure was 120/78 mmHg; - On [DATE] at 1639 hours, the resident's blood pressure was 119/78 mmHg; - On [DATE] at 1713 hours, the resident's blood pressure was 136/64 mmHg; - On [DATE] at 1940 hours, the resident's blood pressure was 136/69 mmHg; - On [DATE] at 0925 hours, the resident's blood pressure was 121/66 mmHg; and - On [DATE] at 0807 hours, the resident's blood pressure was 122/70 mmHg. On [DATE] at 0919 hours, during the initial tour of the facility, an observation and concurrent (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview was conducted with Resident 18. Resident 18 was observed sitting in his wheelchair and stated he goes to the dialysis three times a week. Resident 18 stated his dialysis access site was on the left upper arm. On [DATE] at 0900 hours, a follow up observation and concurrent interview was conducted with Resident 18. Resident 18 stated he never allowed the licensed nurses to take his blood pressure on the left upper arm. On [DATE] at 0940 hours, an interview and concurrent medical record review for Resident 18 was conducted with LVN 7. LVN 7 verified the above findings. On [DATE] at 1055 hours, an interview was conducted with the DON. The DON was informed and verified the above findings. The DON stated the resident's blood pressure should have not been taken on the left upper arm, where the AV Fistula was located. 2. Review of the facility's P&P titled Documentation in Medical Record date revised [DATE], showed each resident's medical record shall contain a representation of the experiences of the resident and include enough information to provide a picture of the resident's progress. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. Documentation can be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. Documentation shall be factual, objective, and resident centered. Medical record review for Resident 102 was initiated on [DATE]. Resident 102 was admitted to the facility on [DATE]. Review of Resident 102's H&P examination dated [DATE], showed both options to indicate Resident 102 had the capacity and had no capacity to understand and make decisions were both marked with a check. Further review of Resident 102's medical record showed another H&P examination dated [DATE]. The H&P showed the option box for has the capacity to understand and made decisions was marked with a check mark, and the option box for does not have the capacity to understand and make decisions was crossed out with scribbled lines and the word error was written next to the scribbled lines. However, there was no initials and date written to show who corrected the error and when. The two H&P examination forms dated [DATE], contained identical information, with the exception of the resident's capacity. On [DATE] at 1401 hours, an interview and concurrent medical record review for Resident 102 was conducted with LVN 7. LVN 7 verified the above findings. On [DATE] at 1417 hours, an interview and concurrent medical record review for Resident 102 was conducted with the Medical Records Director. The Medical Records Director was asked regarding the process of correcting information entered incorrectly in the residents' medical records. The Medical Records Director stated only the physician who completed the original entry could correct error the H&P. The Medical Records Director stated the word error was not documented by the MD who completed Resident 102's H&P. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1425 hours, an interview and concurrent medical record review was conducted with the Administrator and DON. The DON stated the physician was in the facility last night and made the correction on Resident 102's H&P. On [DATE] at 1442 hours, an interview was conducted with Primary Physician 1 regarding Resident 102's H&P. Primary Physician 1 stated the facility called him regarding the check marks on the resident's H&P about the resident's capacity (both has the capacity to understand and make decisions and does not have the capacity to understand and make decisions options were marked with a check mark). Primary Physician 1 told the facility Resident 102 had the capacity to understand and make decision. Primary Physician 1 was asked regarding the process of correcting information entered incorrectly in the residents' medical records. Primary Physician 1 stated he would need to write on the resident's progress note or make addendum on the resident's medical record. Primary Physician 1 further stated he did not write error for the does not have the capacity to understand and make decisions option box on Resident 102's H&P. On [DATE] at 0822 hours, an interview was conducted with the DON. When the DON was asked regarding the facility's process of correcting information entered incorrectly in the residents' medical records, the DON stated the best practice was to have two licensed nurses call the physician and verify the incorrect information or the physician would need to come and write an addendum on the resident's medical record. The DON verified and acknowledged the above findings. 3. Closed medical record review for Resident 99 was initiated on [DATE]. Resident 99 was admitted to the facility on [DATE], and expired on [DATE]. Review of Resident 99's H&P examination dated [DATE], showed Resident 99 had no capacity to understand and make decisions. Review of Resident 99's physician's order dated [DATE] at 2105 hours, showed to release the resident's remains to the mortuary. Review of Resident 99's Record of Death showed the date of death was on [DATE] at 2100 hours. Review of Resident 99's progress note dated [DATE] at 2125 hours, showed an entry to monitor the temperature and oxygen saturation every four hours. However, Resident 99 had expired on [DATE]. On [DATE] at 1313 hours, an interview and concurrent medical record review was conducted with the Medical Records Director. The Medical Records Director verified the above findings and stated she was not sure why there was an entry on the resident's progress note on [DATE], when Resident 99 had expired on [DATE]. In addition, the Medical Records Director stated there should not be any entry in the resident's progress notes, after the resident had expired. On [DATE] at 1340 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 acknowledged the above findings and stated there should not be an entry in Resident 99's progress notes when the resident had expired. On [DATE] at 1446 hours, an interview was conducted with the DON and Nurse Consultant. The DON and Nurse Consultant were informed of the above findings.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary care and services to ensure one of one final sampled resident (Resident 7) reviewed on hospice services attained and maintained their highest practicable well-being. * The facility failed to ensure the hospice physician's orders for the frequencies of the visits of the hospice staff were transcribed in Resident 7's electronic health record. In addition, the facility failed to ensure the CHHA and LVN visited Resident 7 per the hospice physician's orders. This had the potential for a delay in providing hospice care and services to Resident 7.Findings: Review of the facility's P&P titled Coordination of Hospice Services revised 9/2/22, showed the following:- When a resident/resident representative chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental, and psychosocial well-being;- The facility will maintain communication with hospice as it relates to the resident's plan of care and services to ensure each entity is aware of their responsibilities; and- The facility will contact and communicate with the hospice staff, attending physician/practitioner and the family resident representative regarding any significant changes in the resident's status, clinical complications or emergent situations. Review of the facility's document titled Nursing Facility Services Agreement with Hospice Provider A (undated) showed the following:- Under Article 2, Responsibilities of Facility, Designation of Facility Representative section, showed the facility shall designate a member of the facility's IDT who is responsible for working with hospice representatives to coordinate care to the residents provided by the facility staff and hospice staff. The designated IDT member is responsible for communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the resident and family;- Under Article 3, Responsibilities of Hospice, Physician Orders section, showed all physician orders communicated by hospice under this agreement shall be in writing. Hospice shall maintain adequate records of all physician orders communicated in connection with the Plan of Care;- Under Article 6, Records, Creation and Maintenance of Records section, showed the facility shall prepare and maintain complete and detailed records concerning each hospice resident receiving facility services under this agreement in accordance with prudent record-keeping procedures and as required by applicable federal and state laws and regulations, and Medicare and Medicaid program guidelines. Each clinical record shall completely, promptly and accurately document all services provided to, and events concerning, each hospice resident, including evaluations, treatments, progress notes, authorizations to admission to hospice and/or facility, physician orders entered pursuant to this Agreement and discharge summaries. Medical record review for Resident 7 was initiated on 7/29/25. Resident 7 was readmitted to the facility on [DATE]. Review of Resident 7's Order Summary Report showed the following physician's orders dated 12/18/24:- to admit the resident to hospice services under Hospice Provider A; and- to call Hospice Provider A for any change of condition or symptoms. Do not call 911 and no hospitalization without notifying Hospice Provider A. Further review of Resident 7's Order Summary Report did not show any physician's order for the frequency of the hospice staff visits. Review of Resident 7's Hospice Orders in the hospice binder showed the following physician's orders dated 12/18/24:- CHHA visits three times per week for ADL care assistance;- Skilled nurse visits once per week, and three PRN visits; and- RN visit every 14 days. Review of the document titled Projected Hospice Staff Visit Calendars from January to July 2025 showed the following:- for January and February 2025 showed a handwritten note for the CHHA visit frequency was for two times per week;- for March 2025, the start of the month (3/1/25) was incorrectly listed as a Friday, when it should have been a Saturday. The calendar also failed to show the frequency of the LVN and (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CHHA visits; and- for April, May, June, and July 2025 failed to show the frequency of the LVN and CHHA