STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555901	A. Building B. Wing	06/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anberry Post Acute	1000 West Yosemite Avenue Merced, CA 95341

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Number of residents sampled: 6Number of residents cited: 2Based on observation, interview, and record review, the facility failed to provide needed care and services in accordance with professional standards of practice for two of six sampled residents (Resident 25 and Resident 74) when Resident 25 and Resident 74's fingernails and toenails were thick, long and had jagged edges.These failures placed Resident 25 and Resident 74 to experience discomfort and pain when wearing footwear and risk of skin breakdown which could lead to skin infection. During a concurrent observation and interview of 6/16/26 at 11:24 a.m. during initial tour in Resident 74's room, Resident 74 was observed sitting up in his wheelchair at bedside. Resident 74 observed fingernails and toenails thick, long with jagged edges. Resident 74 stated he did not remember the last time his nails were cut. Resident 74 stated he wanted his toenails cut because he could not wear his shoes or socks because his nails got caught in the socks. Resident 74 stated he wanted his fingernails cut because they were too long and could also scratch himself. During a concurrent observation and interview on 6/19/26 at 10:15 a.m. with Resident 25 and Administrator (ADM) in the hallway, Resident 25 was observed sitting up in her wheelchair and propelling self in hallway. Resident 25 was wearing open-toed footwear and her toenails were observed to be thick and long. Resident 24 stated she had not had her toenails trimmed for a while. The ADM stated, The podiatrist was in the facility a month ago. Resident 25 stated she had not seen the podiatrist for a while and was difficult to wear her new shoes because her toenails are too long. The ADM stated he will follow up with the podiatrist.During an interview on 6/17/26 at 3:09 p.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated nail care is provided on resident's shower days which was twice a week. CNA 3 stated CNAs only cut or trim nails of non-diabetic residents, licensed nurses trim or cut nails of diabetic residents. CNA 3 stated she usually let the nurse know if a diabetic resident needs their nails trimmed. During an interview on 6/17/26 at 4:16 p.m. with CNA 1, CNA 1 stated nail care is provided on resident shower days. CNA1 stated CNAs are only allowed to trim or cute non-diabetic residents and not allowed to trim toenails. CNA 1 stated she usually let the charge nurse know when residents needed their toenails trimmed. CNA 1 stated she did not remember seeing a podiatrist (foot doctor) providing services to residents in the facility.During a concurrent observation and interview on 6/18/26 at 1:55 p.m. with Licensed Vocational Nurse (LVN) 1 and Resident 74, observed Resident 74 sitting in his room at bedside. LVN 1 checked Resident 74's fingernails and toenails. LVN 1 stated, His nails are long and needed to be trimmed. LVN 1 asked Resident 74 if he preferred his nails long and Resident 74 stated, No, I want my nails trimmed. Resident 74 stated he could not wear his shoes and socks because of his long toenails. LVN 1 stated nursing staff are responsible in trimming and cutting residents' nails. LVN 1 stated the podiatrist takes care of resident's toenails. LVN 1 stated she did not remember the last time she saw the podiatrist come in the facility and when Resident 74 was last seen by podiatrist. During an interview on 6/19/26 at 10:30 a.m. with Social Services Director (SSD), the SSD stated there was a new podiatrist providing services at the facility and the last time podiatrist was in the facility was 5/2/26. The SSD stated the podiatrist only saw 10 residents and Resident 25 and Resident 74 were not seen. The SSD stated the podiatrist will be going to the facility once a month on Saturdays. The SSD stated the licensed nurses usually give her a resident list of resident that need to be seen. During an (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 6/19/26 at 11:21 a.m. with the Director of Staff Development (DSD), the DSD stated nail care is provided to residents on shower days and as needed. The DSD stated CNAs are not allowed to trim toenails. The DSD stated CNAs are expected to let the charge nurse know when a resident needs to be seen by a podiatrist and the nurse would then let the SSD know. During an interview on 6/19/26 at 1:55 p.m. with the Director of Nursing Services (DNS), the DNS stated her expectation was for CNAs to provide nail care to residents who are not diabetic on their shower days and licensed nurse to provide nail care to diabetic residents. The DNS stated, The podiatrist comes in once a month to take care residents toenails.' The DNS stated they send residents out to the local podiatrist if unable to wait for the next podiatry visit. During an interview on 6/19/26 at 2:30 p.m. with the ADM, the ADM stated he knew the podiatrist was in the facility in May. The ADM stated he did not know Resident 25 and Resident 74 were not seen. The ADM stated he talked to the podiatrist and agreed to increase the number of residents seen every month. The ADM stated, The podiatrist is local and we could send residents in his clinic for any emergencies.During a review of facility's policy and procedure (P&P) titled, Fingernails/Toenails, