STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555883	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Anaheim Medical Center D/P Snf	3033 W Orange Ave Anaheim, CA 92804

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the appropriate care and services for the use of the GT were provided for four of six final sampled residents (Residents 3, 4, 8, and 12) reviewed for tube feedings. * The facility failed to ensure Resident 3 and 4's HOB were elevated above 35 degrees while the enteral feeding formula was infusing, as per the physician's orders. * The facility failed to ensure Resident 12's enteral feeding formula was labeled with the correct feeding rate. * The facility failed to ensure LVN 1 mixed the crushed medication with water prior to the administration of the medication via GT for Resident 8. These failures posed the risk of complications related to use of the GT for Residents 3, 4, 8, and 12.Findings: Review of facility's P&P titled Enteral Feeding, Administration Of dated 10/28/25, showed for the pump or infusion controller method, to elevate the head of the bed at a 30-to-45-degree angle, except during direct resident care. 1. On 3/24/26 at 0824 hours, Resident 12 was observed in bed with the HOB elevated and the GT feeding of [NAME] Farms (enteral feeding formula) running at 35 ml/hr via the GT. The feeding rate on Resident 12's enteral feeding formula bag was labeled 5A. Medical record review for Resident 12 was initiated on 3/24/26. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's Active Order Sets showed a physician's order dated 1/22/26, to administer tube feeding with [NAME] Farms 1.4 via GT at 35 ml/hr continuously for 24 hours daily. May use Compleat Peptide (enteral feeding formula) 1.5 at 35 ml/hr continuously as an alternate if out of [NAME] Farms. On 3/24/26 at 0841 hours, an observation and concurrent interview was conducted with LVN 2. LVN 2 reviewed Resident 12's physician's orders and stated Resident 12 was currently receiving [NAME] Farms 1.4 at 35 ml/hr continuously for 24 hours. LVN 2 stated when hanging the enteral feeding formula, the licensed nurse should label the enteral feeding formula bag with the resident's name, the date and time when the formula was hung, and the ordered formula and rate to be administered. LVN 2 verified the above findings and stated the ordered rate was not labeled correctly on the enteral feeding formula bag. On 3/26/26 at 1030 hours, an interview was conducted with the DON. The DON stated the enteral feeding formulas should be labeled with the resident's name, the time, date, and order rate. The DON further stated the rate on the enteral feeding formula should match the ordered rate. On 3/26/26 at 1045 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. On 3/24/26 at 0830 hours, during the initial tour of the facility, Resident 3 was observed lying in bed with the GT feeding of Jevity 1.2 running at 50 ml/hr. The indicator at Resident 3's foot of the bed showed the HOB was 26 degrees. On 3/24/26 at 0834 hours, an observation and concurrent interview was conducted with RN 1. RN 1 was observed entering Resident 3's room to turn off the GT feeding. RN 1 stated when the enteral feeding was infusing, the HOB should be above 30 degrees to prevent aspiration (inhalation of food, liquid or foreign objects into the airways). RN 1 verified the indicator at the foot of Resident 3's bed showed 26 degrees. RN 1 stated there was another indicator under the resident's head of the bed to show the angle. Concurrent observation was conducted of the indicator under Resident 3's head of bed and RN 1 verified the indicator showed the angle was less than 30 (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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	degrees. Medical record review for Resident 3 was initiated on 3/24/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 12/30/25, showed Resident 3 was GT dependent. Review of Resident 3's Physician's Orders for March 2026 showed a physician's order dated 5/6/25, to elevate Resident 3's the head of the bed 35 degrees at all times for aspiration precautions. On 3/25/26 at 1105 hours and 3/26/26 at 0820 hours, Resident 3 was observed lying in bed with the HOB at 30 degrees. On 3/26/26 at 0832 hours, an interview and concurrent observation was conducted with CNA 3. CNA 3 stated Resident 3 had a GT and received GT feedings. CNA 3 stated when the GT feeding was infusing, the HOB should be at 30 degrees. CNA 3 verified the indicator at Resident 3's foot of the bed showed the HOB was at 30 degrees and the GT feeding was infusing at 50 ml/hr. 3. On 3/24/26 at 1421 hours, Resident 4 was observed lying in bed receiving Jevity 1.2 (enteral feeding formula) infusing at 45 ml/hr and water flush at 70 ml/hr via the GT. Resident 4's HOB was observed at 30 degrees. Medical record review for Resident 4 was initiated on 3/24/26. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's H&P examination dated 11/29/25, showed Resident 4 had the presence of a GT. Review of Resident 4's Physician's Orders for March 2026 showed a physician's order dated 12/30/23, to elevate Resident 4's head of the bed 35 degrees at all times for aspiration precautions. On 3/26/26 at 0835 hours, Resident 4 was observed lying in bed, with the water flush infusing at 70 ml/hr. The indicator under Resident 4's head of bed showed the HOB was less than 30 degrees. On 3/26/26 at 0840 hours, an interview and concurrent observation was conducted with CNA 4. CNA 4 stated Resident 4 had a GT and when the GT feeding was infusing, the HOB should be 30 degrees of more to prevent aspiration. CNA 4 verified the indicator at the foot of Resident 4's bed showed 30 degrees. On 3/26/26 at 1018 hours, an interview and concurrent medical record review for Residents 3 and 4 was conducted with the DON. The DON stated for the residents with the GT feeding infusing, the HOB should be at 30 to 35 degrees. The DON further stated, the facility staff entering the residents' rooms should check to ensure the HOB was appropriately elevated when the GT feeding was infusing. The DON reviewed Resident 3 and 4's medical records and verified the physician's orders showed to elevate the HOB at 35 degrees at all times, for aspiration precautions. On 3/26/26 at 1045 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 4. Review of the facility's P&P titled Medication Administration Through a Feeding Tube dated 10/28/25, showed medications will be administered via the feeding tube by an RN or LVN, as per the physician's orders. To crush the pills, tablets, or empty the contents of the capsules into separate containers and mix with water. To mix with a minimum of five to 10 ml of water for each medication, rinse the medication cup if residue is present. To check e-MAR to confirm medications administered. Medical record review for Resident 8 was initiated on 3/25/26. Resident 8 was admitted to the facility on [DATE]. On 3/25/26 at 0508 hours, a medication administration observation for Resident 8 was conducted with LVN 1. LVN 1 prepared and crushed Resident 8's baclofen (muscle relaxant) 10 mg medication and placed it into the plastic medication cup. After checking for GT placement and gastric residual, LVN 1 was observed pouring 10 ml of water into the syringe. LVN 1 then poured the crushed medication into the syringe. LVN 1 was then observed adding 10 ml of water into the syringe. LVN 1 added another 10 ml of water to the syringe and swirled the mixture in the syringe. LVN 1 was not observed adding water to the medication cup and mixing the contents prior to pouring the medication into the syringe. On 3/25/26 at 0526 hours, an interview was conducted with LVN 1. LVN 1 was asked about the facility's process for the administration of medications via the GT. LVN 1 stated her process was to flush the GT with water, then added the crushed medication into the syringe (not mixed with water), and then added the water to the syringe. LVN 1 verified she did not add water to the crushed medication and thoroughly mixed the medication prior to adding the medication to the syringe. LVN 1 stated when she added the water to the syringe, she swirled the water with