STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555852	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Avenue Healthcare & Wellness Center	1550 North Park Avenue Pomona, CA 91768

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review, the facility failed to offer milk for one of one resident (Resident 113).in accordance with the resident's preference This deficient practice had the potential to result in Resident 113 to feel ignored and to possibly stop verbalizing necessary needs. During a review of Resident 113's admission Record (AR), the AR indicated the facility admitted Resident 113 on 9/27/2010, with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember, it is severe enough to affect a person's daily functioning), contracture (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints to the right and left hand). During a review of Resident 113's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 5/1/2025, the MDS indicated Resident 113 had a severe cognitive deficit. The MDS indicated Resident 113 usually understands verbal content and was usually able to express ideas and wants. The MDS indicated Resident 113 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating and with rolling left and right for bed mobility. During an observation on 7/22/2025 at 10:40 AM, Resident 113 was repeatedly asking for milk and pointed to the right side where the bedside table is located, there was no milk and no water pitcher at the bedside.During an observation on 7/22/20925 at 10:46 AM, Certified Nursing Assistant 9 (CNA 9) came inside the room and Resident 113 repeatedly asking for milk and pointed to the right side towards the bedside table. CNA 9 stated during breakfast, you had your milk, juice and water. CNA 9 did not call other staff to get milk and CNA 9 did not go out of the room to get milk and continued chatting with Resident 113.During an interview on 7/22/2025 at 10:54 AM, CNA 9 stated Resident 113 would always ask for milk and the resident already had milk for breakfast. CNA 9 stated there was no water at the bedside because Resident 113 needed thickened liquid. CNA 9 stated Resident 113 was asking for milk because the resident wanted to drink milk or the resident was thirsty. During a review of the facility's Policy and Procedure (P&P) titled Resident Rights - Quality of Life dated March 2017, the P&P indicated residents are offered meals and snacks in accordance with their individual and/or cultural preferences.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, the facility failed to complete a Preadmission Screening and Resident Review Level II [2] (PASARR-a federal assessment requirement to help ensure individuals, who have a mental disorders or intellectual disabilities, are placed in facilities that provide appropriate care) screening for one of two sampled residents (Resident 6) when the facility did not reply to recommendations by the California Department of Health Care Services (DHCS-a state agency that oversees the provision of services such as health care and mental health).This failure resulted in Resident 6 not receiving the PASARR level 2 screening for serious mental illness (SMI-a diagnosable mental, behavioral, or emotional disorder that significantly impairs a person's ability to function in major life activities) in a timely manner and had the potential for Resident 6 to not receive specialized services (the services specified by the State that exceed the services ordinarily provided by the nursing facility) for SMI. Findings:During a review of Resident 6's admission Record (AR), the AR indicated the facility admitted Resident 6 12/20/2024 with diagnoses including depression (a mental health disorder characterized by sadness, loss of interest, and other symptoms that impact daily life), schizoaffective disorder (a mental illness that causes a person to experience dramatic changes in their thoughts, moods, and behaviors), and schizophrenia (a mental illness characterized by disturbances in thought).During a review of Resident 6's PASARR Level 1 Screening (the PASARR prescreening process that determines if a resident has a mental disorder or intellectual disability or related condition), dated 6/13/2025, the PASRR Level 1Screeing indicated a result of positive for SMI.During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool), dated 6/19/2025, the MDS indicated Resident 6's cognitive (the ability to think and process information) skills for daily decision making were intact.During a concurrent interview and record review with the Minimum Data Set Nurse (MDSN), on 7/23/2025 at 8:30 AM, Resident 6's California Department of Health Care Services (DHCS) notification letter, dated 6/22/2025, was reviewed. The DHCS notification letter indicated a subject of Notice of attempted evaluation. The DHCS notification letter indicated, In the event of a positive SMI Level 1 Screening [PASSAR Level 1 Screening], a SMI Level 2 Mental health Evaluation [PASSAR Level 2 Screening] is required to determine if the individual can benefit from specialized services. However, a SMI Level 2 Mental Health Evaluation was not scheduled for the following reason: Facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level 1 Screening. The MDSN stated the facility did not respond to Resident 6's DHCS notification letter. The MDSN stated the facility should have responded to Resident 6's DHCS notification letter to verify Resident 6 was receiving proper care and services.During an interview on 7/24/2025 at 4 PM with Director of Nursing (DON) 2, DON 2 stated it was important to follow up on PASSAR Level 2 screening, so the facility made sure residents were receiving proper care. DON 2 stated medical records received the notification letter from DHCS and should have reached out to DHCS to follow up on the PASSAR Level 2 screening. During a review of the facility's Policy and Procedure (P&P) titled, Pre-admission Screening Level II Resident Review-PASARR Level II, revised 4/25/2024, the P&P indicated the facility will log onto the PASARR portal daily to check for level 2 determinations and evaluators reports. The P&P indicated the facility will report the status of the PASARRs; including Level 2 recommendations with evaluation dates. The P&P indicated the IDT will review the Level 2 evaluation report to develop a care plan and arrange specialized services recommended for the resident as appropriate.

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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 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 observation, interview, and record review, the facility failed to implement care plan interventions and monitor and record pain characteristics every shift for one of one sampled resident (Resident 51) and failed to ensure a comprehensive person - centered care plan was developed and implemented for one of three sampled residents (Resident 2), who received an anticoagulant (blood thinner - e.g., warfarin, heparin, or low-molecular weight heparin) and was at risk for bleeding. This deficient practice had the potential to result in unmet individualized needs for Resident 2 and Resident 51 and had the potential to affect the resident's physical well-being. Findings: A. During a review of Resident 51's admission Record (AR), the AR indicated Resident 15 was admitted to the facility on [DATE], with diagnoses that included COPD (a common lung disease causing restricted airflow and breathing problems), acute respiratory failure with hypoxia (results from acute or chronic impairment of gas exchange between the lungs and the blood causing hypoxia with or without hypercapnia), dysphagia (swallowing difficulties), Parkinson's disease (a brain condition that causes problems with movement, mental health, sleep, pain and other health issues) and polyneuropathy (many nerves in different parts of the body are involved). During a review of Resident 51’s care plan titled “the resident has chronic pain related to disease process”, initiated on 3/5/2025, the care plan indicated interventions that included to monitor/record pain characteristics every shift and as needed, the quality of the pain, severity, the anatomical location, duration whether continuous or intermittent and if there’s aggravation or relieving factors. During a review of Resident 51’s Minimum Data Set (MDS – a federally mandated resident assessment tool) dated 4/25/2025, the MDS indicated Resident 51 had moderate cognitive impairment. Resident 51 was usually able to express ideas and wants and usually understands verbal content. The MDS indicated Resident 51 was dependent with toileting hygiene and personal hygiene. The MDS indicated Resident 51 required maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) with bed mobility such as sit-to-lying and lying-to-sitting on the bed. During an interview on 7/22/2025 at 1:47 PM, Resident 51 stated the resident had knee pain that might need surgery. During a review of Resident 51’s Order Summary Report (OSR), active orders as pf 7/23/2025, the OSR indicated an order for hydrocodone-acetaminophen (an opioid [a class of medicine used to provide relief for moderate to severe pain] pain reliever) tablet 10-325 milligrams (mg), 1 tablet every 4 hours as needed for moderate to severe to excruciating pain (5-10). The OSR indicated an order for Tylenol tablet 325 mg, give 2 tablets by mouth every 6 hours as needed for mil pain. During a review of Resident 51’s Medication Administration Record (MAR) dated 7/1/2025 to 7/31/2026 with the Minimum Data Set Nurse (MDS Nurse), the MAR indicated Resident 51 received hydrocodone-acetaminophen on the following dates: 7/2/2025 – 7/6/2025, 7/9/2025 – 7/11/2025, 7/15/2025, 7/16/2025, 7/18/2025, 7/20/2025-7/21/2025. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 51’s Progress Notes (PN) from 7/1/2025 to 7/23/2025 with the MDSN, the PN indicated there was no documentation of the location of the pain when the narcotic pain medication was administered on the following dates: On 7/2/2025, 7/3/2025, 7/4/2025, 7/5/2025, 7/6/2025, 7/9/2025, 7/10/2025, 7/11/2025, 7/16/2025, 7/20/2025 and 7/21/2025. During an interview on 7/23/2025 at 3:09 PM, the MDSN stated it was important to monitor and record the location of the pain to be able to determine if the complaint of pain for the shift was chronic or if the pain was a new onset pain. The MDSN stated if the pain was identified as new onset or a different location, the attending physician needed to be notified. During a concurrent observation and interview on 7/23/2025 at 3:52 PM, Resident 51 complained of pain to the left hip, the left thigh and the left knee at 10/10 pain level. Resident 51 was able to move the right side upper and lower extremities but did not move the left lower extremities. During a review of the facility’s P&P titled “Person-Centered Care Planning” dated 5/22/2025, the P&P indicated the facility must develop and implement a comprehensive person-centered care plan for each resident. B. During a review of Resident 2’s admission Record (AR), the AR indicated Resident 2 was admitted to the facility on [DATE], with diagnoses including encounter for attention to tracheostomy (a surgically created hole [stoma] in your windpipe [trachea] that provides an alternative airway for breathing), unspecified atrial fibrillation (AFib - an irregular and often rapid heartbeat), and sepsis (a life-threatening blood infection), unspecified organism. During a review of Resident 2’s History and Physical Examination (H&P), dated 6/22/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2’s cognitive skills (ability to think and process information) for daily decision making was severely impaired. The MDS indicated Resident 2 was taking an anticoagulant. During a review of the Physician’s OSR as of 7/1/2025, the OSR indicated on 6/20/2025 Resident 2 was to receive Amiodarone HCL (medication that prevents and treats an irregular heartbeat) oral tablet 100 mg (milligrams - metric unit of measurement used for medication dosage and/or amount), via gastrostomy tube (G-tube - a type of feeding tube) one time a day for AFib. The OSR indicated on 6/20/2025 Resident 2 to receive Eliquis (apixaban – a blood thinner medicine) one tablet via G-tube every 12 hours for deep vein thrombosis prophylaxis (DVT PPX, measures taken to prevent blood clots from forming in the deep veins, particularly in the legs). During a review of Resident 2’s Order Details (OD) dated 7/22/2025 in the Point Click Care (PCC – an electronic health record system), the OD indicated an alert drug interaction with the drug-to-drug interaction details that Amiodarone may increase the plasma (the yellowish portion of blood) concentrations and the pharmacologic effects of Eliquis. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2’s Consultant Pharmacist’s Medication Regimen Review (MRR), dated 7/25/2025, the MRR indicated Resident 2 had an order for Amiodarone and Eliquis, which may lead to increase in Eliquis concentrations and may increase the risk of bleeding. During a concurrent interview and record review on 7/23/2025 at 8:22 AM with Registered Nurse (RN) Supervisor 2, Resident 2’s Situation, background, assessment, recommendation (SBAR – a communication tool used by healthcare workers when there is a change of condition among the residents), dated 4/25/2025 and the Change in Condition Evaluation (COC) dated 6/14/2025 were reviewed. The SBAR indicated Resident 2 had blood in the urine. The COC indicated Resident 2 had blood in the urine and two episodes of vomiting (light brown vomitus). RN 2 stated Resident 2 was sent to the hospital. RN 2 stated Resident 2 was on Eliquis and Amiodarone and should have been care planned for the risk of bleeding. RN 2 stated a care plan included interventions and should have been created on the “day of the COC about blood in urine.” During an interview on 7/23/2025 at 9:45 AM, RN 3 stated a baseline care plan should be created at the time of admission and the comprehensive care plan within the first week of admission. RN 3 stated it was important that a care plan was created so “We know how to care of the patient,” and the interventions for a specific problem. RN 3 stated Resident 2’s care plan for risk of bleeding should have been created “within the time frame Eliquis and Amiodarone were ordered.” During a review of the facility’s policy and procedure (P&P) titled, “Person-Centered Care Planning,” revision date 4/24/2025, the P&P indicated the baseline care plan would be developed and implemented, using the necessary combination of problem specific care plans to promote continuity of care and communication among facility task, increase resident safety and safeguard against adverse events, within 48 hours of the resident’s admission. The P&P indicated the facility must develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights, that includes measurable objectives, and timeframes to meet a resident's medical, nursing, mental and psychological needs that were identified in the comprehensive assessment. The P&P indicated within 7 days from the completion of the comprehensive MDS assessment, the comprehensive care plan would be developed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure appropriate care and services were provided for two of two sampled residents (Resident 2 and 83) by failing to:A. Ensure Resident 2, who was on anticoagulant (medication that thins the blood) therapy, was monitored for bleeding in the month of June 2025.B. Follow up on an infectious disease consult (a consultation with a specialist [a doctor who has special knowledge and skill relating to a particular area of study] in infectious diseases to help diagnose, manage, or prevent infections) for Resident 83's recurrent urinary tract infections (an infection in any part of the urinary system: kidneys, bladder, or urethra [tube through which the urine leaves the body]) as per the physician's order, dated 7/10/2025.These deficient practices had the potential to result in serious health complications and rehospitalization for Resident 2 and Resident 83. Additionally, the failure resulted in Resident 83 experiencing bladder spasms (a sudden, involuntary contraction of the bladder [hollow muscular organ that acts as a reservoir for urine] muscle causing pain and urine leakage) and resulted in Resident 83 feeling worried Resident 83 might die from an infection.Findings: A. During a review of Resident 2’s “admission Record,” the “AR” indicated, Resident 2 was admitted to the facility on [DATE] with multiple diagnoses including encounter for attention to tracheostomy (a surgically created hole [stoma] in your windpipe [trachea] that provides an alternative airway for breathing), unspecified atrial fibrillation (AFib - an irregular and often rapid heartbeat), and sepsis (a life-threatening blood infection), unspecified organism. During a review of Resident 2’s “Care Plan” (CP), titled, “Resident with history of acute embolism (a sudden blockage of a blood vessel by a clot that travels through the bloodstream from another part of the body) and thrombosis (blood clots that reduce or block blood flow) of unspecified deep veins of bilateral [both] lower extremity [legs],” initiated 4/25/2025, the CP’s goals indicated Resident 2 would remain free of complications related to anticoagulant therapy. During a review of Resident 2’s “CP,” titled, “Resident noted with blood in the urine,” initiated 4/26/2025, the “CP” indicated, one of the interventions was to monitor urine for blood, sediments, foul odor. During a review of Resident 2’s “History and Physical Examination (H&P),” dated 6/22/2025, the “H&P” indicated, Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 6/25/2025, the MDS indicated, Resident 2’s cognitive skills (ability to think and process information) for daily decision making were severely impaired. The “MDS” indicated, Resident 2 was taking an anticoagulant. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2’s “Order Summary Report [OSR],” active orders as of 7/1/2025, the “OSR” indicated, a physician’s order, dated 6/20/2025 for Amiodarone HCL (medication that prevents and treats an irregular heartbeat) oral tablet 100 mg (milligrams - metric unit of measurement), give 1 tablet via G-tube (gastrostomy tube - a type of feeding tube) one time a day for AFib. The “OSR” indicated, an order, dated 6/20/2025 for Eliquis (Apixaban - blood thinner medicine) oral tablet 5 mg, give 1 tablet via G-tube every 12 hours for DVT PPX (deep vein thrombosis prophylaxis – measures taken to prevent blood clots from forming in the deep veins, particularly in the legs). During a review of Resident 2’s “Order Details (OD),” dated 7/22/2025, the “OD” indicated an order for Eliquis, medication class: anticoagulant. The “OD” indicated, an alert drug interaction. The drug-to-drug interaction details indicated Amiodarone may increase the plasma (the yellowish portion of blood) concentrations and pharmacologic effects of apixaban. During a review of Resident 2’s “Consultant Pharmacist’s Medication Regimen Review [MRR],” dated 7/25/2025, the “MRR” indicated, Resident 2 had an order for amiodarone and apixaban, which may lead to increase in apixaban concentration and may increase the risk of bleeding. During a concurrent interview and record review on 7/23/2025 at 8:22 AM with Registered Nurse Supervisor (RN) 2, Resident 2’s medical records were reviewed. The “Change of Condition (COC), ” dated 4/25/2025 and 6/14/2025 were reviewed. The “COC” dated 4/25/2025 indicated, Resident 2 had blood in the urine. The “COC” dated 6/14/2025 indicated, Resident 2 had blood in the urine. RN 2 stated, Resident 2 was sent to the hospital. RN 2 stated, Resident 2 was on blood thinner [medications] and should be monitored for signs and symptoms of bleeding. RN 2 stated, Resident 2 should have been monitored closely and frequently for bleeding since Resident 2 was also on Amiodarone. RN 2 stated monitoring [for bleeding] was documented in the MAR (Medication Administration Record). A review of Resident 2’s “MAR” dated 6/2025, with RN 2, the MAR did not indicate monitoring for bleeding. RN 2 stated, there was no bleeding monitoring documented in Resident 2’s MAR. During an interview on 7/24/2025 at 9:52 AM with RN 4, RN 4 stated, Resident 2’s foley catheter (a type of urinary catheter) output should be monitored closely, so staff knew if Resident 2 had blood in the urine. During a review of the facility’s policy and procedure (P&P), titled “Resident Rights – Quality of Life,” revised 3/2017, the P&P indicated, the facility ensured that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, consistent with the resident’s comprehensive assessment and plan of care. B. During a review of Resident 83’s AR, the AR indicated the facility originally admitted Resident 83 4/21/2021, readmitted Resident 83 9/2/2023, and readmitted the resident 5/19/2025 with diagnoses including UTI, paraplegia (the loss of the ability to move the legs and lower body), and anxiety disorder (a mental illness characterized by excessive, persistent, and irrational worry or fear that can interfere with daily life). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 83’s MDS, dated [DATE], the MDS indicated Resident 83’s cognitive (the ability to think and process information) skills for daily decision making were moderately intact. During a review of Resident 83’s Progress Note dated 7/10/2025, timed at 2:19 PM, the progress note indicated, “Received new order from [Medical Doctor (MD)1] for [Resident 83] to obtain an infectious disease consult with follow up treatment as indicated secondary to [diagnosis] of MDRO in urine and recurrent UTI. [Resident 83] made aware and verbalized understanding… [MD 2], in-house [Infectious Disease Doctor], was notified…” During a review of Resident 83’s Progress Note, dated 7/21/2025, timed at 12:10 PM, the progress note indicated, “Sent [MD 2] a message requesting for an update regarding [Resident 83’s] infectious disease consult, pending response…” During a review of Resident 83’s OSR, dated active as of 7/24/2025, the OSR included a physician’s order, dated 7/10/2025, indicating “may have infectious disease consult with follow up treatment as indicated secondary to MDRO (Multi-Drug Resistant Organism-microorganisms, predominantly bacteria, that are resistant to antimicrobial agents [medications used to treat infections]) in urine and recurrent UTI.” The OSR indicated an order, dated 5/19/2025, for baclofen (a medication used to treat muscle spasms tablet 20 milligrams (mg-a unit of measurement) one tablet to be given by mouth every four hours as needed for muscle spasms. During a review of Resident 83’s Medication Administration Record (MAR), dated 7/1/2025 to 7/31/2025, the MAR indicated Resident 83 had received baclofen 20 mg one to three times daily from 7/1/2025 to 7/25/2025 for muscle spasms. During an interview on 7/21/2025 at 9:59 AM and 7/23/2025 at 12:50 PM with Resident 83, Resident 83 stated Resident 83 was concerned because Resident 83 had a history of recurrent UTIs. Resident 83 stated it had been a few weeks since the facility had reported Resident 83 was diagnosed with another UTI. Resident 83 stated Resident 83 was supposed to see an infectious disease doctor but had not seen them yet and Resident 83 was worried because no antibiotics had been prescribed. Resident 83 stated the facility had not updated Resident 83 on the status of the infectious disease doctor consultation for Resident 83. Resident 83 stated Resident 83 believed the UTI was causing Resident 83 to experience bladder spasms (a sudden, involuntary contraction of the bladder muscle causing pain and urine leakage) which resulted in pain for Resident 83. Resident 83 stated Resident 83 was worried the UTI would progress, and Resident 83 might die from the infection. During an interview on 7/23/2025 at 12:25 PM and 2:49 PM with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 83 was not receiving antibiotics for Resident 83’s current UTI. LVN 2 stated the infectious disease doctor was made aware of Resident 83’s UTI and the facility requested consultation with the infectious disease doctor on 7/10/2025 but the facility did not follow up with the infectious disease doctor until 7/21/2025. LVN 2 stated it was possible that the UTI infection could cause further health decline for Resident 83 during that time [7/10/2025-7/21/2025]. During an interview on 7/24/2025 at 4 pm with Director of Nursing (DON) 1, DON 1 stated Resident 83 had an order to see the infectious disease doctor for Resident 83’s UTI diagnosis. DON 1 stated the infectious disease doctor was made aware of the order on 7/10/2025 and the facility had not followed up on the appointment time until 7/21/2025. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility’s P&P titled, “Resident Rights-Quality of Life,” revised March 2017, the P&P’s purpose indicated, to ensure each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident’s comprehensive assessment and plan of care. The P&P indicated each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being.”

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow up with optometry (a healthcare profession that focuses on the examination, diagnosis, and treatment of eye and vision disorders) to replace a missing pair of glasses for one of one resident (Resident 13) in a timely manner.This deficient practice had the potential to result in worsened eyesight to Resident 13 and resulted in Resident 13 feeling frustrated and ignored.Findings:During a review of Resident 13's admission Record (AR), the AR indicated Resident 13 was admitted to the facility on [DATE] with multiple diagnoses including hemiplegia (muscle weakness or paralysis on one side of the body) affecting the right dominant side and polyneuropathy (condition where multiple peripheral [situated on the edge] nerves are damaged, causing widespread symptoms throughout the body such as numbness and pain.)During a review of Resident 13's Minimum Data Set (MDS - a resident assessment tool) dated 4/18/2025, the MDS indicated Resident 13 had moderate cognitive (ability to understand and process information) impairment and required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) for bathing and personal hygiene.During a review of Resident 13's Theft/ Loss Report (TLR), dated 7/3/2025, the TLR indicated Resident 13 reported missing glasses to the Social Services Assistant (SSA) on 7/3/2025. The TLR indicated the SSA called Resident 13's optometrist to replace the glasses.During an interview on 7/21/2025 at 3:40 PM, Resident 13 stated Resident 13 reported his glasses missing on 7/3/2025 and had not heard any updates since that day. Resident 13 stated Resident 13 felt frustrated that it was taking a long time to replace Resident 13's glasses. Resident 13 stated he felt as though the facility staff did not care and Resident 13 was being ignored. Resident 13 stated the glasses were used for reading which Resident 13 had not been able to do without glasses.During an interview on 7/23/2025 at 4:04 PM with the SAA, the SSA stated Resident 13 came into the social worker's office on 7/3/2025 and made a report that Resident 13's glasses were missing. The SSA stated the SSA made a call to the optometrist's office and was told that optometry would inform the facility when optometry would be coming back [to the facility]. The SSA stated no follow up phone calls had been made since 7/3/2025 and the SSA did not know when optometry would be coming back to the facility. The SSA stated Resident 13 had not been given any updates since the report was made. The SSA stated the SSA knew Resident 13 like to read periodicals and was unable to do so without glasses.During an interview on 7/24/2025 at 4 PM with the Director of Nursing (DON) 2, DON 2 stated facility staff could always do more to communicate progress of their issues with the residents. DON 2 stated a follow up phone call to optometry could have been made after the initial call on 7/3/2025 to help the residents feel happy and improve their stay and experience at the facility.During a review of the facility's policy and procedure (P&P) titled, Personal Property and Theft and Loss, revised 11/18/2021. The P&P indicated upon completion of the investigation of lost property, the administrator or designee will implement timely corrective action.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of three sampled residents (Resident 38 and Resident 24), were provided an environment free of accident hazards by failing to ensure:A. Resident 38's bed was in a low position when Resident 38 was at high risk for falls (refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of and overwhelming external force) and had a history of falls.B. Resident 24 did not keep cigarettes and a lighter in Resident 24's possession.This deficient practice had the potential to result in recurrent falls for Resident 38. Additionally, the deficient practice had the potential for Resident 24 to cause a fire and placed the residents and healthcare staff in danger.Findings: A. During a review of Resident 38's admission Record (AR), the AR indicated, Resident 38 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) not due to a substance or known physiological condition, difficulty in walking, not elsewhere classified and other lack of coordination (conditions characterized by impaired muscle coordination and balance). During a review of Resident 38’s “Care Plan” (CP) titled,” titled, “The resident is at risk for falls r/t (related to) confusion, gait/balance problems, incontinence” date initiated 7/17/2024, the “CP” indicated, one of the interventions was to follow facility fall protocol. During a review of Resident 38’s “History and Physical (H&P),” dated 2/15/2025, the “H&P” indicated, Resident 38 had fluctuating capacity to understand and make decisions. During a review of Resident 38’s “Change in Condition Evaluation (COC),” dated 5/21/25 timed at 10:57 AM, the “COC” indicated, Resident 38’s son (unidentified) made staff aware Resident 38 was in pain due to a claimed unwitnessed fall that occurred on 5/20/2025. During a review of Resident 38’s “CP” titled, “Resident claimed unwitnessed fall” date initiated 5/21/2025, the “CP” indicated, one of the interventions was to maintain Resident 38’s bed in lowest position. During a review of Resident 38’s “Order Summary Report (OSR),” active orders as of 7/24/2025, the “OSR” included a physician order, dated 5/22/2025, indicating Resident 38 may have low bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 38's Minimum Data Set” (MDS - a federally mandated resident assessment tool), dated 7/3/2025, the MDS indicated, Resident 38’s cognition (ability to think and make decisions) was moderately impaired. The MDS indicated, Resident 38 used a cane. The “MDS” indicated, Resident 38 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with sit to stand (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed). The “MDS” indicated, Resident 38 had one fall with injury (except major) e.g. skin tears, abrasions, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain) since admission/entry or reentry to the facility. During a concurrent observation and interview on 7/21/2025 at 1:15 PM with Certified Nurse Assistant (CNA) 4 in Resident 38’s room, Resident 38 was lying in bed watching tv. Resident 38’s bed was in a high position (at waist level of a 5.5-foot-tall person) and Resident 38’s cane was at the bedside. CNA 4 stated, CNA 4 was unsure why Resident 38’s bed was high since CNA 4 was not Resident 38’s “regular CNA.” CNA 4 stated, it was important for Resident 38’s bed positioned low because of the risk for falls. During a concurrent observation and interview on 7/21/2025 at 1:21 PM with Licensed Vocational Nurse (LVN) 7 in Resident 38’s room, Resident 38 was lying in bed watching tv. Resident 38’s bed was in a high position and Resident 38’s cane was at the bedside. LVN 7 stated, Resident 38’s bed position should not be high “because we do not want the resident to fall.” During a concurrent interview and record review on 7/24/2025 at 11:51 AM with Registered Nurse (RN) 5, Resident 38’s “Fall Risk Evaluation[s] (FRE),” dated 5/21/25, timed at 11:02 PM and dated 7/3/2025 timed at 8:58 PM were reviewed. The “FRE” indicated, “if the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls.” RN 5 stated, the “FRE” dated 5/21/2025 timed at 11:02 PM indicated a score of 15 and the “FRE” dated 7/3/2025 timed at 8:58 PM indicated a score of 13. RN 5 stated, one of the fall preventions [interventions] was to ensure the bed was in a low position to ensure Resident 38 did not fall and/or sustained injuries. During a review of the facility’s policy and procedure (P&P) titled, “Fall Prevention and Management Program,” date revised 8/1/2014, the P&P indicated, the facility provided a safe environment that minimized complications associated with falls. The P&P indicated, the facility would implement a fall prevention and management program that supported providing an environment free from the hazards over which the facility had control. B. During a review of Resident 24’s AR, the AR indicated the facility admitted Resident 24 on 3/18/2025, with diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and history of falling. During a review of Resident 24’s CP titled “the resident has impaired thought processes related to the resident was alert, forgetful,” initiated on 3/28/2025, the CP’s interventions indicated to cue, reorient, and supervise the resident as needed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 24’s CP titled “tobacco use”, initiated on 5/2/2025, the CP indicated a goal for Resident 24 was to adhere to the tobacco/smoking policies of the facility. During a review of Resident 24’s MDS, dated [DATE], the MDS indicated Resident 24’s cognition was intact. The MDS indicated Resident 24 required setup or clean-up assistance with eating, toileting hygiene, personal hygiene, walked 10-150 feet, and was independent with bed mobility. During a review of Resident 24’s Interdisciplinary Team (IDT, a team of health care professionals who work together to establish plans of care for residents) meeting dated 7/9/2025, the IDT meeting notes indicated Resident 24 did not want activities [department] to hold Resident 24’s cigarettes and Resident 24 wished to keep his cigarettes and lighter with Resident 24. The IDT meeting indicated Resident 24 agreed for the facility to provide the resident with a safety box and a key to keep the cigarettes and lighter locked. The IDT meeting notes indicated Resident 24 would like to smoke earlier than the first smoking schedule and the Administrator (ADM) would add another slot (6:00 AM) to the smoking schedule. During a review of Resident 24’s document titled “Smoking and Safety” (SS) evaluation, dated 7/9/2025, the SS evaluation indicated Resident 24 would adhere to the Tobacco/Smoking Policies of the facility. The SS evaluation indicated supervision, designated smoking location, and smoking times were determined by facility policy. During a concurrent interview and observation on 7/23/2025 at 10:35 AM, Resident 24 stated Resident 24 kept his own cigarettes and lighter. Resident 24 showed the surveyor a half pack of cigarettes and a black colored lighter. Resident 24 stated Resident 24 followed up with the ADM regarding the safety box but did not get a safety box so Resident 24 stated he kept the cigarettes and lighter. Resident 24 stated the resident bought the cigarettes and lighters and needed to have his own lighter because Resident 24 wanted to smoke earlier than the scheduled smoking time and Resident 24 went outside the facility to smoke around 5 AM or 6 AM. During an interview on 7/23/2025 at 4:46 PM, the ADM stated the facility would not collect the lighter from Resident 24. The ADM stated Resident 24 was assessed as independent with smoking and independent smokers had agreed to return lighters to the nurses to be kept at the medication cart. The ADM stated Resident 24 might have returned to his room without returning the lighter and cigarettes. During a review of Resident 24’s IDT meeting notes, dated 7/23/25, timed at 4:58 PM, the IDT meeting notes indicated the IDT met with Resident 24 on 7/11/25 to discuss the agreement to keep Resident 24’s cigarettes in a safe box. The IDT notes indicated the safety box was not an option due to safety reasons and the cigarettes needed to be kept by facility staff and provided to Resident 24 when needed. The IDT notes did not indicate a plan for Resident 24’s lighter. During an interview on 7/23/2025 at 5:14 PM, LVN 5 stated LVN 5 was the assigned nurse to care for Resident 24. LVN 5 opened the medication cart, there was a blue colored lighter inside the medication cart and no cigarettes inside the medication cart. LVN 5 stated the LVN would not have to follow-up with Resident 24 regarding the resident’s lighter and cigarettes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/25/2025 at 4:10 PM with the Director of Nursing (DON), the DON stated it would not be safe to allow residents to have cigarettes and lighters at the bedside [in resident rooms] because of the risk of fire. The DON stated there were residents [who required the use of] oxygen within the building. The DON answered “Yes” when asked if the residents in the subacute unit were administered oxygen and answered “Yes” when asked if the subacute unit was in the same building? During a review of the facility’s Order Listing Report (OLR) dated 7/25/2025, the OLR indicated 21 residents with continuous oxygen and 7 residents had physician orders for oxygen administration as needed. During a review of the undated facility map, undated facility census, and the OLR dated 7/25/2025, the documents indicated the residents in room [ROOM NUMBER], 215C, 214C, and 108A were being administered oxygen and were located close to Resident 24’s room. During a review of the facility’s P&P titled “Smoking Residents” dated 8/18/2023, the P&P indicated the IDT would develop an individualized plan of care for safe storage, use of smoking materials, assistance and/or required supervision, for residents who smoke. The P&P indicated the resident and/or responsible party will be educated regarding the risks of smoking and the smoking safety measures recommended by the IDT. The P&P indicated this will be documented in the resident’s clinical record.