STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555801	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Creek Care Center	1139 Cirby Way Roseville, CA 95661

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 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. Based on observation, interview, and record review the facility failed to develop and implement a Care Plan (CP, a detailed document outlining a person's healthcare needs, goals, and the specific care and support they will receive) for one out of 27 sampled residents (Resident 79). This failure had the potential for Resident 79 to not receive the highest practible level of care for her health and wellness. Findings: A review of Resident 79's admission Record indicated Resident 79 was admitted to the facility in December 2024 with diagnoses which included dysphagia (difficulty swallowing) and partial paralysis to the left side. During a concurrent observation and interview on 4/8/25 at 10:11 a.m. with Resident 79, in the resident's room, Resident 79 stated, It'd be great if I could get this G-tube [a surgically placed feeding tube inserted through the abdomen directly into the stomach] out. Resident 79 lifted her shirt to where the G-tube was observed. A review of Resident 79's Order Summary Report (OSR, physician orders) did not indicate Resident 79 had an order for a G-tube. A review of Resident 79's CP which included current and resolved items did not indicate Resident 79 had a care plan implemented or resolved for a G-tube. During a concurrent interview and record review on 4/9/25 at 1:10 p.m. with Licensed Nurse (LN) 3, Resident 79's OSR and CP was reviewed. LN 3 acknowledged Resident 79 had a G-tube in place, but did not have a current physician's order or a CP for one. During an interview on 4/10/25 at 9:56 a.m. with the Nurse Practitioner (NP), the NP acknowledged there should still be a current order for Resident 79's G-tube and a CP for the care and treatment of the device. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/11/25 at 10:18 a.m. with the Director of Nursing (DON), Resident 79's OSR and CP was reviewed. The DON acknowledged there were no current orders for the placement, care and treatment of the G-tube and a CP had not been developed, revised or resolved for Resident 79's G-tube. The DON acknowledged the CP should include the resident's diagnoses, medications and medical devices. A review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive, reviewed October 2024, indicated, A comprehensive care plan that includes measurable objectives .to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .The comprehensive care plan will: describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to provide care and services for three (3) of 27 sampled residents (Resident 82, Resident 25 and Resident 67) according to accepted standards of clinical practice when: 1. Resident 82's order for Thrombo-Embolic Deterrent, (TED stockings, also known as anti-embolism stockings, to prevent blood clots and swelling in the legs, particularly after surgery) and lymphatic compression device (devices that work by inflating sleeves around the legs to mimic muscle contractions, helping blood flow back to the heart) were not applied as ordered; and, 2. Resident 25 and Resident 67's TED hose were not applied as ordered. This failure decreased the facility's ability to provide a clear and consistent picture of the residents's conditions, treatment responses, outcomes, and risk factors to improve residents' health and safety. Findings: 1. A review of Resident 82's admission Record (AR) indicated he was admitted in February 2025 with diagnoses which included endocarditis (serious infection and inflammation of the inner lining of the heart chambers and heart valves) and generalized muscle weakness. A review of Resident 82's Physician's Order (PO) dated 2/13/25, indicated, TED Hose: apply TED hose [every] [morning] and remove [every] [afternoon] every day and evening shift; and PO dated 2/28/25, indicated Offer Lymphatic Compression Device (used to help prevent blood clots in the deep veins of the legs) for [BLE, bilateral lower extremities] after meals every shift. A review of Resident 82's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 2/14/25 indicated he had mental capacity to make healthcare decisions. During a concurrent observation and interview on 4/10/25 at 2:03 p.m., inside Resident 82's room, he stated he was wearing regular socks not TED stockings and had not been using the compression device. Resident 82 confirmed he did not like what the compression device effect to his body, that he did not like to wear it and no one had offered it to him. During a concurrent observation, interview, record review, on 4/10/25 at 2:03 p.m., with Licensed Nurse 4 (LN 4), LN 4 confirmed Resident 82 had on order to use TED stocking in the morning and remove in the evening and to offer to wear the compression device after meal time. LN 4 confirmed Resident 82 was wearing black-colored regular socks and the compression device was out of sight and inside Resident 82's room cabinet. LN 4 confirmed she had not applied those devices as ordered. During a concurrent interview and record review on 4/11/25 at 10 a.m., with the Director of Nursing (DON), Resident 82's medical record was reviewed. The DON confirmed Resident 82 had an order for TED hose and compression device due to swelling. The DON stated her expectation was for the nurses to follow physician's order and document Resident 82's response to treatment. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident 25's AR indicated Resident 25 was admitted to the facility in December 2024 with diagnoses which included congestive heart failure (fluid buildup in the body, especially the lower extremities) and muscle weakness. A review of Resident 25's Order Summary Report (OSR, physician orders) indicated an order for: a. Compression stocking during AM shift every day shift, for edema off at nighttime, with a start date of 3/31/25; and, b. Daily weights, with a start date of 12/11/24. During a concurrent observation and interview with Resident 25 on 4/8/25 at 9:56 a.m. in the resident's room, Resident 25 was laying in bed, wearing a facility gown. Resident 25 confirmed she was not wearing compression stockings. During a concurrent observation and interview on 4/10/25 at 10:34 a.m. with LN 6, in Resident 25's room, LN 6 confirmed Resident 25 was not wearing compression stockings. A review of Resident 25's weight summary from 12/6/24 to 4/11/25 indicated Resident 25 was not weighed daily as ordered. During a concurrent interview and record review on 4/11/25 at 9:59 a.m. with the Director of Staff Development (DSD), Resident 25's OSR and weight log was reviewed. The DSD acknowledged Resident 25 had an order for daily weights and confirmed daily weights for Resident 25 were not completed. A review of Resident 67's AR indicated Resident 67 was admitted to the facility in March 2025 with diagnoses which included muscle weakness and multiple sclerosis (autoimmune disorder where the immune system mistakenly attacks the body's own tissues). A review of Resident 67's OSR/Physician's Order (PO) indicated Resident 67 had an order for TED hose: apply in the morning and remove at bedtime, with a start date of 3/29/25. During a concurrent observation and interview on 4/9/25 at 10 a.m. with Resident 67 and the Physical Therapy Assistant (PTA), in Resident 67's room, Resident 67 was observed laying in bed, in her own gown, without TED hose on. Resident 67 stated she has never been fitted for TED hose while at the facility. The PTA acknowledged the license nurses supply the TED hose for the resident. The PTA checked through Resident 67's belongings and closet and confirmed there were no TED hose available. During an interview on 4/10/25 at 9:56 a.m. with the Nurse Practitioner (NP), the NP stated she expected nursing staff to follow resident orders as written. The NP stated, Orders are written for the safety of the resident, or for a specific diagnosis and treatment. During a concurrent observation, interview and record review on 4/10/25 at 1:57 p.m. with LN 6, in Resident 67's room, Resident 67's OSR was reviewed. LN 6 acknowledged Resident 67 had an order for TED hose and confirmed they were not applied. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/11/25 at 10:18 a.m. with the DON, Resident 25 and Resident 67's OSR was reviewed. The DON stated she expected staff to follow physician orders as written for the residents at the facility. A review of the facility's P&P titled, Physician Orders, reviewed October 2024, the P&P indicated, Prescribed medication and treatment orders will be carried out in accordance with the physician/nurse practitioner order . the licensed staff shall carry out physician/nurse practitioners' orders as prescribed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to provide two (2) of 27 sampled residents (Resident 30 and Resident 38) proper hygiene when: 1. Resident 30 and Residents 38's fingernails were untrimmed, jagged and had black substances underneath the nailbeds; 2. Resident 30's skin on right foot was dry and scaly; 3. Resident 38's skin on right and left feet were dry and scaly; and, 4. Resident 30 and Resident 38's traced of colored-liquid, old and dry food residue stacked in between their beards. This failure decreased the facility's ability to maintain Resident 30 and Resident 38's overall health, comfort, and a sense of dignity. Findings: A review of Resident 30's admission Record (AR) indicated he was admitted in June 2024 with diagnoses which included osteoarthritis (a degenerative joint disease where cartilage breaks down, causing pain, stiffness, and reduced movement) generalized muscle weakness and left below the knee amputation (LBKA). A review of Resident 30's revised Care Plan (CP) dated 2/7/25, titled ADL(activities of daily living- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves)/MOBILITY: indicated, Resident 30 is at risk for ADL/mobility decline and requires assistance . During an observation on 4/8/25 at 8:56 a.m. and on 4/9/25 at 11:07 a.m., Resident 30's fingernails were untrimmed, jagged with a black substance underneath the nailbeds, his right foot skin was dry and scaly, and there were traces of colored-liquid and old, dry food residue stacked in between his beard. A review of Resident 38's AR indicated he was admitted in January 2025 with diagnoses which included Parkinsons disease (PD, progressive neurological disorder primarily affecting movement) and dementia (a progressive state of decline in mental abilities). A review of Resident 38's CP initiated on 2/27/25, indicated, Resident 38's ADL/MOBILITY: Resident 38 is at risk for ADL/mobility decline and requires assistance . During an observation on 4/8/25 at 9:12 a.m. and on 4/9/25 at 12:11 p.m., Resident 38's fingernails were untrimmed, jagged, and had black substance underneath the nailbeds. Skin on his left and right feet were dry and scaly and there were traces of colored-liquid and old, dry food residue stacked in between his beard. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During concurrent observations and interviews on 4/10/25 at 9:05 a.m., with the Treatment Nurse (TN), the TN confirmed the findings: Resident 30 and Resident 38's fingernails were untrimmed, jagged and had black substances underneath their nailbeds; their skin were dry and scaly; and traces of colored-liquid, and, old and dry food residue stacked in between their beards. The TN stated he would not like Resident 30 and Resident 38 to look dirty and unkempt for dignity and infection control issues. The TN stated accumulated food residue in facial beard can lead to unpleasant odors and even skin irritation. The TN stated Resident 30 and Resident 38 should have been cleaned and properly groomed but they were not. During an interview on 4/10/25 at 2:43 p.m., with the Assistant Director of Nursing (ADON), the ADON stated Resident 30 and Resident 38 should be groomed and clean at all times. The ADON stated a lack of hygiene could facilitate the spread of infections and could lead to more health problems such as skin complaints and could cause residents' discomfort, low self-esteem, and embarrassment. During an interview and record review on 4/11/25 at 8:24 a.m., with the Director of Nursing (DON), Resident 30 and Resident 38's medical records were reviewed. The DON confirmed Resident 30 and Resident 38's functional capability for ADL's required staff assistance. The DON stated her expectations required Resident 30 and Resident 38 and all residents to be cleaned and groomed. The DON confirmed unkempt residents' fingernails could potentially cause skin irritation, discomfort and affect the residents' dignity. The DON also stated residents' skin should be lotioned and moistiorized, due to when residents get older, skin gets thinner and drier, so, it is prone to damage. A review of the facility's policy and procedure (P/P) titled, :ACTIVITIES OF DAILY LIVING, SUPPORTING, revised 10/24, indicated, Residents will be provided with care. treatment, and services as appropriate to enable to carry out activities of daily living .appropriate care and services will be provided for residents who are unable to carry out ADLs independently .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure controlled medications (medications that the use and possession of are controlled by the federal government) for three residents (Resident 30, Resident 38, and Resident 51) of a census of 95 were accurately accounted for on the Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications given to a resident) and Controlled Drug Record (CDR - a log for tracking dispensing of controlled substances to ensure compliance with relevant regulations). This failure decreased the facility's potential to ensure accurate accountability for residents' controlled medications and prevent their misuse. Findings: A review of Resident 30's admission record indicated he was readmitted on [DATE] with a diagnosis of orthopedic (medical care pertaining to bone injuries or deformities) aftercare following surgical amputation (surgical removal of a body part, usually a limb) and osteoarthritis (degeneration of joint cartilage and underlying bone). A review of Resident 30's Order Summary Report, dated 4/15/25, indicated an order for hydrocodone-acetaminophen (an opioid medication used to treat pain) 5/325 milligrams (mg; a unit of measurement), one tablet every six hours as needed for pain management. A review of Resident 30's CDR and MAR, dated 3/2025, indicated hydrocodone-acetaminophen was given on 3/2/25 at 2:30 p.m. in the CDR and not noted as given in the MAR. A review of Resident 38's admission record indicated he was admitted to the facility on [DATE] with a diagnosis of femur (thigh bone) fracture and subsequent surgical repair. A review of Resident 38's Order Summary Report, dated 4/15/25, indicated an order for hydrocodone-acetaminophen 5/325 milligrams, one tablet every four hours as needed for moderate to severe pain. A review of Resident 38's CDRs and MARs, dated 3/2025 and 4/2025, indicated hydrocodone-acetaminophen was given on 3/29/25 at 5 p.m. in the CDR, but not listed as administered in the MAR. The CDR also indicated the medication was given on 3/30/25 at 5:12 p.m. and 4/6/25 at 8 p.m. and were not listed as given in the MAR. A review of Resident 51's admission record indicated she was admitted to the facility on [DATE] with a diagnosis of thoracic vertebrae (the interlocking bones in the middle section of the spine) fracture. A review of Resident 51's Order Summary Report, dated 4/15/25, indicated there was an order for hydrocodone-acetaminophen 5/325 mg, one tablet every eight hours as needed for moderate to severe pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 51's CDR and MAR, dated 3/2025, indicated a hydrocodone-acetaminophen dose was given on 3/29/25 - the CDR denoted the dose was given at 5:30 p.m., and the MAR displayed an administration time of 3:04 p.m. During interviews on 4/11/25 at 12:29 p.m. and 3:10 p.m. with the Director of Nursing (DON), the inaccuracies of Resident 30's, 38's, and 51's CDRs and MARs were discussed. DON stated correct documentation was important for controlled drug accountability. Incorrect records of doses could be associated with medication misuse and drug diversion. A review of the facility's policy and procedures titled, Controlled Medications, revised 9/2024, indicated, When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record . Date and time of administration . Amount administered . Signature of the nurse administering the dose, completed after the medication is actually administered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. During a concurrent observation and interview on [DATE] at 12:39 p.m. with Licensed Nurse (LN 5) in the hallway by medications cart #3, the medications cart was inspected, and one round, white unlabeled tablet was found at the bottom of one of the drawers that stored blister packs of medications. LN 5 disposed the medication in the medication disposal container and stated that medication carts should be free of loose or unlabeled medications. During a review of the facility's P&P titled, Storage of Medications, revised [DATE], the P&P indicated, Drugs and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. 2. During an observation on [DATE] at 12:05 p.m. at Nursing Station 1, one medication cart was observed unlocked and unattended by staff. During a concurrent observation and interview on [DATE] at 12:09 p.m. with LN 3, LN 3 observed and acknowledged the medication cart was unlocked and unattended at Nursing Station 1. LN 3 stated, .it's [the medication cart] supposed to be locked .it's a safety concern. During an interview on [DATE] at 11:15 a.m. with the DON, the DON acknowledged the medication carts should be locked when unattended. The DON stated, Yes, I expect the medication carts to be locked when unattended, that's a safety concern. During a review of the facility's Policy and Procedure (P&P) titled, Storage of Medications, revised [DATE], the P&P indicated, The facility stores all drugs and biologicals in a safe, secure and orderly manner . compartments (including, but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use .unlocked medication carts are not left unattended. Based on observation, interview, and record review, the facility failed to ensure that: 1. Discontinued medications were not available for resident use; 2. Medications were stored locked in medication cart; and, 3. Medications were stored in original packaging with pharmacy approved labels. These deficient practices had the potential for unsafe medication storage and administration for a census of 95. Findings: A review of Resident 29's Face Sheet indicated she was admitted to the facility on [DATE] with diagnoses which included acute respiratory failure with hypoxia (not enough oxygen in the blood), and chronic obstructive pulmonary disease (a condition of lung damage which makes it hard to breathe). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 29's Order Summary Report indicated she was prescribed Arformoterol Tartrate Inhalation Nebulization Solution 15 micrograms/2 milliliter (mcg/ml - units of measure) (a medication used for maintenance of air flow blockage in the lungs) on [DATE]. A review of Resident 29's Discharge summary, dated [DATE], indicated Resident's discharge date and time was [DATE] at 11 a.m. During a concurrent observation and interview on [DATE] at 12:28 p.m. with Licensed Nurse (LN) 1 in Medication room [ROOM NUMBER], the prescription drug Arformoterol Tartrate Inhalation Nebulization Solution 15 mcg/2 ml, was found in the medication refrigerator next to active medications. LN 1 stated Resident 29 was discharged from the facility days earlier, and the inhaler should have been removed from the medication refrigerator immediately upon the resident's discharge. He took the discontinued medication out of the refrigerator, placed it in a locked cabinet in the medication room for disposal. He stated discontinued medications should be locked there until they can be properly disposed of. During an interview on [DATE] at 9:32 a.m. with the Director of Nursing (DON), DON stated discontinued medications should not be located next to active, current medications. DON stressed that it is the responsibility of the nurse performing resident discharge to set aside remaining discontinued medications for disposal. She stated an inexperienced nurse could possibly give the discontinued medication to another patient if the nurse doesn't read the label accurately or misinterprets the resident's name. During an interview on [DATE] on 12:29 p.m. with DON, she stated that discharged residents' discontinued medications should be discarded the day of the patients' release. If not done the same day, it should be done immediately after - the next day. DON stated this medication should not have remained in the medication refrigerator six days after the resident went home. She and the Assistant Director of Nursing (ADON) stop by the units weekly to pick up expired or discontinued medicines for disposal. A review of facility policy titled, Storage of Medications, revised [DATE], indicated, Discontinued, outdated, or deteriorated drugs or biologicals are placed in designated appropriate bins for destruction.