the crushed meds to mix it. On 3/26/26 at 1035 hours, an interview was conducted with the DON. The DON stated the medications administered via the GT should be crushed, placed in the medication cup, and dissolved with water prior to pouring into (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the syringe to prevent clogging of the GT. On 3/26/26 at 1045 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care services for four of seven final sampled residents (Residents 2, 3, 12, and 15) reviewed for respiratory care. * The facility failed to ensure Yankauer suction tubing was changed as per the physician order for Resident 2. * The facility failed to ensure the Yankauer suction tips were changed as per the physician's order and care plan for Residents 3 and 12. * The facility failed to ensure the manufacturer's recommendation for cleaning and disinfecting of the ventilator machines was followed for Resident 15. These failures had the potential to affect the respiratory health and well-being of the residents in the facility.Findings: 1. Review of the [NAME]-C1 Ventilator Operator's Manual dated 4/20/20, under the cleaning, disinfection, and sterilization section showed to clean the device parts by washing in warm water and soap or an appropriate mild detergent solution. Rinse parts thoroughly with clean, warm water, and air dry. Medical record review for Resident 15 was initiated on 3/24/26. Resident 15 was admitted to the facility on [DATE]. On 3/24/26 at 0943 hours, an observation was conducted for Resident 15. Resident 15 was observed asleep in bed. Resident 15 was observed with the tracheostomy connected to the ventilator machine and oxygen supply from the concentrator machine. Review of Resident 15's Physician's Order dated 9/15/25, showed an order for the ventilator setting as follows: Mode: VC/AC; Rate: 18; Total Volume: 350; PEEP: 5; Fi02: 30; and titrate Fi02 to keep Sp02 94%. Further review of Residents 15's physician's order, failed to show the physician's order to clean and disinfect the ventilator machine per manufacturer's recommendation was obtained. Further review of Resident 15's medical record failed to show documented evidence of the cleaning and disinfecting of the ventilator machine. Review of Resident 15's respiratory flowsheet for respiratory treatment showed the breathing treatment, respiratory care, and assessment. However, there was no documentation for the cleaning and disinfecting of the ventilator machine per the manufacturer's manual was documented. On 3/25/26 at 0623 hours, an interview and concurrent medical record review for Resident 15 was conducted with RT 3. RT 3 verified Resident 15's physician's order for the respiratory treatment and ventilator machine setting. RT 3 was asked who was responsible for cleaning the resident's ventilator machine. RT 3 was uncertain who was responsible for cleaning the ventilator machine. RT 3 acknowledged the cleaning of the ventilator machine was a must. On 3/25/26 at 0923 hours, an interview and concurrent medical record review for Resident 15 was conducted with RT 4. RT 4 stated the facility did not have a specific regular cleaning and disinfecting of the ventilator machines, only as needed. RT 4 was asked if the facility had a P&P on cleaning the ventilator machine, RT 4 stated no. The ventilator machine manual was provided and reviewed with RT 4. RT 4 verified the manual showed the regular cleaning for the ventilator machine. RT 4 stated and verified the facility cleaned the ventilator machine with the bleach wipes as needed and the facility did not follow the manual for the cleaning and disinfecting of the ventilator machine. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/26/26 at 1402 hours, an interview and concurrent medical record review for Resident 15 was conducted with the DON. The DON was informed and verified the above findings. Cross Reference to F0657, example # 3. 2. On 3/24/26 at 0824 hours, Resident 12 was observed lying in bed receiving oxygen via the trach-bar at 28% FIO2. A Yankauer suction tip was observed opened and stored inside the original packaging on top of Resident 12's bedside drawer. The Yankauer packaging was not observed labeled with the opened date. Medical record review for Resident 12 was initiated on 3/24/26. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's plan of care showed a care plan problem dated 1/20/26, addressing Resident 12's risk for respiratory distress. The interventions included to change the Yankauer suction every 24 hours and as needed. Review of Resident 12's Active Order Sets showed the following physician's orders dated 1/21/26: - to suction every two hours and as needed. - to change the Yankauer suction daily and as needed. 3. On 3/24/26 at 0830 hours, Resident 3 was observed lying in bed receiving oxygen via the mechanical ventilator machine. An opened Yankauer suction tip was observed opened and stored inside the original packaging, kept inside a clear bag. The opened Yankauer was not observed labeled with the opened date. Medical record review for Resident 3 was initiated on 3/24/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's plan of care showed a care plan problem dated 5/6/25, addressing Resident 3's risk for respiratory distress. The interventions included to change the Yankauer suction every 24 hours and as needed. Review of Resident 3's Active Order Sets for March 2026 showed the following physician's orders dated 5/7/25: - to suction every two hours and as needed. - to change the Yankauer suction daily and as needed. On 3/24/26 at 0904 hours, an observation at Resident 3 and 12's bedside and concurrent interview was conducted with RT 1. RT 1 stated the Yankauer suction tip was used for oral suctioning and should be labeled with the date when it was opened. RT 1 stated the Yankauer suction tip should be changed every shift for infection control purposes. RT 1 verified the above findings. When asked, RT 1 was unable to state when the Yankauer suction tips were first opened. RT 1 was observed discarding the Yanker suction tips for Residents 3 and 12. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/26/25 at 1018 hours, an interview and concurrent medical record review for Residents 3 and 12 was conducted with the DON. The DON stated the Yankauer suction tip was used for oral care and suctioning for the residents. The DON stated the Yankauer suction tips should be changed every 24 hours and when opened, the Yankauer suction tips should be labelled with the resident's name and the opened date. The DON further stated the date labeled was used as a reference for the staff to determine when the Yankauer suction tip was last changed. The DON reviewed Resident 3 and 12's medical records and verified the physicians' orders and care plans showed to change the Yankauer suction every 24 hours. On 3/26/26 at 1045 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 4. Medical record review for Resident 2 was initiated on 3/24/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Active Order Sets showed the following physician's orders: - dated 7/14/25, for oxygen therapy via trach collar (Tˆbar) to maintain oxygen saturation at 94%. - dated 7/14/25, to suction every two hours and as needed. - dated 7/14/25, to change the Yankauer suction device every 24 hours and as needed. On 3/24/26 at 0916 hours, Resident 2 was observed lying in his bed receiving oxygen via T-bar. An opened Yankauer suction device was observed in the original packaging (opened) on the left side of the resident's bed. The label on the packaging of the suction device showed 3/22/26. On 3/24/26 at 0926 hours, an observation and concurrent interview was conducted with RT 1. RT 1 stated the Yankauer suction tubing should be changed every 24 hours as per the facility's practice. RT 1 verified the above observation and stated the Yankauer suction tubing should have been changed after 24 hours, once opened. RT 1 was observed discarding the Yankauer suction tubing. On 3/27/26 at 0953 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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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. Based on observation and interview, the facility failed to store the drugs and biologicals in a safe manner for one of two medication carts (Medication Cart A) and one of 12 final sampled residents (Resident 3). * The facility failed to discard the bottle of sterile water at Resident 3's bedside. * Two sterile alginate wound dressings (highly absorbent wound dressing) with antimicrobial silver (potent antimicrobial agent), and one sterile Puracol (Collagen) Plus wound dressing were observed opened and stored inside Medication Cart A. These failures had a potential to negatively impact residents' physiological well-being by exposing the residents to contaminated dressings and irrigation fluids.Findings: 1. On 3/24/26 at 0830 hours, during the initial tour of the facility, a bottle of sterile water was observed at Resident 3's bedside table. The bottle of sterile water was observed opened and labeled with the date 3/20/26. The label showed: sterile, single-dose container; to discard the unused portion. On 3/24/26 at 0850 hours, an interview and concurrent observation was conducted with LVN 2. LVN 2 stated the sterile water was used to flush Resident 3's Foley catheter (flexible, indwelling tube inserted through the urethra into the bladder to drain urine) as needed. LVN 2 stated when opened, the sterile water should be labeled with the opened date. LVN 2 verified the above findings. On 3/24/26 at 1535 hours, a follow-up interview was conducted with LVN 2. LVN 2 stated the bottle of sterile water should be discarded 24 hours after opening. 2. On 3/25/26 at 0812 hours, a concurrent inspection of Medication Cart A and interview was conducted with the DON. The following was observed:- Two opened- sterile alginate wound dressings with antimicrobial silver; and- One opened- sterile Puracol (Collagen) Plus wound dressing.The DON verified the above findings and stated the sterile dressings should not be opened until ready for use due to infection control purposes. On 3/26/26 at 1035 hours, an interview was conducted with the DON. The DON stated the dressings should be opened prior to the wound treatments and the remaining unused sterile dressings should be discarded after each use to prevent transmission of microorganisms or infections to the wound bed. The DON stated the bottles of sterile water used for the irrigation of the indwelling urinary foley catheter, should be discarded after 24 hours of opening. On 3/26/26 at 1045 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen. * The facility failed to ensure a blender container was dried thoroughly. * The facility failed to ensure the food preparation equipment was properly cleaned. * The facility failed to ensure proper labeling and dating of opened food items in the refrigerator. * The facility failed to ensure a dry food was stored properly. * The facility failed to ensure the proper storage of the employees' personal food in the kitchen was observed by the staff. * The facility failed to ensure the use of hair restraints was implemented by the facility staff who entered the kitchen. * The facility failed to ensure the cooking utensils were in good condition. * The facility failed to ensure the sanitary condition of the ice machine was maintained in the kitchen. * The facility failed to ensure the Dietary Aide performed hand hygiene after wearing a disposable gloves in the kitchen and before donning a new disposable gloves. * The facility failed to ensure the kitchen floor was free from debris and dirt. These failures had the potential to cause foodborne illnesses in a medically vulnerable residents population who consumes food prepared from the kitchen.Findings: Review of the facility's CMS-802 document titled Matrix for Providers showed two residents who resided in the facility consumed food prepared in the kitchen. 1. According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required, that after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food. Review of the facility's P&P titled Cleaning Procedures dated 6/19/25, showed the food processor or blender must be cleaned to and allow to air dry. On 3/24/26 at 0810 hours, during the initial tour of the kitchen, an observation and concurrent interview was conducted with the FSS. The following was observed:- Two heavy-duty blenders stored with the lids on and visible water inside the blenders. The FSS acknowledged the above findings and stated the blenders would be washed again. 2. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. Review of the facility's P&P titled Dish and Utensil Procedure dated 3/3/20, showed any dish, tray, or utensil with debris should not be used. Send back to the dish room to be properly washed and sanitized. On 3/24/26 at 0810 hours, during the initial tour of the kitchen, an observation and concurrent interview was conducted with the FSS. There was one blender stored with food particles on the base of the machine. The FSS acknowledged the above findings and stated the blender machine would be cleaned again. 3. a. Review of the facility's P&P titled Labeling and Dating dated 3/21/24, showed opened products can be stored in original containers if the container can be closed properly. All products must clearly be labeled with the date when the product was opened. Opened products that cannot be stored in their original containers must be transferred to a plastic re-usable container and covered. Appropriate coverings include plastic wrap, foil, or tight-fitting lids, the products should be clearly labeled and dated. The items stocked in the resident refrigerators are labeled with the date the items expired. During the initial kitchen tour on 3/24/26 at 0810 hours, the following was observed in the walk-in refrigerator- sliced carrots opened in a plastic bag with no label and no date. - a rice bin with no label and no date. The FSS stated all the food items in the refrigerator and in the kitchen should have been covered, labeled, and dated. b. On 3/25/26 at 0816 hours, an inspection of the resident refrigerator and concurrent interview was conducted with MDS Coordinator. A container of ice cream sherbet with an expiration date of 12/2/25, was observed inside the freezer. The MDS Coordinator verified and removed the expired food item. 4. Review of the facility's P&P titled Personal Hygiene/ Employee Health dated 6/19/25, showed personal belongings are kept out of the kitchen. Lockers or (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	desk drawers are used for personal belongings. On 3/24/26 at 0810 hours, during the initial tour of the kitchen, an observation and concurrent interview was conducted with the FSS. An unlabeled disposable food container was observed inside the walk-in refrigerator. The FSS verified and acknowledged the food was belonged to the kitchen staff. The FSS removed the kitchen staff's personal food from the walk-in refrigerator and threw it away in the garbage. 5. According to the USDA Food Code 2022, Section 2-402.11 Effectiveness (A), Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils. Review of the facility's P&P titled Personal Hygiene/ Employee Health dated 6/19/25, showed hair nets or caps and/ or beard restraints are worn when cooking, preparing, or assembling food to keep hair from contacting exposed food, clean equipment, utensils, and linens. On 3/25/26 at 0840 hours, the Maintenance Manager was observed inside the kitchen with uncovered facial hair, as he checked the ice machine. The FSD verified the Maintenance Manager should wear a facial hair covering when inside the kitchen. 6. According to the USDA Food Code 2022, Section 4-601.11, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils:(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch.(B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations.(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. On 3/24/26 at 0810 hours, during the initial tour of the kitchen, a concurrent observation and interview with the FSS was conducted. Two white cutting boards with heavily marred with black discoloration were observed. The FSS verified the above findings. The FSS stated the above kitchen equipment would need to be replaced. 