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure appropriate treatment and catheter care services for two of three sampled residents (Resident 147 and Resident 2). For Resident 147 and Resident 2, who had indwelling catheters (a medical device that drains urine from your bladder into a bag outside your body), there was no assessment or monitoring of the catheters for any change in condition.This deficient practice could potentially result in Resident 147 to develop a urinary tract infection (UTI - an infection in the bladder/urinary tract) and Resident 2 to develop a recurrence of a UTI leading to more serious complications. Findings:During a review of Resident 147's admission Record (AR), the AR indicated Resident 147 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including encounter for attention to tracheostomy (a surgically created hole [stoma] in your windpipe [trachea] that provides an alternative airway for breathing), neuromuscular dysfunction of bladder (neurogenic bladder - lacks bladder control due to a brain, spinal cord, or nerve condition), and unspecified functional quadriplegia (complete inability to move due to severe disability).During a review of Resident 147's Physician's History & Physical (H&P) dated 3/19/2025, the H&P indicated Resident 147 was not capable of participating in the plan of care. During a review of Resident 147's Minimum Data Set (MDS, a resident assessment tool), dated 5/12/2025, the MDS indicated Resident 147's cognitive skills (ability to think and process information) for daily decision making were severely impaired. The MDS indicated Resident 147 had an indwelling catheter (including suprapubic catheter and nephrostomy tube).During a review of the Physician's Order Summary Report (OSR) as of 7/24/2025, the OSR indicated that on 6/24/2024 Resident 147 was to receive a change of foley catheter and foley drainage bag as needed for leaking, occlusion, dislodgement, and excessive sedimentation. The OSR indicated an order on 9/16/2024 for UTI-Stat oral liquid, give 30 ml (milliliters - a measure of volume) via gastrostomy tube (G-Tube - a type of feeding tube) two times a day for UTI prophylaxis (an attempt to prevent disease).During a review of Resident 147's Care Plan (CP) titled, Resident has foley catheter (#16) r/t (related to) neurogenic bladder, initiated 8/10/2022, the CP indicated the goal was for Resident 147 to show no signs and symptoms of UTI. The care plan interventions indicated foley catheter care to be provided every shift and prn (as needed), monitor output, and monitor for signs and symptoms of UTI.During a review of Resident 147's CP titled, Risk for impaired urinary elimination, dated 3/24/2025, the CP intervention indicated to evaluate the character of urine.During a review of Resident 147's CP titled, Risk for urinary tract infection, dated 5/21/2025, the CP intervention indicated to evaluate urine characteristics.During a review of Resident 2's AR, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including encounter for attention to tracheostomy, sepsis (a life-threatening blood infection), unspecified organism, and urinary tract infection site not specified.During a review of Resident 2's H&P dated 6/22/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions.During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making was severely impaired and Resident 2 had an indwelling catheter.During a review of the Physician's Order Summary Report (OSR) as of 7/1/2025, the OSR indicated on 6/20/2025 for Resident 2 to receive a Foley (a brand of indwelling catheter) / SP (suprapubic) catheter provided every shift, Foley Catheter maintenance, and an order for indwelling catheter size 16Fr with 5 ml (milliliters) balloon (inflated with 10 ml sterile water) via gravity drainage, for neurogenic bladder. The OSR indicated on 6/23/2025 for Resident 2 to receive a urology consult and follow up as needed.During a review of Resident 2's CP titled, The resident has indwelling catheter for neurogenic bladder, dated 4/24/2025, the CP indicated the goal was for Resident 2 to show no signs and symptoms of a urinary infection, to monitor the output, and monitor for signs and symptoms of UTI.During a concurrent observation and interview on 7/21/2025 at 10:40 AM with Registered Nurse Supervisor (RN) 3, Resident 147's F/C was draining to gravity, and cloudy urine with sediments were observed. RN 3 stated Resident 147 had a F/C for neurogenic bladder and started milking the F/C (a technique used to clear obstructions within the catheter tubing and encourage urine flow) as more urine with sediments drained out. RN 3 stated due to the sediments, it was important to monitor for infection, specifically for UTI. RN 3 stated the facility had standard orders for flushing the F/C, a urology (a medical and surgical specialty that focuses on the urinary tracts) consult, and for F/C change.During a concurrent observation and interview on 7/21/2025 at 11:16 AM with RN 3, Resident 2's F/C was draining to gravity, with cloudy urine sediments observed. RN 3 stated Resident 2 had an indwelling catheter for

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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. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of one sampled resident (Resident 115), who was receiving enteral feeding (nutrition taken through the mouth or through a tube that goes directly to the stomach or small intestine), received appropriate care and services by failing to respond timely to the continuous alarm (beeping) from Resident 115's gastrostomy tube (GT - a type of feeding tube) pump. This deficient practice could lead to GT complications and potentially harm Resident 115.Findings:During a review of Resident 115's admission Record (AR), the AR indicated Resident 115 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen [02] into the blood or eliminate enough carbon dioxide [C02, a colorless, odorless gas that is a waste product made by the body], unspecified whether with hypoxia (low levels of 02 in the body), or hypercapnia (abnormally high level of CO2 in the blood), encounter for attention to tracheostomy (a surgically created hole [stoma] in your windpipe [trachea] that provides an alternative airway for breathing), and encounter for attention to gastrostomy (a surgical procedure used to insert a tube, often referred to as GT through the belly that brings nutrition and/or medications directly to the stomach). During a review of Resident 115's Physician's History & Physical (H&P) dated 10/21/2024, the H&P indicated Resident 115 was not capable of participating in the plan of care.During a review of Resident 115's Minimum Data Set (MDS - a resident assessment tool) dated 6/6/2025, the MDS indicated Resident 115 was cognitively intact (no problems with memory, orientation, and judgement). The MDS indicated Resident 115 was dependent (helper does all of the effort) to requiring partial/moderate assistance (helper does less than half the effort) for activities of daily living. The MDS indicated Resident 115's nutritional approaches included a feeding tube and mechanically altered diet (require change in texture of food or liquids).During a review of the Physician's Order Summary Report (OSR) as of 7/24/2025, the OSR indicated on 6/12/2025 for Resident 115 to receive a regular small portion diet, pureed texture, nectar thick consistency. The OSR indicated on 11/4/2024 for enteral feed two times a day continuous H20 (water) flushes at 35 ml/hr (milliliters [a measure of volume] per hour) x 20 hrs=700 ml/24hrs, start pump at 2 PM until 10 AM or until dose limits were met. The OSR indicated on 3/4/2025 Resident 115 to receive enteral feeding, two times a day Jevity 1.2 (a high-protein, fiber-fortified, complete and balanced nutritional formula designed for tube feeding) at 40ml/hr via GT x 20 hrs, start pump at 2 PM and stop 10 AM or until dose limit met.During a review of Resident 115's Care Plan (CP) titled, The resident requires tube feeding G tube r/t dysphagia (difficulty swallowing), dated 9/22/2023, the CP indicated one of the goals was for Resident 115 to remain free of side effects or complications related to tube feeding.During a review of Resident 115's CP titled, The resident is at risk for nausea and vomiting r/t. presence of gastrostomy tube, dated 9/22/2023, the CP intervention indicated to maintain a quiet restful environment.During an observation on 7/21/2025 at 9:50 AM, Resident 115 was asleep in bed and Resident 115's GT pump started alarming. During a concurrent observation and interview on 7/21/2025 at 10:12 AM with Resident 115, Resident 115's GT pump continued to alarm indicating, Caution: Patient Tube Block. The GT pump had a bottle of Jevity 1.2 and water flush bag loaded. The tube feed was dated 7/20, start time 10:15p, rate 40 ml/hr and had 750 ml left in the bottle. Resident 115 mouthed, the beeping had been almost half an hour and it gets annoying while gesturing covering her right ear. During a concurrent observation and interview on 7/21/2025 at 10:15 AM with Licensed Vocational Nurse (LVN) 6, Resident 115's GT pump continued to alarm indicating, Caution: Patient Tube Block. LVN 6 stated Resident 115's GT pump alarm should have been checked if there was another licensed nurse since LVN 6 was on the other side (of the unit). LVN 6 stated, LVN 6 was unsure what the cause of the beeping, it showed blocked. LVN 6 stated it was important to fix the cause of the beeping because the GT could get clogged and cause more complications.During an interview on 7/24/2025 at 8:38 AM, Registered Nurse Supervisor (RN) 3 stated part of the care and maintenance of a tube feeding included ensuring the tube was not kinked which could result in Resident 115 not getting the complete feeding nutrition ordered and the tube to get clogged.

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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 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 and record review, the facility failed to ensure one of one sampled resident (Resident 115), received proper respiratory (relating to breathing) care by failing to ensure Resident 115's tracheostomy (trach - a surgically created hole [stoma] in your windpipe [trachea] that provides an alternative airway for breathing) mask (T-mask) was properly in place. This deficient practice resulted in Resident 115 not receiving the physician ordered oxygen (02 - a colorless, odorless, tasteless gas essential for living) therapy, could potentially cause Resident 115's respiratory status (the movement of air in and out of the lungs) to be compromised, and could lead to respiratory distress / failure.Findings:During a review of Resident 115's admission Record (AR), the AR indicated Resident 115 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen [02] into the blood or eliminate enough carbon dioxide [C02, a colorless, odorless gas that is a waste product made by the body), unspecified whether with hypoxia (low levels of 02 in the body), or hypercapnia (abnormally high level of CO2 in the blood), encounter for attention to tracheostomy and other specified diseases of upper respiratory tract.During a review of Resident 115's Physician History & Physical (H&P), dated 10/21/2024, the H&P indicated Resident 115 was not capable of participating in the plan of care.During a review of Resident 115's Minimum Data Set (MDS - a resident assessment tool), dated 6/6/2025, the MDS indicated Resident 115 was cognitively intact (no problems with memory, orientation, and judgement). The MDS indicated Resident 115 was dependent (helper does all of the effort) to requiring partial/moderate assistance (helper does less than half the effort) for activities of daily living and the resident had respiratory treatments including oxygen therapy and tracheostomy care.During a review of the Physician's Order Summary Report (OSR) dated 7/24/2025, the OSR indicated that on 5/15/2025 Resident 115 was to receive a T-mask with humidification oxygen, titrate (adjust) 1-5 (one to five) 02 LPM (liters per minute) to maintain 02 saturation (a measurement of how much 02 the blood is carrying as a percentage) greater than or equal to 92% (ninety two percent) every shift, for respiratory failure.During a review of Resident 115's Care Plan (CP) titled, The resident has a tracheostomy r/t (related to) impaired breathing mechanics, dated 9/22/2023, the CP intervention indicated to ensure the trach ties were secured at all times. During a concurrent observation and interview on 7/21/2025 at 9:54 AM with Respiratory Therapist (RT) 1, Resident 115 was asleep in bed with Resident 115's T-mask on the left side of Resident 115's neck. Resident 115's trach tie was slightly loose, and the trach mask was on 2L/min 02. RT 1 stated Resident 115 moved and Resident 115's T-mask was not on Resident 115's trach and should be right on the stoma for Resident 115 to get the proper oxygenation.During an interview on 7/24/2025 at 8:38 AM, Registered Nurse Supervisor (RN) 3 stated part of the care and maintenance of a trach mask or for any medical device was to ensure proper placement. RN 3 stated Resident 115's trach mask not directly on the stoma could result in Resident 115 getting out of breath, short of breath and not getting the 02 as ordered. That's what a trach mask is for.During a review of the facility's policy and procedure (P&P) titled, Tracheostomy Care, dated 7/30/2020, the P&P indicated all residents using tracheostomy tubes would be provided routine tracheostomy care to prevent airway obstruction, impaired ventilation and infection.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure performance evaluations (PEs) were conducted every 12 months for one out of four certified nursing assistants.This deficient practice had the potential to compromise resident safety and well-being. During a record review of CNA 7's personnel file, no PE was due as of 7/25/25 due to a recent date of hire for CNA 7.During a concurrent interview and record review on 7/25/25 at 7:45 a.m. with the Director of Development (DSD), the DSD provided the two most recent PEs for CNA 4, CNA 5 and CNA 6.CNA 4 and CNA 6 received timely PEs or were not yet due for their annual PE as of 7/25/25.CNA 5 was due for a PE on or before 5/26/24 and 5/26/25. The DSD provided 2 PEs for CNA 5, one dated 6/2/25 and the second PE dated 4/10/23. CNA 5's PE dated 6/2/25 indicated the evaluation was signed only by the evaluator and not by CNA 5. The PE date of 6/2/25 indicated it was late by 7 days. There was no record of a PE given to CNA 5 in 2024. During an interview with CNA 5 on 7/25/25 at 11:22 a.m., CNA 5 stated he had not seen or signed the PE dated 6/2/25. CNA 5 stated he did not receive a PE in 2024. CNA 5 stated he remembered the performance review from 4/10/23. CNA 5 stated he signed and dated the performance review from 4/10/23. CNA 5 stated the 2023 performance review dated 4/10/23 was the most recent PE CNA 5 received.During an interview with the Administrator on 7/25/25 at 3:31 p.m., the Administrator stated the facility did not have a policy for staff performance evaluation review. The Administrator provided a copy of HR01 Staff Competency Validation Policy, and stated the facility follows all state and federal regulations regarding performance evaluation review. During a review of the facility's policy and procedure (P&P) titled, HR01 Staff Competency Validation, effective date 6/4/24, the P&P indicated, Policy: Competency validation is completed to evaluate an individual's performance, evaluate group performance, meet standards set by regulatory agencies, address problematic issues, and enhance performance reviews. Competency validation is a determination based on an individual's satisfactory performance of each specific element of his/her job description, and of the specific requirements for the area in which he or she is employed. The P&P further indicated, Purpose: To protect the health, safety, and well-being of residents.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the pharmacist's recommendations, dated 5/31/2025 and 6/30/2025 on the Medication Regimen Review (MRR), related to Tylenol (a pain reliever and fever reducer) was acted upon for one of two sampled residents (Resident 5).This deficient practice placed the resident at risk of not receiving the correct dosage of Tylenol from May 31, 2025 to July 25, 2025. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was originally admitted to the facility on [DATE] with diagnoses that included non-pressure chronic ulcer of right ankle with unspecified severity, unspecified edema (swelling caused by an accumulation of fluid in the body's tissues) and cellulitis (a skin infection that causes swelling and redness) of right lower limb.During a review of Resident 5's History and Physical (H&P) dated 1/25/2025, the H&P indicated Resident 5 had the capacity to understand and make decisions.During a review of the Minimum Data Set Assessment (MDS, a standardized assessment and care screening tool), dated 5/1/2025, the MDS indicated Resident 5's cognition (ability to understand and process information) was moderately impaired.During a review of Resident 5's Medical Administration Record (MAR) for the month of May 2025, The MAR indicated the resident had Tylenol oral tablet 325 MG and instructed to give 2 tablets by mouth every six hours as needed for Mild Pain 1-4 NTE 3gm/24hr of APAP from all sources, start date 10/21/2024 1045.During a review of Resident 5's Medical Administration Record (MAR) for the month of June 2025, the MAR indicated the resident had Tylenol oral tablet 325 MG and instructed to give 2 tablets by mouth every six hours as needed for Mild Pain 1-4 NTE 3gm/24hr of APAP from all sources, start date 10/21/2024 1045.During a review of Resident 5's Medical Administration Record (MAR) for the month of July 2025, the MAR indicated the resident had Tylenol oral tablet 325 MG and instructed to give 2 tablets by mouth every six hours as needed for Mild Pain 1-4 NTE 3gm/24hr of APAP from all sources, start date 10/21/2024 1045.During a review of the Medication Regimen Review (MRR) for Resident 5, dated 5/31/2025, the MRR indicated the pharmacist recommended to change Tylenol (acetaminophen) 325mg 2-tabs Q6H prn (as needed) pain. Please NOTE: If there is a PRN pain medication for moderate or severe or mild pain, then there has to be one for all levels. All levels of pain need to be addressed. If not, then PRN Pain is adequate. Follow-through column further indicated, No change.During a review of the Medication Regimen Review (MRR) for Resident 5, dated 6/30/2025 the MRR indicated the pharmacist recommended to change Tylenol (acetaminophen) 325mg 2-tabs Q6H prn (as needed) pain. Please NOTE: If there is a PRN pain medication for moderate or severe or mild pain, then there has to be one for all levels. All levels of pain need to be addressed. If not, then PRN Pain is adequate. Follow-through column had no notes.During a review of the Progress Notes for Resident 5, dated 7/9/2025, the Progress Notes indicated an order note with the system having identified a possible drug interaction with the following orders: Tylenol Oral [NAME] 325 MG. Interaction: The analgesic and antipyretic effectiveness of acetaminophen might be delayed and/or reduced when given concurrently with Benztropine Mesylate Oral Tablet 1 MG, Olanzapine Oral Tablet 15 MG, and Zyprexa Oral Tablet 15 MG.During a concurrent interview and record review on 7/24/2025 at 3:54 PM with the Director of Nursing (DON) 1, Resident 5's Medication Regimen Review (MRR), dated 5/31/2025 & 6/30/2025 was reviewed. The MRR's indicated the pharmacist recommendations for Tylenol were not acted upon and documented by the facility staff and or the prescriber. DON 1 stated, pharmacist recommendations were not followed due to facility protocol. Pain medication needs to specify pain scale of mild pain (1-4 pain scale).During a concurrent interview and record review on 7/25/2025 at 2:52 PM with the Assistant Director of Nursing (ADON), Resident 5's Medication Regimen Review (MRR), dated 5/31/2025 & 6/30/2025 was reviewed. The MRR's indicated the pharmacist recommendations for Tylenol were not acted upon and documented by the facility staff and or the prescriber. The ADON stated, the pharmacist recommendations are documented on the PCC - progress notes and the ADON was Still looking for May & June progress notes on the doctor's decisions to accept or decline recommendations. Following proper medication protocols: the pharmacist gives recommendations for medications. We contact the doctor with those recommendations and document in the progress notes to show communication with the doctor. The main goal is to keep the patient safe.During a review of the facility's policy and procedure titled, Consultant Pharmacist Reports: Medication Regimen Review dated October 2012, the policy indicated, G. Recommendations are acted upon and documented by the facility staff and or the prescriber

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure milk was not left at room temperature for more than 2 hours for three of three sampled residents (Resident 20, Resident 72 and Resident 98).This deficient practice had the potential to result in foodborne illness.a. During a review of Resident 20 admission Record (AR), the AR indicated the facility admitted Resident 20 on 11/21/2020, with diagnoses that included generalized muscle weakness, hypothyroidism (when the thyroids does not make and release enough hormone into the bloodstream which slows down metabolism which make you gain weight or feel tired all the time).During a review of Resident 20's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 3/2/2025, the MDS indicated Resident 20 had moderate cognitive deficit, the MDS indicated Resident 20 required setup or clean-up assistance with eating, and with bed mobility such as rolling left and right, sit-to-lying, lying-to-sitting.b. During a review of Resident 72's AR, the AR indicated the facility admitted Resident 72 on 3/16/2025, with diagnoses that included dysphagia (difficulty swallowing), generalized muscle weakness.During a review of Resident 72's MDS dated [DATE], the MDS indicated Resident 72 had moderate cognitive deficit, the MDS indicated Resident 72 required maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) with eating and was dependent with all bed mobility.c. During a review of Resident 98's AR, the AR indicated the facility admitted Resident 98 on 1/31/2025, with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning), type 2 diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine).During a review of Resident 98's MDS dated [DATE], the MDS indicated Resident 98 had moderate cognitive deficit, the MDS indicated the resident required setup or clean-up assistance with eating and supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with rolling left and right for bed mobility.During an observation on 7/21/2025 at 3:46 PM with the Dietary Services Supervisor (DSS), there was a carton of milk, a cup of cranberry juice and apple juice on top of Resident 72's table placed in front of Resident 72.During a concurrent observation and interview on 7/21/2025 at 3:49 PM with the DSS, there was milk on top of Resident 98's table. Resident 98 stated the milk came with the lunch tray and stated the resident would still drink the milk.During a concurrent observation and interview on 7/21/25 3:51 PM with the DSS, there were 2 cartons of milk on top of Resident 20's table, within reach of the resident. Resident 20 stated would still drink the milk later.During an interview 7/21/2025 at 3:58 PM, the DSS stated residents need to finish the milk before 2 hours would be up by encouraging the resident to finish the milk and dispose of the milk before 2:30 PM. The DSS stated when milk leaves the kitchen, the temperature of the milk would be at 41.F or less, when the temperature is above 41.F, bacteria could grow and could put the residents at risk for nausea, vomiting and/or diarrhea.During a review of the facility's Policy and Procedure (P&P) titled Food Storage and Handling dated 6/4/2024, the P&P indicated eggs and dairy should be stored at a temperature below 41 degrees Fahrenheit, dairy items should be kept under refrigeration until use.