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide sufficient hydration for four residents (Resident 13, Resident 298, Resident 299, Resident 300) of a census of 95, when staff did not deliver bedside water pitchers for two days. This failure had the potential to cause dehydration (a harmful reduction in the amount of water in the body) to the residents. Findings: A review of all four residents' care plans (Resident 13, Resident 298, Resident 299, Resident 300) indicated they were at risk for dehydration due to their medical conditions. A review of Resident 13's face sheet indicated she was admitted to the facility on [DATE] with diagnoses including urinary tract infection (an illness in the urinary system-kidneys, bladder, or urethra-typically caused by bacteria), type 2 diabetes mellitus (a disease in which the body's inability to produce or respond to the hormone insulin is impaired - symptoms include thirst and frequent urination) and high blood pressure. A review of Resident 13's Order Summary Report indicated her primary physician did not put her on fluid intake restrictions (medically prescribed regime limiting the amount of daily fluid consumption to assist in preventing fluid build-up in the body) when her diet was ordered on 3/10/25. Resident 13 also had a medication order for furosemide 20 milligram (mg-unit of measure), which is a diuretic (a medication that helps reduce fluid buildup in the body, prescribed for high blood pressure or heart problems. Side effects include dry mouth, increased thirst and frequent urination.) A review of Resident 13's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 3/17/25, indicated her BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 11 out of 15, indicating she had moderate cognitive impairment. During a concurrent observation and interview on 4/8/25 at 11:37 a.m., Resident 13 had no water pitcher on her bedside table or nightstand. There was a partially filled cup of water on her bedside table. Resident 13 stated she was unsure why the Certified Nursing Assistants (CNAs) were not giving her a daily water pitcher, but she would have liked one as she gets thirsty during the day. During an observation on 4/9/25 at 3:48 p.m. in Resident 13's room, no water pitcher was on the bedside table. Resident 13 told Licensed Nurse (LN) 2 she was very thirsty and asked for water. Resident 13's Fluid Intake sheet indicated that on 4/8/25, her fluid intake was 680 milliliters (ml-unit of volume measure), and on 4/9/25, her fluid intake was 330 ml. The average fluid intake for the rest of the month was 1070 ml per day. A review of Resident 298's face sheet indicated he was admitted to the facility on [DATE], with a diagnosis of type 2 diabetes mellitus. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 298's Order Summary Report indicated that the facility physician did not order fluid restrictions on 3/31/25 when the physician prescribed the resident's diet. A review of Resident 298's Minimum Data Set, dated [DATE], showed that his BIMS score was 8 out of 15, indicating he had moderate cognitive impairment. During a concurrent observation and interview with Resident 298 on 4/8/25 at 11:22 a.m. in his room, no water pitcher was found at his bedside. Resident 298 stated the CNAs will bring a cup of water to him at mealtimes. During an observation 4/9/25 at 4:03 p.m., it was noted there was no pitcher of water on resident's bedside table. A review of Resident 299's face sheet indicated he was admitted to the facility on [DATE]. A review of Resident 299's Order Summary Report indicated his diet was prescribed on 4/3/25, without fluid intake restrictions. According to the Medical Records Administrator on 4/9/25, Resident 299's BIMS score was yet to be entered in his records since he had been recently admitted . The MDS and BIMS score was not available at the time of survey exit. During a concurrent observation and interview with Resident 299 on 4/8/25 at 11:28 a.m. in his room, his bedside table had no water pitcher. He denied being on fluid restrictions. During a subsequent observation on 4/9/25 at 4 p.m. in Resident 299's room, no pitcher of water was found on resident's bedside table. A review of Resident 300's face sheet indicated she was admitted to the facility on [DATE]. A review of Resident 300's Order Summary Report stated her physician ordered her diet on 4/2/25, with no fluid restrictions. A review of Resident 300's BIMS score on 4/5/25 (care plan) denoted she scored 9 out of 15, indicating she was moderately cognitively impaired. Her MDS report was not available at time of survey exit. During an observation of Resident 300 on 4/8/25 at 11:48 a.m. in her room, it was observed that the resident did not have a water pitcher at her bedside table. During an observation on 4/9/25 at 3:57 p.m. with Resident 300, no water pitcher was found on resident's bedside table. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Licensed Nurse (LN) 2 on 4/9/25 at 3:50 p.m., LN 2 stated that Resident 13 vomited earlier that day and needed to drink fluids. LN 2 confirmed that Resident 13's water pitcher was missing and would bring one to her. She stated all patients are supposed to have water pitchers on their bedside table. She added that even if a resident is on fluid restrictions, they are still given a pitcher with the restricted amount of water, so every resident should have a water pitcher at their bedside. During an interview with Certified Nursing Assistant (CNA) 1 on 4/9/25 at 3:55 p.m., CNA 1 stated the night shift is supposed to provide fresh water pitchers for the residents on their bedside tables. The CNA stated that if the day shift CNAs do not see pitchers on the bedside tables, they put a new pitcher on the bedside table. She had not noticed any missing pitchers that day. During an interview on 4/10/25 at 8:25 a.m. with LN 2, LN 2 stated that the outcome of patients not having a water pitcher by the bedside could have an adverse consequence like dehydration in a resident who is already medically compromised. During an interview with the Director of Nursing (DON) on 4/10/25 at 9:32 a.m., DON stated that limiting residents' fluid intake by not giving them water pitchers could result in not getting enough fluids, putting them at risk for dehydration. A review of facility document titled, Hydration, dated September 2024, indicated, The staff will monitor the individual's current hydration status .The staff will provide supportive measures such as supplemental fluids and adjusting environmental temperature, where indicated. A review of facility job description titled, Certified Nursing Assistant, undated, indicated, Keep residents' water pitchers clean and filled with fresh water (on each shift), and within easy reach of the resident .Record the resident's food/fluid intake.

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are assessed for appropriateness for a feeding assistant program, receive services as per their plan of care, and feeding assistants are trained and supervised. Based on observation, interview and record review the facility failed to provide one resident out of 27 sampled residents (Resident 79) with appropriate supervision and assistance during meals. This failure had the potential for Resident 79 to experience malnutrition and an increased risk of choking during meals. Findings: A review of Resident 79's admission Record indicated Resident 79 was admitted to the facility in December 2024 with diagnoses which included dysphagia (difficulty swallowing) and partial paralysis to the left side. A review of Resident 79's Order Summary Report (physician orders) indicated an order with a start date of 3/1/25 for 1:1 supervision for meals, cue resident to slow rate, pre-cut food into bite sized pieces with meals. During a concurrent observation and interview on 4/8/25 at 12:37 p.m. with Resident 79, in her room, Resident 79 was sitting up in bed, leaned over to the right side, unattended. Resident 79 acknowledged staff bring the meal trays, sit her up to eat and then leave. During a follow-up observation on 4/09/25 at 7:33 a.m. in Resident 79's room, Resident 79 was sitting up in bed with her eyes closed and her breakfast tray in front of her uncovered and unattended. A review of Resident 79's point of care electronic record indicated Resident 79 was to be provided with 1:1 supervision for meals. There was no data recorded for the last 30 days. A policy and procedure (P&P) which included the definitions of various levels of meal assistance was requested on 4/9/25 at 10:50 a.m. from the Administrator. A P&P was not provided. During an interview on 4/10/25 at 9:56 a.m. with the Nurse Practitioner (NP), the NP stated she expected nursing staff to follow resident orders as written. The NP stated, Orders are written for the safety of the resident, or for a specific diagnosis and treatment. A review of the facility's P&P titled, Assistance with Meals, revised October 2023, the P&P indicated, Residents will receive assistance with meals in a manner that meets the individual needs of each resident. A review of the facility's P&P titled, Physician Orders, reviewed October 2024, the P&P indicated, Prescribed medication and treatment orders will be carried out in accordance with the physician/nurse practitioner order . the licensed staff shall carry out physician/nurse practitioners' orders as prescribed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 2. A review of Resident 25's AR indicated Resident 25 was admitted to the facility in December 2024 with diagnoses which included congestive heart failure (fluid buildup in the body, especially the lower extremities) and muscle weakness. A review of Resident 25's Order Summary Report (OSR, physician orders) indicated an order for compression stockings (TED hose) during the morning shift every day, for edema, and off at nighttime, with a start date of 3/31/25. During a concurrent observation and interview with Resident 25 on 4/8/25 at 9:56 a.m. in the resident's room, Resident 25 was in bed, wearing a facility gown. Resident 25 confirmed she was not wearing compression stockings and she had not been since being admitted to the facility. During a concurrent observation, interview and record review on 4/10/25 at 10:34 a.m. with LN 6, in Resident 25's room, Resident 25's April 2025 Medication Administration Record (MAR) was reviewed. LN 6 confirmed Resident 25 was not wearing compression stockings. LN 6 acknowledged her initials on the April 2025 MAR and she had documented that Resident 25's TED hose had been applied on 4/4/25 and 4/6/25 when she had not applied the TED hose. LN 6 acknowledged she documented a treatment she did not administer, and she should not document something she did not do. A review of Resident 67's AR indicated Resident 67 was admitted to the facility in March 2025 with diagnoses which included muscle weakness and multiple sclerosis (autoimmune disorder where the immune system mistakenly attacks the body's own tissues). A review of Resident 67's OSR/(PO-physician orders) indicated Resident 67 had an order for TED hose: apply in the morning and remove at bedtime, with a start date of 3/29/25. During a concurrent observation and interview on 4/9/25 at 10 a.m. with Resident 67 and the Physical Therapy Assistant (PTA), in Resident 67's room, Resident 67 was observed laying in bed, in her own gown, without TED hose on. Resident 67 stated she has never been fitted for TED hose while at the facility. The PTA acknowledged the license nurses supply the TED hose for the resident. The PTA checked through Resident 67's belongings and closet and confirmed there were no TED hose available. During a concurrent observation, interview and record review on 4/10/25 at 1:57 p.m. with LN 6 and Resident 67, in Resident 67's room, Resident 67's OSR and April 2025 MAR were reviewed. LN 6 acknowledged Resident 67 had an order for TED hose and confirmed her initials were on the April 2025 MAR that indicated she had applied the TED hose on 4/4/25, 4/6/25 and 4/10/25. LN 6 observed Resident 67 was not wearing the TED hose. Resident 67 acknowledged she was not wearing TED hose and retrieved them from her bedside table. LN 6 admitted she documented something she did not do. 3. A review of Resident 249's AR indicated Resident 249 was admitted to the facility in April 2025 with diagnoses including pseudomonas aeruginosa (a bacterial infection) and cystitis (an infection in the bladder). A review of Resident 249's OSR indicated an order for 2 grams of ceftriaxone sodium (antibiotic) intravenously one time a day for sepsis. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 249's April 2025 MAR indicated LN 7 had administered Resident 249's IV antibiotics on 4/6/25 and 4/8/25. During a concurrent interview and record review on 4/9/25 at 4:20 p.m. with LN 7, Resident 249's April 2025 MAR was reviewed for the administration of IV antibiotics. LN 7 stated a Registered Nurse needs to administer IV antibiotics and the staff member who administers the medication or treatment documents the action in the medical record. LN 7 confirmed her initials were on the MAR for the administration of IV antibiotics on 4/6/25 and 4/8/25. LN 7 agreed those entries in Resident 249's MAR were inaccurate and she should not document something she did not do. During a concurrent interview and record review on 4/10/25 at 11:15 a.m. with the DON, Resident 25's, Resident 67's and Resident 249's records were reviewed. The DON acknowledged LN 6 and LN 7 had documented entries in the Residents' MAR that were inaccurate, and staff should not sign off on something they did not do. A review of the facility's policy and procedure (P&P) titled, Charting and Documentation, revised 2024, indicated, Services provided to the resident shall be documented in the resident's medical record . documented information in the in a resident medical record can include: .medications administered . treatments or services performed .Entries may only be recorded in the resident's clinical record by licensed personnel .in accordance with state law and facility policy .Documentation of procedures and treatments may include .The name and title of the individual(s) who provided the care. 4. During a concurrent observation and interview of the kitchen dishwashing on 04/11/25 09:39 a.m. with the kitchen Dishwasher (DW) employee, the DW was observed scraping the leftover breakfast food from the trays into the garbage container. The contents of the garbage was observed to contain scraped food items, and further observation of the garbage container it was observed there were other resident's meal tickets at the bottom of the garbage container. There were two meal tickets observed on the top portion of the garbage which were within reach. There were two meal tickets obtained from the garbage which were identified for Random Resident 1 and Random Resident 32. Further observation, the two meal tickets were printed with the resident's name, room number, allergies to food, food likes and dislikes. During the interview with the DW, she confirmed in preparation for washing the dishes she must first scrape off the food and the meal tickets are disposed in the garbage. During an interview with the Dietary Manager (DM) on 4/11/25 at 9:41 a.m., the DM was shown the meal tickets obtained from the garbage can. The DM confirmed they were the residents meal tickets from the breakfast meal. The DM stated the current practice were for the food scraps and meal tickets to be disposed of together into the regular garbage. Further interview with the DM confirmed the printed meal tickets had the resident's name, room number, diet, likes and dislikes and allergies. The DM confirmed the printed meal tickets contained resident's confidential information, and should be disposed of in the confidential shredding bin and not into the regular garbage. Record review of the facility Policy and Procedure Confidentiality of Information and Personal Privacy revised 10/24 indicated: .Our facility will protect and safeguard resident confidentiality and personal privacy .1. The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records .4. Access to resident personal and medical records will be limited to authorized staff and business associates . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility Policy Retention of Medical Records and Destruction dated 2001 indicated: .Facility is contracted with [Name of Medical Record Destruction Company] for the destruction of records . 5. During a record review of Resident 48's AR indicated he was admitted to the facility with diagnoses of dementia (the loss of cognitive functioning, thinking, remembering, and reasoning), anxiety disorder (persistent and excessive anxiety and worry about activities or events, even ordinary or routine), and depression. Review of Resident 48's OSR/PO indicated on 4/7/25 the physician ordered the medication . Brexpiprazole (an antipsychotic medication used to treat major depressive disorder (MDD) and agitation associated with dementia) 0.5 mg (milligram, a unit of measure) tablet by mouth one time a day for dementia with behaviors and psychosis (where an individual experiences a significant loss of touch with reality) agitation for 7 days manifested by auditory hallucinations. Further review of Resident 48's OSR indicated the medication Brexpiprazole was to be administered beginning 4/8 through 4/15/25. Before administering of the medication could begin, an informed consent (IC) must be obtained from the resident or the Responsible Party (RP). Record review of Resident 48's IC with an effective date of 4/7/25 at 1:33 p.m. the IC verification section of the document indicated the licensed nurse obtained a verbal/phone consent on 4/7/27 at 5:40 p.m. as evidenced by two (2) Licensed Nurses (LN) signatures. Further review of the IC document's line 1b indicated: .Name of person giving verbal or phone consent was left blank it did not indicate the name from whom the LNs obtained the consent from. During an interview with the Assistant Director of Nursing (ADON) on 4/11/25 at 12:25 p.m., the IC for the use of Brexipiprazole 0.5 mg was reviewed with the Assistant Director of Nursing (ADON) and he confirmed that the informed consent for Brexpiprazole was signed and witnessed by two (2) LNs and was complete. The ADON stated he also signed and confirmed the IC obtained was complete before administering Brexpiprazole. The ADON was asked to review the consent. The ADON after reviewing the document stated the IC was inaccurate as it did not document the name of the RP giving the consent. He stated the RP name must be confirmed and verified. Review of the facility Policy and Procedure Psychotropic Medication Use dated 10/23 indicated: .4. The licensed nursing staff will verify that an informed consent was obtained by the prescribing licensed healthcare practitioner from the resident or resident's authorized representative prior to administration of psychotropic medications and every six (6) months. Based on observation, interview, and record review, the facility failed to accurately document and secure the care and treatment provided for five of 27 sampled residents (Resident 82, Resident 25, Resident 67, Resident 249, and Resident 48) when: 1. Licensed Nurse 4 (LN4) documented she had applied Resident 82's Thrombo-Embolic Deterrent, (TED stockings, also known as anti-embolism stockings, designed to prevent blood clots and swelling in the legs, particularly after surgery) and lymphatic compression device (helps the trapped lymph fluid to move and flow through the lymph vessels) when she had not; 2. Resident 25 and Resident 67's administration records indicated TED hose had been applied daily by the LNs, when LN's had not; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 249's intravenous antibiotics (IV, a type of antibiotic administered directly into a vein to treat infections) was documented as administered by a Licensed Vocational Nurse (LVN), which was not within the scope of practice; 4. Residents' meal tickets were disposed of in the regular garbage bin; and 5. Resident 48's Informed Consent (IC, voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for the use of psychoactive medications (affecting the mind or behavior) was inaccurate. These failures decreased the facility's ability to provide a clear and consistent picture of the patient's conditions, treatment responses, outcomes, and risk factors to improve patients' health and safety and the potential to expose multiple residents health information by persons not involved in the residents' care for a census of 95 residents. Findings: 1. A review of Resident 82's admission Record (AR) indicated he was admitted in February 2025 with diagnoses which included endocarditis (serious infection and inflammation of the inner lining of the heart chambers and heart valves) and generalized muscle weakness. A review of Resident 82's Physician's Order (PO) dated 2/13/25, the PO indicated, TED Hose: apply TED hose [every] [morning] and remove [every] [afternoon] and offer Lymphatic Compression Device for bilateral lower extremities (BLE) after meals every shift. A review of Resident 82's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 2/14/25 indicated he had mental capacity to make healthcare decisions. During a concurrent observation and interview on 4/10/25 at 2:03 p.m., Resident 82 stated he was wearing regular socks and not TED stockings and had not been using the compression device. Resident 82 confirmed he did not like what the compression device had effect to his body, that he did not like to wear it and no one had offered it to him. During a concurrent observation, interview, record review, on 4/10/25 at 2:03 p.m., with Licensed Nurse 4 (LN 4), LN 4 confirmed Resident 82 had on order to use TED stocking in the morning and remove in the evening and to offer to wear the compression device after meal time. Inside the room, LN 4 confirmed Resident 82 was wearing black-colored regular socks and the compression device was out of sight inside Resident 82's room cabinet. LN 4 confirmed she had not applied those devices as ordered. LN 4 stated she should not document in the treatment administration record (TAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) that she had applied those devices when she had not. During a concurrent interview and record review on 4/11/25 at 10 a.m., with the Director of Nursing (DON), Resident 82's medical record was reviewed and confirmed Resident 82 had an order for TED hose and compression device due to swelling. The DON stated her expectation was for the nurses to follow physician's order and document Resident 82's response to treatment. The DON stated nurses should document accurately when care and treatment were provided and/or not provided. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Policy and Procedure (P/P), titled, Physician's Order, revised 10/24, the P/P indicated, Prescribed medications and treatment orders will be carried out in accordance with the physicians/nurse practitioner's order.