STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555889	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor Senior Residence	6101 Fair Oaks Boulevard Carmichael, CA 95608

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 49821 Based on observation, interview, and record review, the facility failed to provide a comfortable noise level for four residents (Resident 299, Resident 38, Resident 1, and Resident 300) of a census of 45. This failure decreased the facility's potential to maintain the residents' comfort level and sleep. Findings: A review of an admission record indicated Resident 299 was admitted to the facility in April 2025 with a diagnosis of insomnia (trouble falling asleep or staying asleep). A review of Resident 299's Order Summary Report, dated 4/12/25, indicated Resident 299 had the capacity to make healthcare decisions. During an interview on 4/23/25 at 8:40 a.m. with Resident 299, Resident 299 stated staff in the evening shift (3 p.m. - 11:30 p.m.) left the room door open at bedtime and had to be reminded to close it because of the hallway's noise. Resident 299 added the certified nursing assistants constantly yelled for each other from each hallway end while performing resident care. Resident 299 tried to sleep by 9 p.m. but could not fall asleep until 10 p.m. or 11 p.m. due to yelling and when staff eventually closed the door, yelling again continued through the night. A review of an admission record indicated Resident 38 was admitted to the facility in February 2025. A review of Resident 38's Brief Interview for Mental Status score (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident), dated 2/24/25, indicated Resident 38's BIMS score was 10 out of 15 with a partially intact memory. During a concurrent observation and interview on 4/23/25 at 8:51 a.m. with Resident 38, Resident 38's privacy curtain was drawn fully around the bed. Resident 38 stated closing the curtains helped reduce the hallway noises coming from people talking and doors closing. Resident 38 further stated It's loud here, anytime of the day or night. It sounds like the staff are having a party every so often during the night shift, loud and laughing and screeching. I try to adapt, but enough is enough. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of an admission record indicated Resident 1 was admitted to the facility in February 2025 with a diagnosis of insomnia. A review of Resident 1's BIMS score, dated 2/18/25, indicated Resident 1's BIMS score was 14 out of 15 with intact memory. During an interview on 4/23/25 at 9:31 a.m. with Resident 1, Resident 1 stated the noise was bothersome all the time and there were . issues resting because it's so noisy. Resident 1 reported to staff the noise, the sound level got better for a day or two, then became intolerable again. Resident 1 further stated it sounded like staff were having a fundraiser with someone . calling out real loud and it occurred during day and night shifts. A review of an admission record indicated Resident 300 was admitted to the facility in April 2025. During an observation on 4/23/25 at 10:09 a.m. in Resident 300's room, Resident 300's head was covered with a blanket while lying in bed. During an interview on 4/23/25 at 1:11 p.m. with Resident 300, Resident 300 stated placing a blanket over the head muffled out noises. Resident 300 further stated the irritating noises came from staff and residents in the hallway and the noise was worse at daytime. During an interview on 4/23/25 at 2:29 p.m. with the Director of Nursing (DON), DON stated the facility did not want residents to experience issues with loud noises during late hours. DON further stated residents needed rest and a calm environment to heal. A review of the facility's policy titled, Quality of Life - Homelike Environment, revised in May 2017, indicated, The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include . comfortable noise levels.

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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** 43258 Based on interview and record review, the facility failed to develop a comprehensive person-centered care plan for one of 17 sampled residents (Resident 397), when the care plan did not address Resident 397's insomnia (trouble falling asleep or staying asleep) and trazodone (a medication to treat insomnia). This failure decreased Resident 397's potential to receive appropriate care, services, and treatment. Findings: A review of Resident 397's medical record indicated he was admitted to the facility on [DATE] with multiple diagnoses including dementia (a progressive state of decline in mental abilities), depression, anxiety, and personal history of other mental and behavioral disorders. A review of Resident 397's medical record indicated a physician's order for trazodone 50 milligrams (mg; a unit of measure), give 25 mg at bedtime for insomnia, ordered on 4/13/25. During a concurrent interview and record review on 4/23/25 at 10:09 a.m. with Licensed Nurse 1 (LN 1), Resident 397's care plans were reviewed. LN 1 stated she did not see a specific care plan developed for Resident 397's sleep or insomnia. During a concurrent interview and record review on 4/23/25 at 10:56 a.m. with the Director of Nursing (DON), Resident 397's care plans were reviewed. DON stated the expectation was to see a care plan developed for sleep or insomnia and confirmed there was none. A review of the facility's policy and procedure titled, Comprehensive Person-Centered Care Plans, revised in December 2016, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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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. 50750 Based on interview and record review, the facility failed to revise the care plan for one of 17 sampled residents (Resident 397), when Resident 397 sustained a bruise (an injury or mark where the skin has not been broken but is darker in color, often as a result of being hit by something) to the right cheek. This failure decreased the facility's potential to provide Resident 397 with a person-centered care plan that meets the changed care needs. Findings: A review of Resident 397's Admission Record, indicated Resident 397 was admitted to the facility in April 2025 with a diagnosis of vascular dementia (problems with reasoning, planning, judgement, memory and other thought processes caused by brain damage from impaired blood flow to your brain). A review of Resident 397's SBAR (situation, background, assessment, recommendation) Communication Form and Progress Note, dated 4/17/25, indicated Resident 397 had a change of condition that resulted in bruising to face. A review of Resident 397's physician's order, dated 4/18/25, indicated an order to monitor Resident 397's discoloration on the right cheek every shift. During an interview on 4/22/25 at 1:35 p.m. with Licensed Nurse 4 (LN 4), LN 4 stated if a resident had a change of condition, the expectation was to create a SBAR, make a progress note, and update the care plan. During a concurrent interview and record review on 4/23/25 at 1:53 p.m. with the Director of Nursing (DON), Resident 397's care plan dated 4/18/25 was reviewed. DON confirmed Resident 397's care plan did not indicate a bruising in his right cheek and stated her expectation was nurses should have updated the care plans whenever residents had a change of condition. A review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised in December 2016, indicated, . Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 43258 Based on observation, interview, and record review, the facility failed to provide care and services in accordance with acceptable professional standards of quality for one of 17 sampled residents (Resident 196), when Licensed Nurse 2 (LN 2) did not clarify a physician's order with multiple dosages prior to administering medication. This failure had the potential to result in Resident 196 not receiving the correct dosage of medication and worsening of their clinical condition. Findings: During a medication pass observation on 4/21/25 at approximately 9 a.m., LN 2 was observed preparing six medications for Resident 196 including calcium carbonate (a medication to treat heartburn) 500 milligrams (mg, a unit of measurement), one tablet. A review of Resident 196's medical record indicated a physician's order for calcium carbonate 1250 (500 Ca) mg (calcium carbonate), give one tablet by mouth two times a day for heartburn, ordered 4/10/25. During an interview on 4/21/25 at 1:23 p.m. with LN 2, LN 2 stated he prepared and administered one tablet calcium carbonate for a total of 500 mg, not 1250 mg, to Resident 196. LN 2 stated the dose ordered by the physician was unclear and should have been clarified prior to administration to ensure the correct dose was given to Resident 196. During an interview on 4/22/25 at 12:42 p.m. with the Director of Nursing (DON), DON stated nursing staff were expected to clarify an order with the physician if it was not clear. DON further stated whenever in doubt, nurses should contact the doctor. A review of the facility's policy and procedure titled, Administering Medications, revised in December 2012, indicated, Policy Statement: Medications shall be administered in a safe and timely manner . Policy Interpretation and Implementation . 5. If a dosage is believed to be inappropriate or excessive for a resident . the person preparing or administering the medication shall contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 45770 Based on observation, interview, and record review, the facility failed to follow the plan of care for one of 17 sampled residents (Resident 247), when Resident 247's communication board was not available for use during provision of care. This failure decreased the facility's potential to meet Resident 247's ability to communicate her needs. Findings: A review of an admission record indicated Resident 247 was admitted to the facility in April 2025 with a diagnosis of chronic respiratory failure. A review of Resident 247's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 4/5/25, indicated Resident 247 had adequate ability to see and hear with a Brief Interview of Mental Status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 14 out of 15 with no memory problems. A review of Resident 247's communication care plan, dated 4/7/25, indicated Resident 247 had communication barrier due to language used. The care plan further indicated Resident 247 communicated only in Russian and one of the interventions indicated that staff should use a communication board to effectively communicate with Resident 247. During a concurrent observation and interview on 4/21/25 at 8:45 a.m. with Licensed Nurse 1 (LN 1), inside Resident 247's room, Resident 247 was seated on her bed and responded in her native language when asked. No communication board was available, and LN 1 stated Resident 247 only spoke Russian. During a concurrent observation and interview on 4/21/25 at 1:41 p.m. with Social Worker 1 (SW 1), inside Resident 247's room, SW 1 stated she communicated with Resident 247 using a communication board as written in her assessment. SW 1 searched for the communication board and confirmed it was not inside Resident 247's room. During a concurrent observation and interview on 4/22/25 at 8:30 a.m. with LN 4, LN 4 was inside Resident 247's room and was unable to respond back when asked by Resident 247. LN 4 confirmed there was no communication board that can be used inside Resident 247's room and stated communicating with Resident 247 was difficult without a communication board. During an interview on 4/23/25 at 1:59 p.m. with the Director of Nursing (DON), DON confirmed Resident 247's care plan included the use of a communication board as an intervention for the staff to utilize when communicating with Resident 247. DON stated implementing Resident 247's care plan was vital to provide appropriate care. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Translation and/or Interpretation of Facility Services, revised in 5/2017, indicated, Non-bilingual staff will be provided with communication boards for routine communications with residents who have language or communication barriers . The Director of Social Services, or their designee, will serve as the coordinator of the facility's language access program, overseeing the implementation and monitoring of language access services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 45770 Based on observation, interview, and record review, the facility failed to provide respiratory care services according to professional standards of quality for one of 17 sampled residents (Resident 24), when Resident 24's administered oxygen was not consistent with the physician's order. This failure decreased the facility's potential to follow the physician's order when providing respiratory services. Findings: A review of Resident 24's Admission Record, indicated Resident 24 was admitted to the facility in December 2024 with a diagnosis of anxiety disorder. A review of Resident 24's Order Summary Report, dated 2/27/25, indicated an order for oxygen use two liters per minute (l/min, unit of measurement) via nasal cannula as needed for shortness of breath. During a concurrent observation and interview on 4/21/25 at 12:45 p.m. with Resident 24, Resident 24 was sitting up in bed with her oxygen set at one l/min. Resident 24 stated she was still short of breath even with her oxygen on. During a concurrent interview and record review on 4/21/25 at 12:50 p.m. with Licensed Nurse 3 (LN 3), Resident 24's physician order was reviewed. LN 3 confirmed Resident 24's oxygen concentrator was set to one l/min and stated Resident 24's physician order was two l/min of oxygen as needed. During an interview on 4/23/25 at 1:59 p.m. with the Director of Nursing (DON), DON stated her expectation was nurses should have followed the doctor's order accurately to prevent complications from occurring and to be able to provide proper care to residents. A review of the facility's policy titled, Oxygen Administration, revised in 10/2010, indicated, Provide safe oxygen administration .verify .physician's order . the rate of oxygen flow, route, and rationale.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 43258 Based on observation, interview, and record review, the facility failed to ensure: 1. Controlled substance medications (medication with a high potential for abuse and addiction) were accurately accounted on the medication administration record (MAR) and the Controlled Drug Record (CDR) for two of four randomly selected residents (Resident 24 and Resident 197); 2. Controlled drug shift-to-shift count records (a record used to reconcile inventory of controlled medications in the medication cart by the outgoing and incoming nurse during a shift change) were routinely signed by the off-going and on-coming nursing shifts; and 3. Removal of narcotic medication from the emergency kit (e-kit; a kit/box containing medications and supplies for immediate use during a medical emergency) was accurately and completely documented. These failures decreased the facility's potential to have accurate accountability of controlled medications, prevent abuse or misuse of these medications, and meet the residents' therapeutic needs or worsening of their medical conditions for a census of 45 residents. Findings: 1. The controlled medication CDRs for four random residents receiving as-needed controlled medications were requested for review during the survey. Resident 24 had a physician's order for hydrocodone/APAP (a narcotic medication to treat pain) 5/325 milligrams (mg, a unit of measurement), take one tablet every four hours as needed for moderate pain, take two tablets every four hours as needed for severe pain, dated 2/2/25. The CDR indicated hydrocodone/APAP was removed from the medication cart on the following dates and times, but their respective administrations were not documented on the MAR: one tablet on 4/15/25 at 9:23 p.m., one tablet on 4/18/25 at 10:45 a.m., and one tablet on 4/20/25 at 9:10 a.m. Resident 197 had a physician's order for hydrocodone/APAP 10/325 mg, take one tablet every eight hours as needed for pain, dated 4/16/25. The CDR indicated one tablet hydrocodone/APAP was removed from the medication cart on 4/19/25 at 8 p.m. but the administration was not documented on the MAR. During an interview on 4/22/25 at 12:55 p.m. with the Director of Nursing (DON), the DON stated nurses were educated to document every pill that was removed from the bubble pack on the CDR in order to not lose any medication. DON further stated the MAR should reflect the administered dose. A review of the facility's policy and procedure (P&P) titled, Controlled Substances, revised in December 2012, indicated, Policy Interpretation and Implementation . 