visits. Review of the document titled Sign-In/ Sign-Out Sheet showed two CHHA visits on the following weeks:- on 12/29/24 to 1/4/25, the CHHA visited Resident 7 on 12/31/24 and 1/2/25;- on 1/5 to 1/11/25, the CHHA visited Resident 7 on 1/7 and 1/9/25;- on 1/12 to 1/18/25, the CHHA visited Resident 7 on 1/14 and 1/16/25;- on 1/19 to 1/25/25, the CHHA visited Resident 7 on 1/27 and 1/28/25; - on 1/26 to 2/1/25, the CHHA visited Resident 7 on 1/14 and 1/16/25; - on 2/23 to 3/1/25, the CHHA visited Resident 7 on 2/26 and 2/27/25; - on 3/16 to 3/22/25, the CHHA visited Resident 7 on 3/16 and 3/20/25; and- on 3/23 to 3/29/25, the CHHA visited Resident 7 on 3/27 and 3/29/25. Further review of the sign in/sign-out sheet showed only one CHHA visit for the week of 7/20 to 7/26/25, the CHHA visited Resident 7 only on 7/23/25; and there were no CHHA visits for the week of 7/27 to 8/2/25. Review of Resident 7's hospice notes showed no documentation of the LVN, nor the RN visited Resident 7 for the week of 1/5 to 1/11/25, and 7/27 to 8/2/25. Further review of Resident 7's medical records failed to show documented evidence of the CHHAs and skilled nursing visits during the above weeks. On 7/31/25 at 1546 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified the physician's orders (from the hospice, found in the hospice binder) on the frequency of hospice staff visits were not transcribed to Resident 7's electronic health record. RN 2 also verified the hospice projected calendars were inaccurate and incomplete. RN 2 further verified there were missing CHHA and skilled nursing visits. RN 2 stated the facility did not follow-up with Hospice Provider A regarding the missing CHHA and skilled nursing visits. On 8/4/25 at 0946 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated she was the facility's designee as hospice coordinator. The DON stated the hospice orders on the frequency of hospice staff visits were not written in the paper Telephone Order sheets, so these physician's orders were not transcribed to Resident 7's electronic health record. The DON stated the hospice staff were supposed to check in and out with the facility's licensed nurses. The DON stated the Sign-In/ Sign-Out Sheets were the only documentation to show the CHHA visited Resident 7, and the hospice notes were the documentation to show the LVN or RN visited Resident 7.

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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, medical record review, facility document review, and facility P&P review, the facility failed to maintain proper infection control practices. * The facility failed to ensure one laundry rolling rack with clean residents' clothing was appropriately covered when it was transported through the hallways and was left unattended. * The facility failed to ensure the local public health department was informed of Resident 63's unresolved scabies. Additionally, the facility failed to place Resident 63 on proper contact isolation for the unresolved scabies. * The facility failed to ensure CNA 7 did not use the same pair of gloves and gown when providing care to Resident 48 on EBP and then to Resident 105 who was not on EBP. This posed the risk of cross-contamination and spread of infection. * The facility failed to ensure Resident 36's indwelling urinary drainage bag was not touching the floor. This failure had the potential to put the resident at risk for urinary infection. * The facility failed to ensure Resident 1's tubing of negative pressure wound therapy (a therapeutic technique that uses controlled negative pressure to promote wound healing) was not touching the floor.Findings: 1. Review of the facility’s P&P titled Handling Clean Linen revised 12/2022 showed it is the policy of the facility to handle, store, process, and transport clean linen in a safe and sanitary method to prevent contamination of the linen, which can lead to infection. The P&P further showed linen can become contaminated with pathogens from contact with intact skin or body substances or form environmental contaminants or contaminated hands. Moreover, the P&P showed clean linen shall be delivered to resident care units on covered linen carts with covers down. Nothing shall be kept on top of linen carts. On 7/31/25 at 1320 hours, during an observation, one laundry rolling rack with the clean residents’ clothing was transported down the hallway from room [ROOM NUMBER] to room [ROOM NUMBER]. The laundry rolling rack was uncovered and passed by several residents and staff. Further observation showed the laundry rolling rack was left unattended and uncovered in between rooms [ROOM NUMBERS]. On 7/31/25 at 1323 hours, an observation and concurrent interview was conducted with Janitor 1. Janitor 1 returned to the laundry rolling rack and verified the findings. Janitor 1 stated the clean residents' clothes should not be left unattended and uncovered for infection control. On 8/1/25 at 1021 hours, an interview with the DON was conducted. The DON acknowledged the findings and stated the residents’ clean linen cart should be covered when transporting down the hallway and when left unattended to maintain infection control. On 8/4/25 at 1406 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings. 2. Review of the facility’s P&P titled Head Lice and Scabies Exposure and Treatment revised 12/2022 showed the facility ensures the residents who contract scabies or head lice are treated according to current standards of practice to eradicate the infestation and prevent further exposure and transmission. Human scabies are caused by the human itch mite. It is contagious and can be transmitted by direct, prolonged skin to skin contact with an affected person. The P&P further showed proper treatment and infection control measures should be utilized to prevent outbreaks within the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility. The infested resident will be placed in a single occupancy room away from other residents to avoid transmission. Review of the facility's document obtained from The Public Health Nurse titled Prevention and Control of Scabies in California Healthcare Settings, California Department of Public Health Division of Communicable Disease Control in Consultation with Center for Health Care Quality Healthcare-Associated Infections Program dated 8/2020 showed the residents with atypical or crusted scabies often require several scabicides to completely kill all the mites. The document further showed for all optional treatment plans, at least three skin scrapings performed at least one week after the completion of the selected treatment should be negative before scabies is declared cured. Medical record review for Resident 63 was initiated on 7/29/25. Resident 63 was admitted to the facility on [DATE], and readmitted back on 1/19/25. Review of Resident 63’s Quarterly MDS assessment dated [DATE], showed resident had a BIMS score of 3, indicating severe cognitive impairment. Review of Resident 63’s Order Summary Report for August 2025 showed the following physician’s orders: - order dated 6/16/25, for Elimite External Cream 5% apply to the neck, foot, abdominal folds topically for one day and may rinse off after eight hours. - order dated 6/23/25, for Elimite External Cream 5% (medication to treat parasites) apply to the neck, foot, abdominal folds topically for one day and may rinse off after eight hours. - order dated 7/3/25, for Ivermectin (medication to treat parasites) 6 mg give two tablets by mouth one time a day every Friday for scabies until 8/1/25. Review of Resident 63’s Lab Results Report dated 6/18/25, showed the resident was with Sarcoptes scabiei (a parasitic mite that burrows into the skin causes scabies). Further review of Resident 63’s medical record failed to show documented evidence a follow up labs or a skin test were completed after 6/18/25, and prior to the physician’s order for the Ivermectin medication on 7/4/25. On 7/30/25 at 1530 hours, an interview and concurrent medical record review was conducted with LVN 6. LVN 6 verified the above findings. LVN 6 stated although Resident 63 received the Elimite cream as ordered on 6/16 and 6/23/25, the resident’s skin condition did not improve. LVN 6 stated the Medical Director was notified of Resident 63’s unresolved rash and increase itchiness. LVN 6 stated the Medical Director ordered Ivermectin medication on 7/4/25 until 8/1/25. LVN 6 further verified Resident 63 was not on the contact isolation after the Ivermectin medication was ordered, and the resident has been outside her room multiple times. On 7/31/25 at 1446 hours, a telephone interview was conducted with the Public Health Nurse. The Public Health Nurse stated the recommendations for the residents with scabies were to be treated with Elimite cream and can be taken off contact isolation after the treatment; however, the Public Health Nurse stated, if the resident has atypical rashes (crusty rashes), then the resident should be placed on the contact isolation and re-tested for scabies. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/4/25 at 0924 hours, an interview and concurrent medical record review was conducted with the IP. The IP verified the above findings. The IP stated Resident 63 was treated with the Elimite cream; however, the resident’s rash was not healing and described the rash as “generalized,” “pimple-like with whiteheads,” “crusty on the edge,” “clustered,” and “skin redness” due to the increased itchiness. The IP verified Resident 63 was last seen by the wound physician on 6/19/25, and was not seen by the wound physician or a dermatologist after the resident still presented with unresolved rashes and itchiness. The IP verified the facility did not do another skin test after the initial lab result dated 6/18/25 was done. The IP stated another testing of the skin would have allowed information of whether Resident 63’s unresolved skin concern was related to a positive scabies result. Moreover, the IP verified the facility did not inform the Public Health Nurse of Resident 63’s unresolved skin rash and increased itchiness. The IP stated the facility should have informed the Public Health Nurse to obtain further recommendations and instructions on the care of Resident 63 and to reduce the potential exposure of scabies to other residents, visitors, and staff. On 8/4/25 at 1024 hours, a telephone interview with the Medical Director was conducted. The Medical Director verified he ordered the Ivermectin medication for Resident 63. When the Medical Director was informed the facility did not inform the Public Health Nurse of Resident 63’s unresolved rashes and increased itchiness, the Medical Director stated he was not aware of that. The Medical Director also stated the type of strain the resident had would indicate if the resident would need to be placed on the contact isolation. However, the Medical Director was informed there were no other skin scrape tests or dermatologist follow up to determine what type of strain the resident had. The Medical Director was informed and acknowledged the findings. On 8/4/25 at 1406 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings. Cross Reference with F684. 3. According to CDC’s The Basics of Standards Precautions (undated), wear a gown when contact between clothing or skin with resident blood or body substances is expected, and to not wear the same gown between residents. Review of the facility’s EBP sign showed everyone must clean hands, including before entering and when leaving the room, and the providers and staff also wear gloves and gown for the high contact resident care activities: ADLs care, caring for the devices, toileting and changing incontinence briefs, wound care, mobility assistance, transferring and preparing to leave room, and cleaning environment. On 8/1/25 at 0607 hours, an EBP sign was observed posted outside Room A, and a number “6” was observed by Resident 48’s name by the door. The following was observed: - CNA 7 was observed inside the room with gloves and gown on. Resident 48 was awake and in bed. When asked about Resident 48’s call light, CNA 7 looked for the call light. CNA 7 placed the call light within Resident 48’s reach, repositioned Resident 48 by touching his head, back and arms, and then repositioned Resident 47’s pillow. - Without removing the gown and gloves used for Resident 48, CNA 7 untangled Resident 105’s (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	call light cord and placed the call light button on Resident 105’s stomach area. CNA 7 then offered water to Resident 105 and touched the resident’s water pitcher and cup. CNA 7 emptied Resident 105’s urinal. On 8/1/25 at 0620 hours, an interview was conducted with CNA 7. CNA 7 verified the above findings. CNA 7 acknowledged she used the same gown and gloves to reposition Resident 48 and then assisted Resident 105. On 8/4/25 at 0912 hours, an interview was conducted with the IP. The IP stated the number “6” by the resident’s name meant the resident in the room was on EBP. The IP stated the staff cannot wear the same gown and gloves in caring for different residents. 4. According to the CDC guidelines for the Prevention of Catheter-Associated Urinary Tract Infection dated 2009 under the Proper Techniques for Urinary Catheter Maintenance section showed to keep the collecting bag below the level of the bladder at all times and do not rest on the floor. Medical record review for Resident 36 was initiated on 7/29/25. Resident 36 was admitted to the facility on [DATE]. Review of Resident 36's H&P examination dated 4/1/25, showed Resident 36 had the capacity to understand and make decisions. Review of Resident’s 36 MDS quarterly assessment dated [DATE], showed the resident had a BIMS score of 13 (meaning cognitively intact) and had an indwelling urinary catheter. Review of Resident 36's Physician Order Summary showed a physician's order dated 7/30/25, for indwelling urinary foley catheter size French 16/5 ml for obstructive uropathy (a urinary tract disorder that occurs when urine flow is obstructed). On 7/29/25 at 0935 hours, during the initial tour of the facility, an observation was conducted in Resident's 36 room. Resident 36 was lying in bed with an indwelling urinary catheter, with the tubing attached to a drainage bag. The drainage bag was observed touching the floor. On 7/29/25 at 1002 hours, an observation and concurrent interview for Resident 36 was conducted with CNA 1. CNA 1 verified Resident 36's indwelling urinary catheter drainage bag was touching the floor. On 7/29/25 at 1005 hours, an observation and concurrent interview for Resident 36 was conducted with LVN 4. LVN 4 verified the above findings. On 8/4/25 at 0834 hours, an interview was conducted with the DON. The DON acknowledged the above findings and stated the indwelling urinary catheter drainage bag should not be touching the floor to prevent infection. Cross reference to F550 5. Review of the facility’s P&P titled Negative Pressure Wound Therapy dated 12/19/22, showed to promote wound healing of various types of wounds, it is the policy of the facility to provide evidence- based treatment in accordance with current standards of practice and physician wounds. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the P&P showed clean technique shall be utilized unless otherwise specified by the physician. Medical record review for Resident 1 was initiated on 7/29/25. Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 1’s Order Summary Report showed an order dated 7/8/25, for negative pressure wound therapy, wound location sacrum, continuous intensity, low pressure 125 mm/Hg, and to change dressing on every day shift, Monday, Wednesday, and Friday. Further review of the physician's order showed to cleanse the wound with normal saline, pat dry, apply foam, and cover with transparent dressing. On 7/29/25 at 1120 hours, Resident 1 was observed in bed and the negative pressure wound therapy was connected to Resident 1's wound. The tubing of Resident 1’s negative wound pressure therapy was touching the floor. On 7/29/25 at 1249 hours, an observation and concurrent interview was conducted with LVN 4. LVN 4 verified the observation and stated the negative pressure wound therapy tubing should not be touching the floor. On 7/30/25 at 1452 hours, Resident 1 was observed in bed and the negative pressure wound therapy was connected to Resident 1’s wound. The tubing of Resident 1’s negative wound pressure therapy was observed touching the floor. On 7/30/25 at 1332 hours, an observation and interview was conducted with LVN 6. LVN 6 stated he provided wound care treatment to the residents in the facility. LVN 6 verified the tubing of Resident 1’s negative wound pressure therapy was observed touching the floor. LVN 6 stated the negative wound pressure therapy tubing should not touch the floor to prevent contamination and wound infection. On 8/1/25 at 1243 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, facility document review, and facility P&P review, the facility failed to monitor and address the use of the antibiotics when the resident's condition did not meet McGeer's criteria for two of five residents (Residents 4 and 53) reviewed for antibiotic stewardship. This failure had the potential for the antibiotics to be used when it was not indicated and the development of antibiotic-resistant bacteria.Findings: Review of the facility's P&P titled Antibiotic Stewardship Program revised 12/19/22, showed it is the policy of the facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The program included antibiotic use protocols as a system to monitor antibiotic use.the facility uses the (CDC's NHSN Surveillance Definition, updated McGeer's criteria, or other surveillance tool) to define infection. The Loeb Minimum Criteria may be used to determine whether to treat an infection with antibiotics. 1. Medical record review for Resident 4 was initiated on 7/29/25. Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of the facility's untitled document showed Resident 4 had wound infection and was prescribed piperacillin sodium tazobactam (an antibiotics) intravenous solution 4.5 gm. Further review of the document did not show if Resident 4's infection met the McGeer's criteria for a true infection or Loeb's minimum criteria to treat the infection with antibiotics. Review of Resident 4's Infection Screening Evaluation dated 7/9/25, showed Resident 4 had a repeated temperature more than 99 degree Fahrenheit. Further review of the Infection Screening Evaluation failed to show if the symptoms experienced by Resident 4 met the McGeer's criteria for true infection or Loeb's minimum criteria to treat the infection with antibiotics. Review of Resident 4's Antibiotic Time Out dated 7/12/25, showed Resident 4 was prescribed with piperacillin sodium tazobactam intravenous solution 4.5 gm, intravenously every eight hours. The presenting symptoms showed fever, abdominal pain or tenderness, and diarrhea. Under the section for the Narrative note showed the criteria was met, reviewed antibiotic stewardship program and clinical status of the resident with the medical doctor, and as per medical doctor, to continue with the antibiotic treatment as ordered from the acute care hospital. Further review of Resident 4's medical records failed to show if Resident 4 had fever, abdominal pain tenderness, and diarrhea in the facility. On 7/31/25 at 1412 hours, an interview and concurrent medical record review for Resident 4 was conducted with the IP. The IP stated the facility used the McGeer's criteria. The IP stated if a resident did not meet the criteria for a true infection using the McGeer's criteria, the physician would be notified. The IP verified Resident 4 did not have a fever, abdominal pain or tenderness, and diarrhea in the facility. The IP further stated Resident 4's infection did not meet the McGeer criteria for infection. The IP stated she should have accurately notified the physician regarding Resident 4's symptoms that did not meet the McGeer's Criteria for a true infection when the IV antibiotic was ordered. 2. Medical record review for Resident 53 was initiated on 7/31/25. Resident 53 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the facility's untitled document showed Resident 53 had a pneumonia and was prescribed with doxycycline hyclate (an antibiotic) 100 mg. Further review of the document did not show if Resident 53's infection met the McGeer's criteria for a true infection or Loeb's minimum criteria to treat the infection with the antibiotic. Review of the Resident 53's Infection Screening Evaluation dated 7/25/25, showed Resident 53 had new or changed lung exam abnormalities and unproductive cough. Further review of the Infection Screening Evaluation did not show if the above symptoms met the McGeer's criteria for a true infection or Loeb's minimum criteria to treat the infection with antibiotics. Review of the Resident 53's Antibiotic Time Out dated 7/28/25, showed Resident 53 was receiving doxycycline hyclate oral tablet 100 mg medication, by mouth two times a day. Further review of the Antibiotic Time Out showed Resident 53 had presenting symptoms of chest x-ray with pneumonia (a lung infection) or a new infiltrate (the abnormal presence (continued on next page)

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	555797	A. Building B. Wing	08/04/2025

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of substances within tissues or cells, often in a way that is not normal), new or changed lung exam abnormalities, and acute functional decline. Under the section for the Narrative note showed the criteria met per McGeer's, reviewed antibiotic stewardship program and clinical status of the resident with the medical doctor, per the medical doctor, to continue with the antibiotic as ordered. Review of Resident 53's chest x-ray dated 7/25/25, showed mild parabronchial thickening, suggestive of respiratory bronchiolitis (an inflammation of the small airways in the lungs), and no focal infiltrates. Further review of Resident 53's medical records failed to show if Resident 53 had a chest X-ray result showing pneumonia or a new infiltrate, and if Resident 53 had an acute functional decline. On 7/31/25 at 1412 hours, an interview and concurrent medical record review for Resident 53 was conducted with the IP. The IP verified Resident 53's chest x-ray did not show pneumonia or a new infiltrate, and Resident 53 did not have an acute functional decline. The IP verified Resident 53's symptoms did not meet the McGeer's criteria for infection. The IP stated she should have accurately notified the physician regarding Resident 53's symptoms that did not meet the McGeer's criteria for a true infection when the antibiotic was ordered. On 8/1/25 at 1243 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the resident's zone entrapment assessment was completed and the measurements were recorded upon installation during the admission when identifying areas of possible entrapment with the use of side rails for one of two final sampled residents (Resident 4) reviewed for the use of the side rails. These failures had the potential to negatively impact the residents resulting in possible entrapment, serious injury, and death.Findings: According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapment may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is potential for entrapment are:- Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support;- Zone 3: between the rail and the mattress;- Zone 4: under the rail, at the ends of the rail;- Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and- Zone 7: between the head or foot board and the mattress end. Review of the facility's P&P titled Proper Use of Bed Rails revised 12/19/22, showed if the bed rails are used, the facility ensures correct installation, use, and maintenance of the rails. The Installation and Maintenance of Bed Rails section showed the following:- The facility will ensure the correct installation and maintenance of bed rails, prior to use;- The facility will check with the manufacturer(s) to make sure the bed rails, mattress, and bed frame are compatible. Rails should be selected and placed to discourage climbing over rails; and- The facility will ensure that the bed's dimensions are appropriate for the resident by:1. Confirming that the bed rails are appropriate for the size and weight of the resident using the bed;2. Installing the bed rails using the manufacturer's instructions and specifications to ensure a proper fit;3. Inspecting and regularly checking the mattress and bed rails for areas of possible entrapment; 4. Ensuring the bed frame, bed rail and mattress do not leave a gap wide enough to entrap a resident's head or body, regardless of mattress width, length, and/or depth; and5. Checking the bed rails regularly to make sure they are still installed correctly and have not shifted or loosened over time. On 7/29/25 at 0901 hours, during the initial tour of the facility, Resident 4 was observed awake and lying in bed. Resident 4's bed was observed with bilateral 1/2 (half) side rails elevated. Resident 4 stated she had the side rails since her admission and even in her previous admissions in the facility. Resident 4 stated she grabbed or held on to the side rails when she turned or transferred from bed to wheelchair. Resident 4 stated she could turn by herself, but she needed the staff assistance to clean her. Medical record review for Resident 4 was initiated on 7/29/25. Resident 4 was readmitted to the facility on [DATE]. Review of Resident 4's H&P examination dated 7/11/25, showed Resident 4 was able to make decisions. Review of Resident 4's MDS assessment dated [DATE], showed Resident 4 needed partial/moderate assistance with mobility. Review of Resident 4's Order Summary Report showed a physician's order dated 7/9/25, for bilateral side rails, length: 1/2, for turning and repositioning and to monitor resident every shift for appropriate position/movement while in bed. Review of Resident 4's plan of care showed a care plan problem revised 7/18/25, addressing the use of the bilateral 1/2 side rails for turning/repositioning and the risk for entrapment and impairment in skin discoloration. The interventions included the facility to perform visual check of the bed, mattress, and rail for appropriateness of the dimensions. Review of Resident 4's Bed Rails - V2 dated (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/9/25, showed the resident had bilateral 1/2 side rails indicated for mobility/transfer purposes and the resident demonstrated the ability to use the equipment as an enabler. On 7/30/25 at 1013 hours, an observation and concurrent interview for Resident 4 was conducted with CNA 8. CNA 8 was observed inside Resident 4's room and informed the resident she needed to be turned. Resident 4 refused at this time but would do it later. CNA 8 stated Resident 4 had the side rails since admission and even in the past admissions in the facility. CNA 8 stated Resident 4 could turn by herself but needed the staff assistance to clean her. CNA 8 further stated Resident 4 held on to the side rails during turning and when she was being transferred from bed to wheelchair. On 7/31/25 at 1413 hours, an interview and concurrent medical record review for Resident 4 was conducted with LVN 1. LVN 1 stated Resident 4 was well known to him because the resident had been in the facility prior to this new admission. LVN 1 stated Resident 4 had been using the side rails since this new admission and even in the past. LVN 1 stated Resident 4 could turn but she needed to grab on the side rails. LVN 1 stated Resident 4 also used the side rails when being cleaned or transferred from the bed to wheelchair. LVN 1 stated prior to installing the side rails, the licensed nurse had to conduct the side/bed rail assessment which included assessing first for the cognitive status of the resident to make sure the resident would know how to use the side rails, the use of least alternatives interventions and indications, and the rehab staff would also do the assessment. LVN 1 stated if there was an indication for the side rails after the assessment was completed, the licensed nurse would get the order from the physician and the consent as well, then the Maintenance Department would be notified to install the side rails. LVN 1 further stated it was the maintenance staff who would do the zone entrapment assessment. On 7/31/25 at 1503 hours, an interview and concurrent facility document review for Resident 4 was conducted with the Maintenance Director. When asked about installing the side/bed rails, the Maintenance Director stated before installing the side rails he had to check the order, consent, and the assessment of the nurse or rehab staff were completed. The Maintenance Director stated he was responsible for completing the zone entrapment assessment or measuring the side rails upon installation and during the facility's routine bed inspection. Further review of the facility's document failed to show the zone entrapment assessment for Resident 4 was completed on 7/9/25, when the side rails were installed during the resident's current admission to the facility. The Maintenance Director verified the above findings. The Maintenance Director stated the zone entrapment assessment or measurement should have been completed upon installation of the bed rails for Resident 4 for the safety of the resident. The Maintenance Director further stated he would do the zone entrapment assessment right away. On 8/4/25 at 1300 hours, an interview was conducted with the DON. The DON stated the bed rails should not be applied for the resident's use if the zone entrapment assessment was not completed for the safety of the resident. The DON was informed and acknowledged the above findings.

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F 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	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 medical record review, the facility failed to ensure the care was provided in a manner which promoted the resident's dignity and respect for one of four final sampled residents (Resident 36) reviewed for the use of the indwelling urinary catheter. * The facility failed to ensure Resident 36's indwelling urinary catheter drainage bag was fully covered. This failure has the potential to negatively affect the residents' feeling of self-worthy and dignity. Findings: Medical record review for Resident 36 was initiated on 7/29/25. Resident 36 was admitted to the facility on [DATE]. Review of Resident 36's H&P examination dated 4/1/25, showed Resident 36 had the capacity to understand and make decisions. Review of Resident's 36 MDS quarterly assessment dated [DATE], showed Resident 36 had a BIMS score of 13 (meaning cognitively intact) and had an indwelling urinary catheter. Review of Resident 36's Physician Order Summary showed a physician's order dated 7/30/25, for foley catheter French 16/5 ml for obstructive uropathy (a urinary tract disorder that occurs when urine flow is obstructed). On 7/29/25 at 0935 hours, during the initial tour of the facility, an observation was conducted in Resident's 36 room. Resident 36 was observed lying in bed with an indwelling urinary catheter with tubing attached to a drainage bag. The drainage bag was observed with blood-tinged urine and not placed in a privacy bag. The indwelling urinary catheter drainage bag was visible when you walk in the resident room. On 7/29/25 at 1002 hours, an observation and concurrent interview for Resident 36 was conducted with CNA 1. CNA 1 verified Resident 36's indwelling urinary catheter drainage bag was not placed in a privacy bag. CNA 1 stated the drainage bag should be placed in a privacy bag for resident's dignity. On 7/29/25 at 1005 hours, an observation and concurrent interview for Resident 36 was conducted with the LVN 4. LVN 4 verified the above findings. On 7/31/25 at 1612 hours, a follow-up observation and concurrent interview for Resident 36 was conducted with the CNA 9. CNA 9 verified Resident 36's indwelling urinary catheter drainage bag was not placed in a privacy bag. On 8/4/25 at 0834 hours, an interview was conducted with the DON. The DON verified and acknowledged the above findings and stated the indwelling urinary catheter drainage bag needed to be fully covered.