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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 interview and record review, the facility failed to document Restorative Nursing Aide (RNA, nursing aide program that helps residents to maintain their function and joint mobility) services provided for one of one resident (Resident 193) as per the facility's policy and procedure (P&P) titled, Documentation, dated 1/1/2012.This deficient practice led to inaccuracies in Resident 193's medical record and had the potential to lead to inconsistent RNA treatments provided to Resident 193.Findings:During a review of Resident 193's admission Record (AR), the AR indicated Resident 193 was admitted to the facility on [DATE] with multiple diagnoses including quadriplegia (paralysis of all four limbs) and cerebral palsy (a group of conditions that affect movement and muscle tone or posture).During a review of Resident 193's Minimum Data Set (MDS - a resident assessment tool) dated 5/6/2025, the MDS indicated Resident 193 had severely impaired cognition (ability to understand and process information) and was dependent on staff (helper does all of the effort) for personal hygiene and bathing.During a review of Resident 193's Documentation Survey Report v2 (DSR), dated July 2025, the DSR indicated orders for RNA to perform passive range of motion passive range of motion (PROM, movement of a joint through the ROM with no effort from person) to the right and left lower extremities five times a week or as tolerated and RNA to perform passive range of motion exercises to the right and left upper extremities (arms) five times a week or as tolerated. The DSR indicated RNA to apply hand rolls (soft, cylindrical devices used to keep the fingers from being held in a tight fist) to the right and left wrist. The DSR indicated RNA services were provided to Resident 193 four out of five times during the week of 7/7/2025 to 7/13/2025. The DSR did not indicate RNA services were provided to Resident 193 on 7/10/2025.During an interview on 7/24/2025 at 9:21 AM with RNA 1, RNA 1 stated RNA 1 could not recall anything that occurred on 7/10/2025. RNA 1 stated there should have been documentation to indicate if the staff were not able to perform the ordered services. RNA 1 stated the documentation appeared to indicate services were not provided on 7/10/2025 and missed without reason.During an interview on 7/24/2025 at 3:15 PM with RNA 1, RNA 1 stated according to RNA 1's hand written notes from the week of 7/7/2025 to 7/13/2025, RNA 1 had completed all RNA services for Resident 193 but failed to document on the facility's charting system.During an interview on 7/24/2025 at 4:06 PM with Director of Nursing (DON) 2, DON 2 stated RNA services performed should documented accurately to show services given to Resident 193. During a review of the facility's P&P, dated 1/1/2012, the P&P indicated treatment provided by RNAs will be documented on a daily basis and there will be at least weekly documentation of the progress, response to treatment and functional status of each resident in the Restorative Nursing Program.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain and implement its infection control program by failing to ensure:a. personal toiletries were labeled and not stored inside the shared restroom for three of three sampled residents (Resident 38, Resident 107 and Resident 195), b. the lint trap for one of four sampled dryers (Dryer 4) was clean and did not have an excessive lint buildup.These deficient practices had the potential to spread the transmission of disease, infection, and the potential for a fire hazard, which placed residents including Resident 38, Resident 107 and Resident 195 and the healthcare staff at risk. Findings:a.During a review of Resident 38's admission Record (AR), the AR indicated Resident 38 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cellulitis (a bacterial infection of the skin's deeper layers) of the right and left lower limbs, local infection of the skin and subcutaneous tissue, unspecified, and immunodeficiency (prevents your body from fighting infections and diseases) due to conditions classified elsewhere.During a review of Resident 38's History and Physical (H&P) dated 2/15/2025, the H&P indicated Resident 38 had fluctuating capacity to understand and make decisions. During a review of Resident 38's Minimum Data Set (MDS - a resident assessment tool), dated 7/3/2025, the MDS indicated Resident 38 had moderately impaired cognitive status (problems with thinking, memory, judgement). The MDS indicated Resident 38 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with personal hygiene. During a review of Resident 107's AR, the AR indicated Resident 107 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including unspecified dementia (a progressive state of decline in mental abilities), anxiety (a mental health condition characterized by persistent, excessive fear or worry that significantly interferes with daily life), and personal history of Coronavirus 2019 (COVID-19, a mild to severe respiratory illness that spreads from person to person).During a review of Resident 107's MDS dated [DATE], the MDS indicated Resident 107 had severely impaired cognitive status and required setup or clean-up assistance with personal hygiene.During a review of Resident 107's H&P dated 6/14/2025, the H&P indicated Resident 107 was not capable of participating in the plan of care.During a review of Resident 195's AR, the AR indicated Resident 195 was admitted to the facility on [DATE] with diagnoses including unspecified dementia, chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), and muscle weakness (generalized).During a review of Resident 195's H&P dated 4/24/2024, the H&P indicated Resident 195 was alert, oriented to person and place, but not to time, and had decisional capacity (ability to make their own medical decisions).During a review of Resident 195's MDS dated [DATE], the MDS indicated Resident 195 had severely impaired cognitive status and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with personal hygiene.During a concurrent observation and interview on 7/21/2025 at 1:32 PM with Licensed Vocational Nurse (LVN) 7, inside the restroom shared by Resident 38, Resident 107 and Resident 195, an opened, unlabeled can of Fresh Scent (brand name) shave cream was observed. There were two unlabeled, used hairbrushes (one wooden and one white plastic) with few strands of hair and two unlabeled plastic drinking cups stored on top of the paper towel dispenser. LVN 7 stated personal toiletries were supposed to be kept at the resident's (in general) bedside for infection control.During an interview on 7/24/2025 at 3:36 PM, the Infection Preventionist Nurse (IPN) stated residents had their own personal toiletries, which were labeled with resident's name and room number on them prior to the resident using the personal toiletries. The IPN stated these toiletries were kept at the resident's bedside table to prevent usage from other residents and prevent contamination for infection control.During a review of the facility's policy and procedure (P&P) titled, IPC213 Prevention of Cross-Contamination: Resident care items, dated 5/4/2023, the P&P indicated resident care items would be clearly labelled with the resident's name and/or room number upon placing them into service for that resident. The P&P indicated the purpose was to prevent cross-contamination from use of another resident's / unidentified personal care items / belongings and prevent healthcare associated infections.b. During an observation and interview on 7/24/2025 at 9:22 AM, inside the Clean Area of the Laundry Room, with Laundry (LD) Staff 1 and LD Staff 2, there were four commercial dryers. Dryer #1 and Dryer #3 were currently in use. Dryer #2 had signage posted on the door indicating No Sirve (not in service). Dryer #4 was not currently in use and had an excessive lint buildup in the lint trap. LD 2 stated staff used Dryer #4 a lot During a concurrent interview and record review on 7/24/2025

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation and interview, the facility failed to maintain electrical equipment in a safe operating condition when one of one 3-door reach in refrigerator (Refrigerator 1 - a type of commercial refrigerator used in food service that is designed for easy access and storage of items within arm's reach) had water dripping from the condenser fan (a component of the refrigeration system that helps maintain the cooling system) onto the containers below.This failure had the potential to result in food contamination and foodborne illnesses (illness caused by food contaminated with bacteria) for the residents consuming the food at the facility.Findings:During an observation on 7/21/2025 at 8:45 AM in the kitchen, water was observed dripping from the condenser fans located in the ceiling of Refrigerator 1 onto pitchers of juice and water. During an observation and interview on 7/22/2025 at 11:02 AM in the kitchen, with the Dietary Services Supervisor (DSS), water was observed dripping from the condenser fans of Refrigerator 1 onto salad bowls. The DSS stated the salads were prepared for the residents. The DSS stated water should not be dripping from the condenser fans onto the food located below the condenser fans. During an interview on 7/23/2025 at 9:24 AM with the DSS, the DSS stated the water dripping onto the food and containers below the condenser fans could possibly cause food contamination endangering resident's (in general) health.During an interview on 7/24/2025 at 12:29 PM with the Assistant Maintenance Director (AMD), the AMD stated Refrigerator 1 should not have water dripping from the condenser fans and was not working properly. The AMD stated the refrigerator needed to be fixed.During a review of the facility's Policy and Procedure (P&P) titled, Maintenance Service, revised 1/1/2012, the P&P indicated, to protect the health and safety of residents, visitors, and facility staff. The P&P indicated the maintenance department maintains all areas of the building, grounds, and equipment. The P&P indicated the maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review, the facility failed to ensure one of 43 sampled residents (Resident 6) had a call light (a device used to call for assistance) within reach.This failure had the potential to result in Resident 6 being unable to call for assistance and delayed care to Resident 6.Findings:During a review of Resident 6's admission Record (AR), the AR indicated the facility admitted Resident 6 on 12/20/2024 with diagnoses including difficulty in walking and lack of coordination (the ability of the body to work together to perform movements or actions).During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool), dated 6/19/2025, the MDS indicated Resident 6's cognitive (the ability to think and process information) skills for daily decision making were intact. The MDS indicated Resident 6 was dependent (helper does all the effort) with toileting, shower/bathing, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 6 required substantial/maximal assistance (helper does more than half the effort) with oral hygiene and upper body dressing and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating.During an observation on 7/21/2025 at 11:30 AM in Resident 6's room, Resident 6's call light was located on the floor beside Resident 6's bed.During an interview on 7/21/2025 at 11:35 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 6's call light was not within reach of Resident 6. LVN 1 stated the call light should be within reach so Resident 6 called for help if needed.During an interview on 7/24/2025 at 4 PM with the Director of Nursing (DON) 1, DON 1 stated call lights should be within reach of Resident 6 so that the resident can get assistance if needed.During a review of the facility's Policy and Procedure (P&P) titled, Communication-Call System, revised 8/24/2024, effective 10/9/2024, the P&P indicated, The call alert device will be placed within the resident's reach.