4. If the count is correct, an individual resident controlled substance record must be made for each resident who will be receiving a controlled substance . This record must contain . l. Signature of nurse administering medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled, Administering Medications, revised in December 2012, indicated, Policy Interpretation and Implementation . 20. As required or indicated for a medication, the individual administering the medication will record in the resident's medical record: a. The date and time the medication was administered; b. The dosage; c. The route of administration; The injection site (if applicable); e. Any complaints or symptoms for which the drug was administered; f. Any results achieved and when those results were observed; and g. The signature and title of the person administering the drug. 2. During a concurrent interview and record review on 4/21/25 at 12:03 p.m. with Licensed Nurse 1 (LN 1), the controlled drug shift-to-shift count records, dated April 2025, for Medication Cart B were reviewed. The record indicated missing signatures by the off-going and on-coming nurse for various shifts. LN 1 acknowledged and confirmed the finding and stated the nurses should have signed between shifts to document there were no discrepancies. A review of the Controlled drug shift-to-shift count records, dated 4/1/25 to 4/21/25, indicated a total of 11 missing signatures (for the dates indicated) between nursing shift changes. During a concurrent interview and record review on 4/21/25 at 1:51 p.m. with LN 1, the controlled drug shift-to-shift count records, dated April 2025, for Medication Cart C were reviewed. The controlled drug shift-to-shift count records, dated 4/1/25 to 4/21/25, indicated four missing signatures by the outgoing and incoming nurse for each shift. LN 1 acknowledged and confirmed the finding. During an interview on 4/22/25 at 12:54 p.m. with the DON, the DON stated the on-coming and off-going nurses were expected to both sign to endorse that the narcotic count in the medication cart was accurate to ensure accountability. A review of the facility's P&P titled, Controlled Substances, revised in December 2012, indicated, Policy Interpretation and Implementation . 9. Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together . 3. During a concurrent observation and interview on 4/21/25 at 10:58 a.m. with Infection Preventionist/Interim Staff Development (IP), the medication storage room was inspected. A narcotic e-kit with a red plastic tie (indicating it had been opened) was identified. Inside the e-kit was a log indicating one tramadol (a narcotic medication used to treat pain) 50 mg tablet had been removed, but the date and time of the removal was not documented. IP stated nursing staff were expected to fill out the log in full, including the date and time. During an interview on 4/22/25 at 12:42 p.m. with the DON, DON stated nursing staff were expected to fill out the e-kit log completely whenever they removed medication. A review of the facility's P&P titled, Emergency Medications, revised in April 2007, indicated, Policy Interpretation and Implementation . 7. Required documentation after dispensing an emergency medication is the same as for any other medication. 8. Any medication that is removed from the emergency kit must be documented on the emergency medication administration log.

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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. 43258 Based on observation, interview, and record review, the facility failed to ensure: 1. Multi-dose medications were dated with an open and discard date to confirm they were not used beyond the discard date; 2. Prescription medications were appropriately labeled with a pharmacy label or name to correctly identify which resident they were for; 3. Medications with different routes of administration were stored in accordance with facility policy and procedures (P&P); and 4. Expired medications were not available for resident use. These failures increased the residents' potential to unsafely receive inadequately labeled medications with reduced potency, past their discard date, and through the wrong route of administration for a census of 45 residents. Findings: During a concurrent observation and interview on 4/21/25 at 10:58 a.m. with the Infection Preventionist/Interim Staff Development (IP), the medication storage room was inspected. IP confirmed the following findings: - One bottle Sea Aloe (a natural supplement used to boost energy and support digestive health), four Novolog Flex Pens (a fast-acting insulin to treat diabetes-a disorder characterized by difficulty in blood sugar control and poor wound healing), and four Lantus Solostar Pens (long-acting insulin to treat diabetes) were identified without pharmacy labels. IP stated the medications should have had pharmacy labels on them to indicate which residents they were for; and - One ceftriaxone (an antibiotic to treat infection) two grams/50 milliliters (g/ml, a unit of measurement) intravenous (administered through the vein), expired on 4/9/25 and one vial of Tubersol (a medication used to diagnose tuberculosis-a serious infectious disease primarily affecting the lungs) opened and unlabeled with an open date, were also identified. IP stated the ceftriaxone should have been given to the Director of Nursing (DON) for destruction and the Tubersol needed to be labeled with an open date because it was only stable for 30 days once used. A review of the manufacturer's labeling for Tubersol, revised on 3/18/22, indicated, 11. Storage, Stability and Disposal . A vial of Tubersol which has been entered and in use for 30 days should be discarded. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled, Storage of Medications, revised in April 2007, indicated, Policy Interpretation and Implementation . 3. Drug containers that have missing, incomplete, improper or incorrect labels shall be returned to the pharmacy for proper labeling before storing. 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. A review of the facility's P&P titled, Labeling of Medication Containers, revised in April 2007, indicated, Policy Interpretation and Implementation . 3. Labels for individual drug containers shall include all necessary information, such as: a. The resident's name; b. The prescribing physician's name; c. The name, address, and telephone number of the issuing pharmacy; d. The name, strength, and quantity of the drug; e. The prescription number (if applicable); f. The date that the medication was dispensed; g. Appropriate accessory and cautionary statements; h. The expiration date when applicable; and I. Directions for use . 10. Expired medications must not be stored in the medication carts or med rooms. All expired medications must be properly disposed of. A review of the facility's P&P titled, Administering Medications, revised in December 2012, indicated, Policy Interpretation and Implementation . 9. The expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be recorded on the container . 14. Insulin pens will be clearly labeled with the resident's name or other identifying information . During a concurrent observation and interview on 4/21/25 at 11:50 a.m. with Licensed Nurse 1 (LN 1), Medication Cart (Med Cart) B was inspected. LN 1 confirmed the following findings: - One vial of professional monitoring blood glucose test strips (used to measure blood sugar levels) and one pouch of budesonide (a medication used to treat asthma-a chronic respiratory disease characterized by inflammation and narrowing of the airways, making breathing difficult) inhalation suspension 0.5 milligrams/2 milliliters (mg/ml, a unit of measurement) opened and unlabeled with an opened date, were identified. LN 1 confirmed the manufacturer's labeling on the test strips indicating Use within 4 months of opening the vial, and stated it should have been labeled with a date on the vial. LN 1 also confirmed the manufacturer's labeling on the budesonide inhalation solution indicating . Once the foil envelope is opened, use the ampules within 2 weeks and stated the pouch did not have an opened date, but should have. - Inspection of the drawers in the med cart containing oral medications identified one bag of rivastigmine (a medication to treat Alzheimer's disease, a condition that affects memory and mental processes) transdermal (applied topically to the skin) patches 9.5 mg/25 hours and one bag lidocaine 5 percent (%; unit of measure) patches. LN 1 confirmed the medications were used topically and were comingled with the oral medications and stated the patches were to be stored separately with the inhaled medications. - Further inspection inside the drawers identified four loose tablets and capsules. LN 1 stated loose pills were to be disposed of in a drug buster (a substance used to inactivate medication and prevent its removal and diversion). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/21/25 at 1:51 p.m. with LN 1, Med Cart C was inspected. The following items were identified opened and unlabeled with opened dates: one vial of professional monitoring blood glucose test strips, one pouch of budesonide 0.5 mg/2 ml inhalation solution, two Stiolto Respimat (a medication used to treat lung disease) 2.5/2.5 microgram (mcg, a unit of measurement) inhalers, one Combivent Respimat (a medication to treat lung disease) 20/100 mcg inhaler, one Anoro Ellipta (a medication used to treat lung disease) 62.5/25 mcg inhaler, and one Breyna (a medication used to treat asthma) 80/4.5 mcg inhaler. LN 1 confirmed the findings and the manufacturer's labeling on each medication that indicated shorter expiration dates once used or opened. During the same inspection of Med Cart C with LN 1, one vial nitroglycerin (a medication used to treat chest pain) 0.4 mg sublingual (under the tongue) tablets was identified without a pharmacy label. LN 1 confirmed the finding and stated the medication should have had a label on it to indicate which resident it was for. A review of the manufacturer's labeling for Stiolto, revised in January 2025, indicated, After assembly, the Stiolto Respimat inhaler should be discarded at the latest 3 months after first use or when the locking mechanism is engaged, whichever comes first. A review of the manufacturer's labeling for Combivent Respimat, revised in April 2025, indicated, After assembly, the Combivent Respimat inhaler should be discarded at the latest 3 months after first use or when the locking mechanism is engaged, whichever comes first. A review of the manufacturer's labeling for Breyna, revised in September 2020, indicated, Throw away Breyna when the counter reaches zero (0) or 3 months after you take Breyna out of its foil pouch, whichever comes first. During an interview on 4/22/25 at 12:44 p.m. with the DON, DON stated medications should have labels with at least a resident's name before storing them in the medication storage room or med carts. DON added loose pills and expired medications needed to be removed and disposed of and medications with shorter expirations after use needed to be marked with opened dates. DON further stated she did not have any concern with staff storing patches with oral medications. A review of the facility's P&P titled, Storage of Medications, revised in April 2007, indicated, Policy Interpretation and Implementation . 2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner . 5. Drugs for external use, as well as poisons, shall be clearly marked as such, and shall be stored separately from other medications.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 50168 Based on interview and record review, the facility failed to ensure two food service personnel were able to safely and effectively carry out the functions of the food and nutrition services, when Dietary Aide (DA) 1 and DA 2 were unable to verbalize the process of manual dishwashing by using two-compartment sinks correctly. This failure had the potential to place 45 out of 45 highly susceptible residents who received food from the kitchen at risk for food-borne illness. Findings: During an interview on 4/21/25 at 9:30 a.m. with DA 1, DA 1 was asked about the manual dishwashing process. DA 1 stated the steps were wash, sanitize, rinse and air-dried and answered with the same steps three times. DA 1 did not know the wash and rinse water temperature during the manual washing, was not sure how long the dishes submerge in the sanitizer solution and then stated a few minutes. DA 1 further stated the concentration for the sanitizer should be 200 parts per million (ppm; concentration measurement units). During an interview on 4/21/25 at 9:30 a.m. with Certified Dietary Manager (CDM), CDM confirmed and stated DA 1's answer was not correct, and stated the correct steps were wash, rinse, sanitize and air-dried. CDM further stated staff, especially the dishwasher, should have a good knowledge about manual dishwashing. During an interview on 4/22/25 at 9:40 a.m. with DA 2, DA 2 was asked about the manual dishwashing process. DA 2 verbalized the process of dishwashing using a two-compartment sink. DA 2 stated the steps were wash, rinse, sanitize and that he would take the large bucket from the shed for the sanitizer as third compartment sink. DA 2 also stated during the sanitizing step, the dishes would submerge in the sanitizer for one to two seconds and repeated the same answer twice. DA 2 further stated the concentration of the sanitizer should be at 200-400 ppm. During an interview on 4/23/25 at 8:45 a.m. with Registered Dietitian (RD), RD stated the dishwashers should have a good knowledge about manual dishwashing in case the dishwashing machine was not working or there was an emergency. A review of the facility's policy and procedure (P&P) titled, 3-Compartment Procedure for Manual Dishwashing, dated 2023, indicated the steps were wash, rinse, sanitize and air-dried. P&P also indicated the water temperature of the wash and rinse steps were 110-120 degrees Fahrenheit (F; unit of measure), and the immersion time was 60 seconds for the dishes in the sanitizer during the sanitizing process. A review of DA 1's employee file indicated DA 1's date of hire (DOH) was on 5/24/15. A review of DA 2's employee file indicated DA 2's DOH was on 11/30/20. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of DA 1's and DA 2's competency audits titled, Verification of Job Competency Equipment Competency, dated 2/25, indicated both DA 1 and DA 2 were checked off by CDM. The competency further indicated DA 1 and DA 2 were competent to the procedure of three-compartment sink manual dishwashing by demonstration. A review of the facility's document titled, Dietary In-Service, Topic: Cleaning and Sanitizing Dishes, Utensils, Pots and Pans, completed on 2/25 by CDM, indicated the in-service included the 3-Compartment Sink (manual dishwashing) procedure. It also indicated DA 1 and DA 2 attended the in-service. A review of the facility's undated document titled, Job Description: Food & nutrition Services Aide, indicated, . the Food and nutrition Services (Dietary) Aide . follows posted cleaning schedules utilizing proper sanitation and cleaning methods. Practices Safety, infection control, and emergency procedures according to community standards . A review of the facility's undated document titled, Job Description: Director of Food & Nutrition Services (DFNS) (same as CDM), indicated, . DFNS . Responsibilities . Plan and conducts departmental . in-service education programs for the nutrition services (dietary) staff . Maintains competencies for Food & Nutrition Staff . required by Standards of practice and state law, necessary to work safely and adequately .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 50168 Based on observation, interview, and record review, the facility failed to ensure the menu was followed for the therapeutic diet (a modification of a regular diet, tailored to fit the nutritional needs of a particular person - may be part of a treatment or medical condition and usually prescribed by a physician) during the lunch meals on 4/21/25 and 4/22/25, when: A. During a dining observation on 4/21/25: 1. Three residents (Residents 11, 21 and 35) on Consistent Carbohydrate (CCHO) diet (a therapeutic diet to manage diabetic disease and/or to stabilize blood sugar level) got pineapple Bavarian cream square instead of pineapple tidbits as listed on menu; and 2. Resident 17 with CCHO diet received pudding instead of CCHO dessert. B. During a meal service distribution on 4/22/25: 1. 15 residents (Residents 1, 2, 3, 7, 15, 18, 20, 21, 25, 28, 30, 38, 39, 41, and 396) with fortified (add extra calories and nutrients) diet (diet designs for residents who cannot consume adequate amounts of calories and/or protein to maintain their weight or nutritional status) did not receive super soup as fortified food; and 2. Two residents (Residents 6 and 17) on a large portion diet received three ounces (oz., a unit of measure) of meat instead of four oz. These failures had the potential to result in compromising the medical and nutritional status of 19 out of 45 residents who received meals from the facility's kitchen. Findings: A. During a dining observation for lunch meal on 4/21/25 at 12:13 p.m., it was noted as follows: 1. Resident 11, 21, and 35 with CCHO diet received pineapple Bavarian cream square for dessert. A concurrent review of the facility's spreadsheet (a menu in excel sheet format that indicated what items and portions to be served for each prescribed/therapeutic diet) titled, Week 1 Monday, [Facility's Name], Therapeutic Spreadsheet, indicated CCHO diet should have received pineapple tidbits for dessert. During an interview on 4/21/25 at 12:35 p.m. with the Certified Dietary Manager (CDM), CDM confirmed and stated CCHO diets should get pineapple tidbits. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's undated document titled, Job Description: Food and Nutrition Services Aides (Dietary Aides), indicated the dietary aides prepares hot and cold foods and beverage . following menu and recipes for regular, texture modified and therapeutic diets . checks resident's trays for proper and accurate food items .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50168 Based on observation, interview, and record review, the facility failed to ensure food was prepared, stored, served, or distributed in accordance with professional standards of food service safety, when: 1. The ice machine was not clean; 2. The blade of the can opener was not well maintained; 3. Significant scratches were found on the cooking surfaces on the nonstick cooking pans with coating; 4. Significant amount of food items were found with inconsistent dating practices in the reach-in refrigerators, dry storage and walk-in freezer; 5. Opened food packages were found not resealed properly; 6. The thawing meat was found with no pull date to indicate when the meat thawing started; 7. Produce food items were found not fresh; and 8. The resident's food refrigerator was found with two issues: a. The freezer section was not clean; and b. The monitor system of the refrigerator and freezer was not practiced correctly. These failures had the potential to cause food contamination and food borne illness among the 45 medically vulnerable residents who consumed food from the kitchen and resident's refrigerator in the facility. Findings: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. During a concurrent observation and interview on 4/21/25 at 10:33 a.m. with the Maintenance Supervisor (MS), MS stated he was responsible to clean the ice machine once a month, his last cleaning was completed on 3/23/25, and he changed the water filter every six months. MS took apart the top machinery part of the ice machine and took down the water curtain (a component that controls the water flow over the evaporator surface, ensuring the ice is made uniformly). A yellow-orange substance was noted inside the water curtain and could be removed easily with a paper towel. MS took out the water trough (a component that holds water within the ice maker) and a pink substance was noted on the top and could be removed easily with a paper towel. Significant amount of black and yellow substances were noted on the bottom of the evaporator unit (the core component where ice formation takes place) and could be removed with wiping of the paper towel. The surface area was also rough to touch. MS confirmed all the findings and stated he got the training from the manufacture's technician when he started working in the facility eight months ago. During an interview on 4/23/25 at 8:45 a.m. with Registered Dietitian (RD), RD stated the ice machine should be cleaned monthly because the ice machine made ice and ice was food. A review of the facility's policy and procedure (P&P) titled, Ice machine Cleaning Procedures, dated 2023, indicated, . Clean inside ice machine with sanitizing agent per manufacturer's instructions. A review of the [Manufacturer name] Ice Machines manual, revised in 9/2019, indicated, Use of nylon brush or cloth to descale (remove of lime scale and mineral deposits) side walls, evaporator plastic parts including top, bottom, and sides . When sanitizing, pay particular attention to the following areas: side walls, base (area above water trough), evaporator plastic parts-including top, bottom and sides, bin or dispenser . According to 2022 Food and Drug Administration (FDA) Food Code, on section 4-602.11 Equipment Food-Contact Surface and Utensils, it stated equipment like ice makers and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms (a living thing that is so small it must be viewed with a microscope, such as bacteria or algae). In addition, on Section 4-202.11 Food-Contact Surfaces, it stated, . The purpose of the requirements for multiuse food-contact surfaces is to ensure that such surfaces are capable of being easily cleaned and accessible for cleaning. Food-contact surfaces that do not meet these requirements provide a potential harbor for foodborne pathogenic organisms. Surfaces which have imperfections such as cracks, chips, or pits allow microorganisms to attach and form biofilms. Once established, these biofilms can release pathogens to food. Biofilms are highly resistant to cleaning and sanitizing efforts . and . Multiuse Food-Contact Surfaces shall be: 1. Smooth; 2. Free of breaks, open seams, cracks, chips, inclusions, pits . 2. During a concurrent observation and interview on 4/21/25 at 9:13 a.m. with the Certified Dietary Manager (CDM), CDM confirmed the blade of the can opener was chipped with the metal surface worn off and stated the blade was worn out and needed to be replaced. During an interview on 4/23/25 at 8:45 a.m. with RD, RD stated the blade should have been replaced when it chipped and worn off. RD further stated the risk for chipping blade might have physical contamination and the metal material might fall into the content of the food when opening the cans. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's P&P titled, Can Opener and Base, dated 2023, indicated, . Proper sanitation and maintenance of the can opener and base is important to sanitary food preparation. Metal shavings and shredding can result from a dull cutting blade . Replace blade on can opener as needed . 3. During a concurrent observation and interview on 4/21/25 at 9:10 a.m. with CDM, CDM confirmed two non-stick coating pans were found with scratches on the cooking surface and stated they should be replaced with new pans. During an interview on 4/21/25 at 9:05 a.m. with RD, RD stated the cooking pans with scratches needed to be replaced because it might lead to physical contamination if the coating piece fell off from the scratches into the food. A review of the facility's P&P titled, Sanitization, dated 2001, indicated, . All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair . free from chips that may affect their use or proper cleaning . 4. During a concurrent observation and interview on 4/21/2025 at 8:28 a.m., 9:36 a.m., and 10:02 a.m. with CDM, CDM confirmed the following food items in the reach-in refrigerators, dry storage and the walk-in freezer had inconsistent dating practices: - An opened bag 1/3 full of parsley (no opened and used by dates). CDM confirmed the bag's manufacturer used by date of 3/29/25 and stated the parsley was passed the used by date and should have been discarded; - An opened bag 1/2 full of salad mix stored in a zip lock bag (no opened and used by dates); - A bag sandwich with label of M&C (meat and cheese) and a date of 4/20/25. CDM stated the date was the prepared date and it should have a used by date and was good for three days; - A tub of lime pudding with label of opened date of 4/20/25 (no used by date); - An opened tub of fruit salad with an opened date of 4/17/24 (no used by date); - An opened tub of cottage cheese with an opened date of 4/19/25 (no used by date); - An opened tub of sour cream with an opened date of 4/19/25 (no used by date); - One opened bag of cereal with an opened date of 4/6/25, and three opened bags of cereal without opened and used by dates. CDM stated the opened food items should have opened and used by dates; - One opened bag of frozen diced ham with opened date of 4/8/24 (no used by date); - One opened bag of frozen veggie rotini pasta (no opened and used by dates); and - One opened bag of frozen cinnamon rolls with an opened date of 4/6/25 (no used by date). CDM confirmed the findings and stated the opened food packages should have opened and used by dates, and the prepared food should have prepared date and used by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's P&P titled, Procedure for Refrigerated Storage, dated 2023, indicated, . food items should be dated so that the older items are used first . and dating the packages or containers will facilitate this practice. A review of the facility's P&P titled, Procedure for Freezer Storage, dated 2023, indicated, . All frozen food should be labeled and dated . A review of the facility's P&P titled, Labeling and Dating of Foods, dated 2023, indicated, . All food items in the storeroom, refrigerator, and freezer need to be labeled and dated . Newly opened food items will need to be closed and labeled with an open date and used by the date . All prepared food needs to be . labeled and dated . 5. During a concurrent observation and interview on 4/21/25 at 8:28 a.m., 9:36 a.m., and 10:02 a.m. with CDM, the reach-in refrigerators, dry storage, and the walk-in freezer were found to have the following: - One opened bag of 1/2 full refrigerated salad mix stored in a zip lock bag but not sealed; - Four opened bags of dry cereal stored in zip lock bags but not sealed; - One opened bag of frozen diced ham stored in a zip lock bag and not completely sealed; - One opened bag of frozen veggie rotini pasta stored in a zip lock bag and not completely sealed; and - One opened bag of frozen cinnamon rolls stored in a zip lock bag and not completely sealed. CDM confirmed the findings and stated the opened food packages should be kept sealed tightly. During an interview on 4/23/25 at 8:45 a.m. with RD, RD stated the opened food packages should have been resealed tightly to avoid contamination and to keep the food fresh. A review of the facility's P&P titled, Storage of Food and Supplies, dated 2023, indicated, . Dry food items which have been opened . will be tightly closed, labeled, and dated. A review of the facility's P&P titled, Procedure for Freezer Storage, dated 2023, indicated, . store frozen food sin an airtight moisture-resistant wrapper such as a plastic bag . to prevent freezer burn . A review of the facility's P&P titled, Storing Produce, dated 2023, indicated, . Keeping fresh vegetables tightly wrapped with as little air in the bag/container as possible will keep them fresh longer . 6. During a concurrent observation and interview on 4/21/25 at 8:41 a.m. with [NAME] (CK) 1, a bucket was found at the reach-in refrigerator containing a beef steak with a label stated, use by date of 4/21/25 for dinner. CK 1 stated the beef steak was pulled out from the freezer for thawing and the practice for thawing meats was staff should put a pulled-out date and a used by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/23/25 at 8:45 a.m. with RD, RD stated staff should pull the frozen meat from the freezer in advance and thaw it in the refrigerator. RD further stated staff should have labeled the thawing meat with pull out date and use by date. A review of the facility's P&P titled, Thawing of Meats, dated 2023, indicated, . Label defrosting meat with pull and use by date . 7. During a concurrent observation and interview on 4/21/25 at 9:36 a.m. with CDM, seven out of 16 tomatoes were found at the dry storage with black and white fuzzy indented spots. CDM confirmed the finding and stated, look like they (refer to the dietary staff) did it again, not checking the vegetables. CDM also confirmed one out of 45 oranges with green and white fuzzy spots and stated the orange needed to be thrown away. During an interview on 4/23/25 at 9:13 a.m. with RD, RD stated the produce should be kept fresh and staff should check them before use. A review of the facility's P&P titled, Storing Produce, dated 2023, indicated, Check boxes of fruit and vegetables for rotten, spoiled items . Throw away all spoiled items . 8. During a concurrent observation and interview on 4/21/25 at 12:54 p.m. with Infection Preventionist (IP), IP confirmed the two issues found in the Resident's food refrigerator located in the nursing station: a. A dry frozen spill in the freezer and the freezer did not have a thermometer to monitor the temperature; and b. A review of the Resident Food Fridge Temp (Temperature) Log, dated March 2025 and April 2025, had: - No entries from 3/16/25 to 3/31/25 and 4/16/25 to 4/21/25 for AM (morning) shift; - No entries on PM (evening) shift for March 2025 and April 2025; and - The temperature entries for the freezer at 40 degrees Fahrenheit (F; a unit of measure) for March 2025 and April 2025. IP confirmed there was a spill in the freezer, agreed it was not clean, and stated there was no thermometer for the freezer. IP reviewed the temperature log for March 2025 and April 2025, confirmed the record of freezer temperature of 40 degrees F and stated it was not correct, and it should be at zero-degree F. IP confirmed there were no temperature recorded from 3/16/25 to 3/31/25 and 4/16/25 to 4/21/25 for AM shift and no temperature recorded for the PM shift in March 2025 and April 2025. IP further stated the charge nurse was responsible to monitor the refrigerator and freezer temperatures every AM and PM shift. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's P&P titled, Refrigerators and Freezers, dated 12/2014, indicated, . Acceptable temperature ranges . less than 0 degree F for freezer . designated employees will check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening . the supervisor will take immediate action if temperatures are out of range . Refrigerators and freezers will be kept clean, free of debris, and mopped with sanitizing solution on a scheduled basis and more often as necessary .