7. According to the USDA Food Code 2022 Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils (C) Nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. On 3/25/26 at 0840 hours, an inspection of the kitchen ice machine and concurrent interview with the Maintenance Manager was conducted. The ice machine front cover was removed by the maintenance Manager and observed with dried water scale, whitish to dark color around the motor and on the base of the ice machine. The Maintenance Manager verified the inside of the ice machine was dirty. The Maintenance Manager stated and verified the ice machine had a work order on 3/9/26, by a private company. The Maintenance Manager was able to show the work order. 8. Review of the facility's P&P titled Handwashing dated 3/16/23, showed all food services employees shall keep their hands and exposed areas of their arms clean thoroughly wash their hands after touching or handling soiled equipment and utensils, or objects that are unclean such as door handles, garbage can lids, and before putting on a clean pair of gloves to work with food. On 3/25/26 at 1130 hours, during the tray line observation, the Kitchen Aid was observed wearing disposable gloves while preparing for the tray line. The Kitchen Aid was observed picking up a trash from the floor wearing the disposable gloves, then he was observed removing the disposable gloves and donned new disposable gloves; however, the Kitchen Aid did not perform hand hygiene prior to donning the new disposable gloves. The FSS verified and acknowledged the Kitchen Aid should have washed his hands before donning on new disposable gloves. 9. Review of the facility's P&P titled Floor Cleaning dated 6/15/23, showed the floors in the food and nutrition department should be cleaned daily to maintain the kitchen sanitation standards. On 3/24/26 at 0810 hours, during the initial tour of the kitchen, an observation and concurrent interview was conducted with the FSS. The floor drainage with dirt near the drainage area in the kitchen was observed. The FSS verified and acknowledged the findings. On 3/26/26 at 1348 hours, an interview was conducted with the FSD. The FSD was informed of the above findings in the kitchen. The FSD verified and acknowledged the findings. On 3/26/2026 at 1415 hours, an interview was conducted with the DON. The DON was informed and verified the above findings.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the staff provided care and services to promote dignity and respect for one of 12 final sampled residents (Resident 13). * Resident 13's family member preferred Resident 13 not to be covered or to wear a shirt. The facility failed to ensure Resident 13's curtain was pulled to provide Resident 13 with dignity. These failures had the potential to negatively impact the resident's self-worth and well-being.Findings: Review of the facility's P&P titled Resident Privacy, Dignity, and Confidentiality revised 2/2024 showed the subacute facility will provide privacy for the residents, including but not limited to accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings with legal representative, family, and groups. Nursing staff will use curtains to provide full visual privacy and dignity during resident care, toileting, treatments, and issues of dignity and other requested times. This includes closing doors, removing residents from public view and providing clothing and draping residents to prevent unnecessary exposure of body parts. On 3/26/26 at 0810 hours, Resident 13 was observed lying in bed. Resident 13 was visibly seen with his upper body exposed and a blanket at the resident's waist from the doorway of Resident 13's room. On 3/26/26, from 0810 to 0816 hours, an ongoing observation was conducted of multiple staff members walking in the hallway passing Resident 13's room. On 3/26/26 at 0818 hours, an interview and concurrent observation was conducted with IP 2. IP 2 verified the above findings. IP 2 stated Resident 13's family member requested for the resident to be without a shirt. IP 2 stated the curtain should be pulled to provide Resident 13 with privacy and dignity when he did not have a shirt covering him. Medical record review for Resident 13 was conducted on 3/26/26. Resident 13 was admitted to the facility on [DATE]. Review of Resident 13's care plan for risk for alteration in comfort dated 11/4/25, showed per Resident 13's family member, Resident 13 liked to remain in a cooler temperature and not to be covered with blankets. The interventions showed to not cover the resident with a blanket and may cover his private area only. Review of Resident 13's Nursing Note dated 12/5/25, showed Resident 13 did not wear the gown per Resident 13's family member request due to excessive perspiration and tachycardia. Review of Resident 13's MDS assessment dated [DATE], showed Resident 13 had severely impaired cognitive skills for daily decision making. On 3/26/26 at 1045 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to develop a comprehensive plan of care to reflect the individual care needs for one of five final sampled residents (Residents 16) reviewed for unnecessary medication. * The facility failed to develop a care plan for Resident 16's use of Xarelto (anticoagulant medication). This failure posed the risk of not providing appropriate, consistent, and individualized care to the resident.Findings: Review of facility's P&P titled Care Planning dated 10/28/25, showed a comprehensive care plan must be developed within 14 days and completed no later than seven days after a comprehensive assessment has been completed. Resident care planning includes participation from all involved health care disciplines at resident care conferences with continual reassessment, and updating at least quarterly, and upon change of condition, until resident's discharge. The comprehensive care plan will provide specific information to include resident strengths, goals, life history and preferences, discharge planning and will be completed upon the assessment completion. Medical record review for Resident 16 was initiated on 3/24/26. Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's Physician's Order showed an order dated 12/19/25, to administer Xarelto 10 mg via GT at bedtime for DVT prophylaxis. Review of Resident 16's comprehensive care plans failed to show documented evidence an individualized care plan was developed to address Resident 16's use of the Xarelto medication. On 3/26/26 at 1253 hours, an interview and concurrent medical record review for Resident 16 was conducted with RN 3. RN 3 verified Resident 16 had a physician's order for anticoagulant medication. RN 3 reviewed Resident 16's care plans and verified there was no care plan developed for the Xarelto medication. RN 3 stated the licensed nurse formulate a care plan once there was an new condition of the resident. On 3/26/2026 at 1419 hours, an interview and concurrent medical record review for Resident 16 was conducted with the DON. The DON was informed and verified the above findings.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P, the facility failed to ensure the comprehensive plans of care were revised to reflect the residents' current care needs and interventions for three of 12 final sampled residents (Residents 3, 4, and 15) reviewed for care plans. * The facility failed to ensure Resident 3 and 4's care plans were revised to reflect the physician's order for aspiration precautions, to elevate the head of the bed to 35 degrees at all times. * The facility failed to ensure Resident 15's care plan for the use of the mechanical ventilator machine was revised to include the cleaning of the machine. These failures posed the risk of not providing the residents with individualized and person-centered care.Findings: Review of the facility's P&P titled Care Planning dated 10/28/25, showed a comprehensive care plan must be developed within 14 days and completed no later than seven days after a comprehensive assessment had been completed. Resident care planning included participation from all involved health care disciplines at the resident care conferences with continual reassessment, and updating at least quarterly, and upon change of condition, until the resident's discharge. 1. On 3/24/26 at 0830 hours, during an observation, Resident 3 was lying in bed and connected to a mechanical ventilator machine. Resident 3 was observed receiving Jevity 1.2 (enteral feeding formula) at 50 ml/hr via the GT. The display at the foot of Resident 3's bed showed the head of the bed was 26 degrees. Medical record review for Resident 3 was initiated on 3/24/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's Physician's Orders showed an order dated 5/6/25, to elevate Resident 3's the head of the bed 35 degrees at all times for aspiration precautions. Review of Resident 3's plan of care showed the following care plan problems dated 5/6/25: - risk for respiratory distress with interventions including to position Resident 3 for optimal lung expansion greater than 30 degrees, and to keep the head of bed greater than 30 degrees; and - altered nutrition, on GT feeding with interventions including to elevate the head of the bed at 30 to 45 degrees during and one hour after feeding. Review of Resident 3's H&P examination dated 12/30/25, showed Resident 3 was GT and ventilator dependent. 2. On 3/24/26 at 1421 hours, during an observation, Resident 4 was lying in bed and connected to a mechanical ventilator. Resident 4 was observed receiving Jevity 1.2 (enteral feeding formula) infusing at 45 ml/hr and water at 70 ml/hr via the GT. Resident 4's HOB was observed at 30 degrees. Medical record review for Resident 4 was initiated on 3/24/26. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's Physician's Orders showed an order dated 12/30/23, to elevate Resident 4's (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	head of the bed 35 degrees at all times for aspiration precautions. Review of Resident 4's plan of care showed the following care plan problems dated 4/17/25: - risk for respiratory distress with interventions including to position Resident 4 for optimal lung expansion: with the HOB elevated above 30 degrees; - altered nutrition, on GT feeding with interventions including to elevate the head of the bed at 30 to 45 degrees during and one hour after feeding; and - high risk for aspiration related to the diagnosis of dysphagia (trouble swallowing), with interventions including to maintain the head of bed at 30 to 45 degrees at all times unless contraindicated. Review of Resident 4's H&P examination dated 11/29/25, showed Resident 4 had ventilator-dependent respiratory failure and the presence of a GT. On 3/26/26 at 1018 hours, an interview and concurrent medical record review for Residents 3 and 4 was conducted with the DON. The DON stated the HOB should be at 30 to 35 degrees. The DON stated the MDS nurse or the QA nurse were responsible for reviewing the resident's care plans and should revise the care plans to meet the resident's needs. The DON reviewed Resident 3 and 4's medical records and verified the above findings. The DON stated the care plan interventions should have been revised to reflect the physician's order. On 3/26/26 at 1045 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. Medical record review for Resident 15 was initiated on 3/24/26. Resident 15 was admitted to the facility on [DATE]. On 3/24/26 at 0943 hours, during an observation, Resident 15 was in bed asleep. Resident 15 had a tracheostomy connected to a ventilator machine and with oxygen supply from concentrator machine. Review of Resident 15's care plan for respiratory distress related to ventilator dependency dated 8/11/25, showed interventions for ventilator management. However, the care plan interventions failed to include the cleaning and disinfecting of the ventilator machine per manufacturer's manual were included. On 3/26/26 at 1328 hours, an interview and concurrent medical record review for Resident 15 was conducted with RN 3. RN 3 stated the care plan was formulated and updated by the licensed staff including the nurses, PT and dietician. RN 3 was asked if there was a care plan for the resident use of the ventilator. RN 3 verified the care was formulated for the use of the ventilator machine. RN 3 verified the care plan was not included in the intervention for the cleaning and disinfecting of the ventilator machine per manufacturer's recommendation. On 3/26/2026 at 1402 hours, an interview and concurrent medical record review for Resident 15 was conducted with the DON. The DON was informed and verified the above findings. Cross Reference to F0695, example # 1.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide an individualized and ongoing activity program to meet the needs and interests for one of 12 final sampled residents (Resident 5). * The facility failed to provide documentation Resident 5 had received meaningful activities as per the care plan. This failure had the potential to affect the resident's psychosocial well-being.Findings; Review of the facility P&P titled Activity Plan dated 6/2025 showed an activity plan will be developed and implemented for each resident and shall be integrated with the individual interdisciplinary resident care plan . The purpose of the activity plan is to assist the activity personnel and the rest of the unit staff in providing for each resident those activities that will provide the highest quality of life that is possible for the resident. On 3/24/26 at 0921 and 1443 hours, on 3/25/26 at 0835 hours, and on 3/26/26 at 1010 hours, Resident 5 was observed lying awake in bed, connected to mechanical ventilation, with eyes open and staring at the ceiling. The television was off, no music was heard, and the resident was not observed participating in any activities. On 3/26/26 at 1010 hours, an observation of Resident 5 and concurrent interview was conducted with LVN 4. LVN 4 verified Resident 5 was not engaged in any activity. LVN 4 stated Resident 5 was alert and oriented to person place and time and sometimes used the Tobii device for communication. On 3/26/26 at 1012 hours, an observation of Resident 5 and concurrent interview was conducted with CNA 3. CNA 3 stated Resident 5 was alert and oriented and enjoyed watching Netflix on her Tobii device. CNA 3 verified Resident 5 was not engaged in any activity. CNA 3 reported that a family member typically turned Netflix on for Resident 5 on her Tobii device and that she did not know how to operate Netflix on the resident's Tobii device. When asked whether the activity department assisted with turning on the television or accessing Netflix on the Tobii device, CNA 3 stated activity staff sometimes turned on the television for Resident 5. When asked CNA 3 what other activities were being provided to Resident 5 she stated she did not know. Medical record review for Resident 5 was initiated on 3/24/26. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's Activity assessment dated [DATE], showed the resident was bedbound, nonverbal, and required encouragement to engage in socialization. Further review of the staff assessment of daily activity preferences showed the resident participated in preferred activities, such as watching Korean movies. Review of Resident 5's MDS assessment dated [DATE], showed Resident 5 had no memory problem and had modified independence (some difficulty in new situation only) for cognitive skills for daily decision making. Further review of the MDS assessment showed Resident 5 had impairment on both upper and lower extremities and was dependent on the staff for her activity of daily living. Review of Resident 5's Care Plan dated 2/25/26, showed a problem related to altered activity participation due to a communication deficit. The care plan indicated that Resident 5 was nonverbal and used a Tobii device for communication. The goal included for the resident to engage in independent leisure activities at least once daily and accept activity contact visits twice weekly. Interventions included providing and encouraging participation in preferred activities such as music, watching television or movies, and sensory stimulation. Review of Resident 5's Activity Progress Notes for March 2026, showed the Activity was provided on 3/1, 3/2, 3/3, 3/4, 3/9, 3/11, 3/12, 3/13, 3/14, 3/15, 3/16, 3/18, 3/21, 3/23, 3/24, and 3/25/26. Further review of the activity notes did not show if the activity was provided to Resident 5 on 3/5, 3/6, 3/7, 3/8, 3/10, 3/17, 3/19, 3/20, and 3/22/26. On 3/26/26 at 1012 hours, an interview and concurrent medical record review for Resident 5 was conducted with the Activity Director. The Activity Director confirmed the above findings and stated there was no documented evidence indicating whether activities were provided on 3/5, 3/6, 3/7, 3/8, 3/10, 3/17, 3/19, 3/20, and 3/22/26. The Activity Director stated preferred activities should be offered daily as identified in the resident's care plan and verified Resident 5 enjoyed watching Korean movies. The Activity Director further confirmed activities for Resident 5 should have been (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	offered and documented daily, and if the resident refused, the refusal should also have been documented. On 3/27/26 at 0953 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the quality care and services were provided for one of 12 final sampled residents (Resident 11). * The facility failed to ensure Resident 11's POLST was complete and accurate, and discussed in the facility IDT meeting, when Resident 11 did not have a responsible party. This failure had the potential to result in care being provided that did not reflect the resident's treatment preferences, leading to unwanted interventions, delays in appropriate care, and compromising the resident's overall health and wellˆbeing.Findings: Review of the facility's P&P titled POLST (Physician Orders for Life Sustaining Treatment) dated [DATE], showed the POLST is a physician's order form that converts the wishes of the resident/legal representative regarding life-sustaining treatment and resuscitation for the resident. It is designed to be a statewide mechanism for resident/legal representative to communicate his or her wishes about a range of life sustaining and resuscitative measures regarding the resident. Further review of the P&P showed the POLST form:Can be revised or revoked by resident/legal representative with a decision making at any time;Is legally sufficient and recognized as a physician order;Is recognized and honored across treatment setting. On [DATE] at 1034 hours, Resident 11 was observed lying in bed and connected to a mechanical ventilation (life-support therapy that helps a person breathe or breathes for them) via her tracheostomy tube (curve plastic tube inserted into a surgically created opening in the neck to provide a direct airway, remove secretions, or deliver oxygen). Medical record review for Resident 11 was initiated on [DATE]. Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's acute care hospital physician's progress notes dated [DATE], showed no family or next of kin was found and on [DATE], the resident had been made DNR by two physicians. Review of Resident 11's POLST dated [DATE], showed under Section A, Cardiopulmonary Resuscitation (CPR), Do Not Attempt Resuscitation/DNR (Allow Natural Death) was selected. Section B indicated a preference for comfortˆfocused treatment, with the primary goal of maximizing comfort, including the use of medication by any route as needed, oxygen, suctioning, and manual airway clearing. Under Additional Orders, the POLST specified no invasive or nonˆinvasive mechanical ventilation. Further review of the document showed the POLST was signed by the physician, and the signature section for the resident or legally recognized decisionmaker indicated no known family contacts, IDT responsible. Review of Resident 11's IDT/Care Plan Conference dated [DATE], showed under the POLST section, Do Not Resuscitate was selected; however, the documentation did not indicate whether the resident's preferences for no invasive or nonˆinvasive mechanical ventilation or comfortˆfocused treatment were discussed by the IDT. Review of Resident 11's Active Order Sets showed a physician's order dated [DATE], for mechanical ventilation with the following settings: Volume Control/Assist Control (VC/AC) [ventilator is set to deliver a specific volume each breath, regardless of the amount of pressure required to deliver the volume], respiratory rate of 16 breaths per minute, tidal volume (volume of air inhaled or exhaled during normal, resting breath) of 450 ml, PEEP [Positive End-Expiratory Pressure- mechanical ventilation setting that maintains airway pressure above atmospheric levels at the end of expiration, preventing alveolar (air sacs) collapse] of 5 cmHˆO, and oxygen titrated to maintain an SpOˆ (oxygen saturation) of 94%. On [DATE] at 0902 hours, an interview and concurrent medical record review for Resident 11 was conducted with the MDS/DSD. The MDS/DSD verified Resident 11's POLST showing DNR, comfort focused treatment - primary goal of maximizing comfort, no invasive or non-invasive mechanical ventilation, no defibrillation (an emergency, life-saving treatment for cardiac arrest or life-threatening heart rhythms), no chest compression, no ACLS (drugs). The MDS/DSD stated Resident 11 had no responsible party, so the facility IDT team members and representatives from the Council of Aging were making treatment decisions for the resident. When asked if the facility IDT and representative from Council of Aging discussed the resident's POLST, including the choice for (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	comfort focused treatment - primary goal of maximizing comfort, no invasive or non-invasive mechanical ventilation, the MDS/DSD was not able to show documentation. On [DATE] at 0953 hours, an interview and concurrent medical record review for Resident 11 was conducted with the DON. The DON verified Resident 11's POLST indicated DNR, comfortˆfocused treatment as the primary goal, and directives for no invasive or nonˆinvasive mechanical ventilation. The DON verified Resident 11 was currently receiving mechanical ventilation, which was inconsistent with the POLST instructions. The DON stated Resident 11 was admitted from the acute care hospital with a DNR order; however, she was unable to provide documentation to show the choice for comfortˆfocused treatment and the additional directives including no invasive or nonˆinvasive mechanical ventilation were reviewed or discussed during with the facility IDT team and the representative from the Council on Aging. The DON stated the facility should have arranged an IDT meeting to review Resident 11's POLST and the associated treatment preferences. The DON also verified there was no documented evidence to show the physician was contacted to clarify the resident's POLST. The DON acknowledged the above findings.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure one of three final sampled residents (Resident 11) reviewed for nutritional status received the appropriate services needed to maintain acceptable parameters of the nutritional status. * The facility failed to ensure the physician was notified when Resident 11 had excessive weight changes of more than 5 (five) pounds in a week, and 20 pounds in a month. This failure had the potential to result in the lack of effectiveness of the nutritional interventions and increased the potential for further weight loss and/or nutritional decline.Findings: Review of the facility's P&P titled Weight Variance Monitoring dated 2/2024 showed it was the policy of the facility to provide weight variance monitoring based on good nursing practice and as indicated by resident need or physician order. Further review of the P&P showed excessive weight losses or gains will be more than 2 (two) lbs. per week or more than 8 (eight) lbs. in one month. The physicians will be notified of all excessive losses or gains. Medical record review for Resident 11 was initiated on 3/24/26. Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's Recent Vitals showed the following:- on 1/6/26, a weight of 153 lbs.;- on 1/11/26, a weight of 146 lbs.; a weight loss of 7 lbs. from 1/6/26;- on 1/18/26, a weight of 145 lbs.;- on 1/25/26, a weight of 138 lbs.; a weight loss of 7 lbs. from 1/18/26;- on 2/1/26, a weight of 133 lbs.; weight loss of 5 lbs. from 1/25/26, and 20 lbs. from 1/6/26;- on 2/10/26, a weight of142 lbs.; weight gain of 9 lbs. from 2/1/26; and,- on 2/22/26, a weight of135.6 lbs.; weight loss of 7 lbs. from 2/10/26. Review of Resident 11's Care Plan showed the following:- dated 1/6/26, showed a care plan problem addressing the resident's altered nutrition, risk for weight loss and intolerance to tube feeding. The interventions included to monitor the weight as ordered and to notify the physician of any unplanned significant weight gain or losses.- dated 2/3/26, showed a care plan problem addressing the resident's 20 pound weight loss in 30 days. The goal showed the facility to minimize further significant weight loss/gain in the next 30 days. The intervention included notifying the physician of significant weight change.Review of Resident 11's physician's progress notes dated 1/13/26, showed Resident 11 was noted to have lost about 7 lbs. since admission and the RD to evaluate Resident 11. Further review of the physician's progress notes did not show if the above weight changes on 1/25, 2/1, 2/10, and 2/22/26 was relayed to the physician. Review of the facility's document titled Change of Condition log showed the following:- on 1/11/26, Resident 11 had unplanned wight loss of 7.3 lbs./week and- on 1/25/26, Resident 11 had unplanned weekly weight loss.The change of condition log showed the treatment and duration for above identified change in condition for Resident 11 was 72 hours. However, further review of the resident's medical record failed to show if the physician was notified and if Resident 11 was monitored for 72 hours for the above identified change in condition. Review of Resident 11's Nutrition and Hydration Risk assessment dated [DATE], showed Resident 11 was at high risk for malnutrition and dehydration. Review of Resident 11's Nutrition assessment dated [DATE], showed weight goals per the RD was 140-155 lbs. Review of Resident 11's Dietary Orders showed a physician's order dated 2/26/26, for Jevity 1.5 (type of enteral feeding formula) at 60 ml per hour (totaling 1200 ml/1800 kcal) to be administered via GT. On 3/26/26 at 0834 hours, an interview and concurrent medical record review for Resident 11 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated she was unable to locate the documentation showing the physician was notified of these weight changes on the dates they occurred. RN 1 verified although the physician documented the resident's 7ˆpound weight loss since admission on [DATE], there was no documented evidence to show the physician had been notified at the time the weight loss was first identified. RN 1 stated the physician should be notified as soon as possible when a resident experiences excessive weight changes. On 3/27/26 at 0953 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to provide the necessary care and services to maintain the intravenous (IV) accesses for one of 12 final sampled residents (Resident 13) reviewed for IV care. * The facility failed to ensure a physician's orders were obtained for the IV fluid and peripheral IV access site rotation every 72 hours and as needed. This failure had the potential to delay the identification of intravenous complication of the resident.Findings: Medical record review for Resident 13 was initiated on 3/24/26. Resident 13 was admitted to the facility on [DATE]. On 3/24/26 at 0937 hours, Resident 13 was observed in bed with the normal saline (NS, sterile solution of 0.9 grams or salt per 100 ml of water) IV fluids infusing from the IV pump machine at 10 ml/hr, which was connected to Resident 13's right hand IV access with a transparent dressing dated 3/22/26. Reviewed Resident 13's physician's order dated 3/24/26, showed to administer cefepime (antibiotic medication) 2 grams IVPB every eight hours at 200 ml/hr for 30 minutes. Further review of Resident 13's medical record failed to show documented evidence a physician's order for the normal saline IV fluid and peripheral IV access site rotation every 72 hours and as needed were obtained. On 3/26/26 at 0831 hours, an observation and concurrent interview at Resident 13's beside was conducted with IP 2. IP 2 verified Resident 13 was on IV antibiotic and the resident had IV NS infusing at 10 ml/hr, which was connected to the resident's right hand IV access. IP 2 stated the RNs were responsible for the IV care and maintenance for the residents. On 3/26/26 at 1025 hours, an interview and concurrent medical record for Resident 13 was conducted with RN 3. RN 3 stated when the licensed nurses received an order for the IV antibiotic, she would inform the pharmacy about the order and start an IV access for the resident. RN 3 added, when the IV antibiotic was available she would then start an IV fluid, usually a NS 250 ml bag, via the IV pump machine. RN 3 stated she then would administer the IV antibiotic as ordered. RN 3 was asked about Resident 13's IV medication. RN 3 verified Resident 13's physician's order for the IV ATB for sepsis for seven days. RN 3 was asked for the physician's orders for the NS IV fluid and the care and maintenance of the IV access site. RN 3 reviewed the Resident 13's medical record and verified there were no physician's orders for the NS IV fluid and the care and maintenance of the IV access site obtained. On 3/26/2026 at 1416 hours, an interview and concurrent medical record review for Resident 13 was conducted with the DON. The DON was informed and verified the above findings.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the pharmaceutical services to ensure the accurate administration of the medications when two of four licensed nurses were observed to have made errors. * LVN 5 failed to follow the administration instructions to dissolve the GlycoLax (laxative) for Resident 21. * During the medication administration observation, LVN 6 failed to administer the Pro-Stat (liquid protein supplement) medication to Resident 6. These failures had the potential to negatively affect the residents' health conditions and posed the risk of possible complications or delay in interventions. Findings: Review of the facility's P&P titled Medication Administration revised 3/2025 showed all dosing frequencies for inpatients will be administered at fixed times approved by nursing and the medical staff. The pharmacy information system would be programmed to include standard medication frequency abbreviations and administration times. Prior to administration, the practitioner will verify the prescriber's order against the medication being administered. To review the medication administration record (MAR) for any special considerations that would influence the administration of medications including but not limited to, clinical parameters, NPO status. Medications at odd hours, one time only medications, or medications that must be given with food. The pharmacy will dispense medications in ready to use form whenever possible. If dispensing the product in ready to use form is not possible, the healthcare professional administering the medication may appropriately manipulate the dosage form prior to administration. 1. On 3/25/26 at 0825 hours, a medication administration observation for Resident 21 was conducted with LVN 5. LVN 5 prepared the following medications for Resident 21:- 30 milliliters of lactulose (laxative) 20 grams;- one tablet of famotidine (antacid) 20 mg;- one tablet of Vitamin D3 (supplement) 25 mcg;- one tablet of Thera multivitamin (supplement);- one tablet of aspirin (antiplatelet) 81 mg;- one capsule of cranberry (supplement) 465 mg;- 5 milliliters of valproic acid (mood stabilizer) 250 mg;- one tablet of simethicone (antacid) 80 mg;- one tablet of metformin (antidiabetic) 500 mg;- one capsule of tamsulosin (for benign prostatic hyperplasia) 0.4 mg;- two tablets of memantine (dementia medication) 5 mg;- one packet of GlycoLax (laxative) 17gm;- one drop of refresh plus (lubricant) 0.5% to each eye; and- one drop of azelastine (eye drop used to treat itching, redness, and swelling) 0.05% to the left eye. During the observation, LVN 5 was observed emptying the packet of GlycoLax powder into a cup. LVN 5 then added chocolate pudding and mixed the contents with a tongue depressor. LVN 5 was observed administering the above medications to Resident 21. Medical record review for Resident 21 was initiated on 3/25/26. Resident 21 was admitted to the facility on [DATE]. Review of Resident 21's Active Order Sets dated 3/26/26, showed the following physician's orders:- dated 12/24/23, may give oral medications with a small amount of thickened water.