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 40841 Based on interview and record review, the facility failed to ensure the Quality Assessment and Assurance (QAA) committee was composed of the required committee members for a census of 45 residents. This failure decreased the facility's potential to identify, monitor, implement and enhance the quality of care for residents. Findings: During a concurrent interview and record review on 4/23/25 at 10:42 a.m. with the Administrator (ADM), the facility's quarterly Quality Assurance and Performance Improvement (QAPI) meeting, dated April 2024 was reviewed. ADM confirmed the Medical Director (MD) did not attend the quarterly QAPI team meeting held in April 2024. A review of the facility's document titled, QA [Quality Assessment] Sign-In Sheet, dated 4/9/24, indicated the MD name and signature were missing as part of the QAA committee for the quarterly QAPI meeting on 4/9/24. A review of the facility's undated document titled, QA Committee Information, indicated the MD was one of the required QAA Committee members. A review of the facility's undated policy titled, 2024/2025 Quality Assurance & Performance Improvement (QAPI) Plan for [facility's name], indicated, The QAPI Committee, which includes the medical director, is ultimately responsible for assuring compliance with federal and state requirement and continuous improvement in quality of care and customer satisfaction.

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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. 45770 Based on observation, interview, and record review, the facility failed to implement infection control practices for a census of 45 residents, when: 1. Enhanced Barrier Precautions (EBPs) were not implemented for Resident 1, Resident 246, Resident 147, Resident 26, Resident 296, Resident 297, Resident 298, and Resident 396; and 2. Certified Nurse Assistant 5 (CNA 5) did not follow proper hand hygiene protocol while passing lunch trays to residents. These failures had the potential to spread infections among residents. Findings: A review of an admission record indicated Resident 1 was admitted to the facility in February 2025 with a diagnosis of chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing). A review of Resident 1's Progress Notes, dated 3/27/25, indicated on 3/26/25 Resident 1 was sent to the hospital for sustaining a deep laceration to her left lower extremity (LLE) and returned back the same day with sutures. During a concurrent observation, interview, and record review on 4/21/25 at 2 p.m. with Licensed Nurse 3 (LN 3), Resident 1's physician orders were reviewed. LN 3 confirmed Resident 1 had an order for EBPs due to LLE wound. LN 3 stated the EBPs order was not followed because there was no sign posted outside or inside Resident 1's room and there were no personal protective equipment (PPE-equipment worn by healthcare workers for protection from hazards including infections) available to use inside the room. During an interview on 4/21/25 at 2:25 p.m. with the Infection Preventionist (IP), IP confirmed Resident 1's EBPs order should have been started and implemented due to her LLE wound to prevent infection. A review of Resident 246's Admission Record, indicated he was admitted to the facility in April 2025 with a diagnosis of cellulitis (bacterial infection of the skin and underlying tissues) on buttock. A review of Resident 246's Order Summary Report (OSR), dated 4/20/25, indicated an intravenous (IV, inside a vein) antibiotic vancomycin (used to treat bacterial infections) 1.25 grams (g; a unit of measurement) to be given daily until 5/12/25. The OSR further indicated an order for care of a peripherally inserted central catheter (PICC, a long thin tube inserted into a vein in the upper arm threaded up to a large vein near the heart) line in the left upper arm (LUA). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/21/25 at 2:25 p.m. with the IP, IP confirmed Resident 246 had a PICC line in the LUA. IP stated the PICC line was considered an indwelling medical device, and EBPs should have been ordered and implemented right away according to the facility's policy. 40841 A review of Resident 147's Admission Record, indicated Resident 147 was admitted to the facility in 2025 with diagnoses including right leg cellulitis and right ankle and foot osteomyelitis (a bone infection characterized by inflammation of the bone tissue). A review of Resident 147's OSR, dated 4/23/25, indicated Resident 147 had an open wound dressing on the right arm, left wrist, and left front arm, a surgical site to right foot, and wound care to bilateral feet. During a concurrent observation and interview on 4/22/25 at 8:23 a.m. with CNA 6, CNA 6 confirmed and stated there were no EBPs signage or PPEs placed by Resident 147's room. During a concurrent observation and interview on 4/23/25 at 8:39 a.m. with LN 6, LN 6 confirmed there was no EBP signage or PPE cart available in front of Resident 147's room. During an interview on 4/24/25 at 9:42 a.m. with the IP, IP stated Resident 147 had a wound dressing and should have EBPs in place. 49821 A review of an admission record indicated Resident 26 was admitted to the facility in March 2025 with a diagnosis of liver abscess (a puss-filled mass in the liver that can develop from infection or injury). A review of Resident 26's care plan, dated 4/4/25, indicated Resident 26 had a biliary drain (tubing that allows bile to flow out from a blocked bile duct into a collection bag outside the body; bile is a digestive liquid made by the liver). During an observation on 4/21/25 at 9:02 a.m., Resident 26 was noted with a biliary drain, located in the right upper quadrant (abdominal area where the liver is located), and draining grayish white fluid. Resident 26 also had a PICC line in the right upper arm (RUA) with two access ports for instilling medications. No EBPs signage was noted around or inside Resident 26's room. A review of Resident 26's OSR, 4/23/25, indicated Resident 26's RUA PICC line was monitored for signs of infection, and dressing changes were ordered on 4/14/25. A review of an admission record indicated Resident 296 was admitted to the facility in April 2025 with diagnoses including end stage renal disease (a serious condition where the kidneys have lost their ability to filter waste from the blood) with dependence on renal dialysis (a life-sustaining treatment for people with kidney failure, replacing the function of healthy kidneys in filtering waste and excess fluid from the blood), and Methicillin Resistant Staphylococcus Aureus infection (MRSA - an infection caused by a type of staph bacteria that become resistant to many antibiotics) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/21/25 at 9:22 a.m. with Resident 296, Resident 296 stated he was recently transferred from the hospital and had MRSA in his left subcostal (below the rib) dialysis port. Resident 296 further stated the dialysis port was closed and a new one was inserted in his right subcostal area. No EBPs signage was noted around or inside Resident 296's room. A review of Resident 296's OSR, dated 4/23/25, indicated Resident 296 had capacity to make healthcare decisions, an order for EBPs on 4/16/25, and an order to monitor the dialysis port on the right upper chest for infection on 4/14/25. The OSR further indicated Resident 296 started receiving intravenous vancomycin three days a week at the dialysis center for MRSA infection on 4/18/25. A review of an admission