- dated 1/24/24, may crush medications and mix with pudding preferably chocolate pudding.- dated 3/24/26, to administer GlycoLax 17 grams by mouth two times daily. Review of Resident 21's MAR for 3/26/26, showed the administration instructions for the GlycoLax 17 grams powder showed to stir the powder in 120 to 240 ml (four to eight ounces) of water, juice, soda, coffee, or tea and administer. On 3/25/26 at 0922 hours, an interview and concurrent medical record review for Resident 21 was conducted with LVN 5. LVN 5 verified the administration instructions for the GlycoLax medication in the MAR and verified she did not mix the powder with water, as per the instructions, and instead mixed it with the chocolate pudding. 2. On 3/26/26 at 0900 hours, a medication administration observation for Resident 6 was conducted with LVN 6. LVN 6 prepared and administered Resident 6's medications via the GT, which included the following:- 10 ml of docusate sodium (stool softener) 100 mg;- 10 ml of levetiracetam (anticonvulsant)1000 mg;- one tablet of calcium carbonate (antacid) 500 mg;- one tablet of vitamin C (supplement) 500 mg;- one tablet of Vitamin D3 (supplement) 25 mcg-1000 units;- one capsule of Culturelle- lactobacillus GG (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(supplement) 10 billion CFUs; and- one tablet of metoprolol (antihypertensive) 25 mg. Medical record review for Resident 6 was initiated on 3/26/26. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's Active Order Sets dated 3/26/26, showed a physician's order dated 4/9/25, to administer Pro-Stat (supplement) Sugar Free 30 ml daily via the GT. Review of Resident 6's MAR for 3/26/26, showed the Pro-Stat Sugar Free 30 ml medication was scheduled to be administered at 0900 hours. On 3/26/26 at 1003 hours, an interview and concurrent medical record review for Resident 6 was conducted with LVN 6. LVN 6 reviewed Resident 6's MAR and verified the Pro-Stat medication was scheduled to be administered at 0900 hours. LVN 6 verified the medication was not administered during the medication administration observation. On 3/26/26 at 1035 hours, an interview was conducted with the DON. The DON stated the medications should be administered as per the physician's orders and should be administered within the ordered time, which was within an hour before and after the scheduled time. On 3/26/26 at 1045 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, medical record review, and facility P&P review, the facility failed to implement their infection control program in accordance with the facility's P&P. * The facility failed to ensure LVN 1 donned the appropriate PPE during the medication administration observation for Resident 8 via the GT; additionally, LVN 1 failed to disinfect the stethoscope after use and prior to exiting Resident 8's room. * The facility failed to ensure RN 2 removed the gloves, performed hand-hygiene, and donned new gloves in between the administration of eye ointment medication for both eyes. These failures had the potential for the spread of infection to the residents, staff, and visitors in the facility.Findings: 1. Review of the facility's P&P titled Guidelines for Enhanced Barrier Precautions dated 4/2025 showed Enhanced Barrier Precautions refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in long-term care facilities. It involved gown and glove use during high contact resident care activities for residents known to be colonized or infected with MDRO as well as those at increased risk of MDRO acquisition which include residents with wounds or indwelling devices. Enhanced Barrier Precautions are indicated for residents with any of the following: wounds and/or indwelling devices (e.g., central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO. Gown and gloves are the minimum level PPE required when performing high-contact activities. On 3/25/26 at 0508 hours, a medication administration observation for Resident 8 was conducted with LVN 1. Resident 8 was on enhanced barrier precautions. LVN 1 prepared and administered Resident 8's baclofen (muscle relaxant) 10 mg medication. During the medication administration, LVN 1 was observed reaching across Resident 8 from the right side of the bed to expose Resident 8's GT from under his gown. After using the stethoscope to check for GT placement, LVN 1 was observed administering the baclofen medication to Resident 8. LVN 1 was not observed wearing a gown during the medication administration observation. On 3/25/26 at 0520 hours, an interview was conducted with LVN 1. LVN 1 verified she did not don the gown during the medication administration via the GT for Resident 8. LVN 1 was then observed donning a gown to perform oral care for Resident 8. On 3/25/26 at 0530 hours, an observation was conducted of LVN 1. LVN 1 was observed removing the gown, gloves, and performing hand hygiene prior to exiting Resident 8's room. LVN 1 was observed with the stethoscope (previously used on Resident 8, to check for the GT placement) around her neck. LVN 1 was not observed disinfecting the stethoscope prior to exiting Resident 8's room. LVN 1 was observed pushing the portable computer from outside of Resident 8's room to the nursing station. LVN 1 was interviewed and LVN 1 stated the stethoscope should be disinfected after each use and prior to exiting the resident's room. LVN 1 verified she did not disinfect her stethoscope after use and prior to exiting Resident 8's room. On 3/25/26 at 0615 hours, an interview was conducted with IP 2. IP 2 stated the stethoscope should be disinfected before and after each use, in between residents, and before exiting the resident's room to prevent the transmission of microorganisms. On 3/26/26 at 1045 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Review of the facility's P&P titled Administration of Eye Drops or Ointments dated 10/2025 showed the eye medications were administered as ordered by the physician and in accordance with the professional standards of practice to lubricate the eye or treat certain eye conditions. For eye ointment: to squeeze a ribbon of ointment on the edge of the conjunctival sac from the inner to outer canthus. Hands are washed or use alcohol gel before and after instilling the medication(s) to one eye and donning and doffing gloves. On 3/25/26 at 0532 hours, a medication administration observation for Resident 13 was conducted with RN 2. During the medication administration observation, RN 2 was observed using the same tissue paper to wipe Resident 13's right and left eyes. RN 2 removed her gloves, performed hand hygiene, and donned a new pair of gloves. RN 2 was then observed administering the ophthalmic ointment to Resident 13's right eye and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	massaging the ointment under Resident 13's right eyelid. RN 2 then applied the ointment to Resident 13's left eye and massaged the ointment over Resident 13's eyelid. RN 2 was not observed doffing the gloves, performing hand-hygiene, and donning new gloves in between the application of the eye ointment to each eye. On 3/25/26 at 0606 hours, an interview was conducted with RN 2. RN 2 was asked about the protocol for the administration of the eye medications when the physician's order was to administer for both eyes. RN 2 stated eye care should first be performed by wiping each eye with a tissue paper. RN 2 stated the gloves should be changed, and hand-hygiene performed. RN 2 stated after donning new gloves, to apply the eye medication and change gloves in between eyes. RN 2 verified she did not change gloves in between the application of the eye ointment to both eyes. On 3/25/26 at 0615 hours, an interview was conducted with IP 2. IP 2 stated for the administration of eye medication to both eyes, the licensed nurse should remove the gloves, perform hand-hygiene, and don new gloves between each eye to prevent any contamination between eyes. On 3/26/26 at 1045 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.