record indicated Resident 297 was admitted to the facility in April 2025 with a diagnosis of left foot open wound. During a concurrent observation and interview on 4/21/25 at 9:51 a.m. with Resident 297, Resident 297's left foot was connected to a wound vacuum (wound vac -a medical device that uses suction to help wounds heal), wrapped in gauze dressing and covered with a sock. Resident 297 stated the hospital's doctor said the success of the current wound vac treatment was very important while Resident 297 was at the facility; otherwise, Resident 297 would have to undergo an amputation of the left foot. No EBPs signage was noted around or inside Resident 297's room. A review of Resident 297's OSR, dated 4/23/25, indicated Resident 297 had capacity to make healthcare decisions and an order for a wound vac connected to the left plantar foot ulcer (an open wound or sore) for treatment on 4/19/25. A review of an admission record indicated Resident 298 was admitted to the facility in April 2025 with a diagnosis of liver cirrhosis (a disease where healthy liver tissue is replaced by scar tissue). During an observation on 4/21/25 at 8:34 a.m. with Resident 298, Resident 298 was noted with a feeding tube covered by dressing near his upper abdominal midline. No EBPs signage was noted around or inside Resident 298's room. A review of Resident 298's OSR, dated 4/23/25, indicated Resident 298 had a gastrointestinal tube inserted into his abdomen, for which cleansing and dressing treatments were ordered on 4/14/25. The OSR further indicated orders for EBPs on 4/10/25. During a concurrent interview and record review on 4/21/25 at 2:11 p.m. with LN 5, Resident 26's, 296's, 297's, and 298's OSRs were reviewed. LN 5 confirmed both Resident 296 and Resident 298 had orders for EBPs and stated residents with wound vac equipment, indwelling medical devices, and MRSA should be placed on EBPs, and a sign should be placed outside the residents' rooms to alert staff to don PPE prior to providing direct care. During an interview on 4/22/25 at 8:17 a.m. with the IP, IP confirmed Residents 26, 296, 297, and 298 had indwelling medical devices, wound vacs, or MRSA and were not placed on EBPs. IP stated Resident 26, Resident 296, Resident 297, and Resident 298 should have been placed on EBPs and had PPE available in their rooms; otherwise, not following the EBPs procedure might cause the spread of infections to vulnerable residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/25 at 10:29 a.m. with the Director of Nursing (DON), DON stated the EBPs policy was not correctly followed for residents requiring it. DON further stated staff might spread infection to medically fragile residents if EBPs were not in place or appropriate PPEs were not used. 50750 A review of Resident 396's Admission Record, indicated Resident 396 was admitted to the facility in April 2025 with a diagnosis of left lower leg open wound. During a concurrent observation and interview on 4/21/25 at 9:08 a.m. with Resident 396, Resident 396's right leg was connected to a wound vac and her left leg was wrapped in an ace bandage. Resident 396 stated she had wounds on both legs. During a concurrent observation and interview on 4/21/25 at 1:57 p.m. with LN 2, LN 2 confirmed no EBPs signage was noted around or inside Resident 396's room. During an interview on 4/21/25 at 2:13 p.m. with the IP, IP stated Resident 396 should have been placed on EBP. A review of the facility's policy titled, Enhanced Barrier Precaution, revised in 8/22, indicated, Enhanced Barrier Precautions (EBP) are used as an infection prevention and control intervention . EBPs are indicated for residents with wounds and/or indwelling medical devices . Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required . PPE is available outside of the resident rooms. 2. During an observation on 4/21/25 at 12:40 p.m. in Hall 1, CNA 5 was passing lunch trays to resident rooms. CNA 5 passed the lunch trays to seven residents. No hand hygiene was observed in between the distribution of lunch trays. During an interview on 4/21/25 at 12:46 p.m. with CNA 5, CNA 5 confirmed he did not perform hand hygiene while passing the lunch trays. CNA 5 stated he should have performed hand hygiene in between passing meal trays to prevent the spread of germs among residents. During an interview on 4/23/25 at 9:10 a.m. with the IP, IP stated staff were expected to do handwashing or sanitizing in between serving meals to residents. A review of the facility's policy titled, Handwashing/Hand Hygiene, revised in August 2015, indicated, Use an alcohol-based hand rub . alcohol; or . soap . and water for the following situations: . Before and after eating or handling food; . Before and after assisting a resident with meals .

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 45770 Based on interview and record review, the facility failed to follow the Antibiotic Stewardship Program for one of 17 sampled residents (Resident 247), when Resident 247 was prescribed an antibiotic without adequate clinical and laboratory findings for its use. This failure increased Resident 247's potential for an unnecessary administration of an antibiotic without appropriate indication. Findings: A review of an admission record indicated Resident 247 was admitted to the facility in April 2025. A review of Resident 247's hospital admission order, dated 4/3/25, indicated Resident 247 was admitted to the facility with no urinary tract infection (UTI) diagnosis. A review of Resident 247's Order Summary Report, dated 4/7/25, indicated an order for levofloxacin (an antibiotic used to treat bacterial infections) 250 milligrams (mg, unit of measurement) one tablet daily for 14 days for chronic UTI, then half tablet daily to be given until 5/21/25 for UTI prophylaxis. A review of Resident 247's Medication Administration Record, indicated Resident 247 was administered levofloxacin 250 mg one tablet daily from 4/7/25 to 4/20/25, then half tablet daily from 4/21/25 to 4/24/25. A review of Resident 247's medical file indicated a sample of urinalysis with culture was collected from Resident 247 on 3/27/25 at the hospital. Resident 247 had asymptomatic bacteriuria (presence of bacteria in urine without UTI symptoms) and no indication of an antimicrobial treatment. A review of Resident 247's Physician Assistant (PA) Note, dated 4/8/25, indicated Resident 247 was started on an antibiotic for UTI per hospital urine culture report and had no UTI symptoms. During a concurrent interview and record review on 4/23/25 at 9:10 a.m. with the Infection Preventionist (IP), Resident 247's physician order, progress notes, PA notes, and hospital urinalysis with culture lab result were reviewed. IP confirmed Resident 247's antibiotic order was started on 4/7/25 for UTI and was based only on the urinalysis lab test done at the hospital. IP stated Resident 247 did not complain of frequent painful/burning sensation when urinating, there was no strong odor in her urine, and had no fever at the facility. IP further stated according to the urine culture lab result, Resident 247 was asymptomatic (had no symptoms) and there was no indication for an antimicrobial treatment. A review of the facility's policy titled, Antibiotic Stewardship, revised in December 2016, indicated, The purpose of Antibiotic Stewardship Program is to monitor the use of antibiotics in residents . laboratory results and current clinical situations will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be . modified or discontinued.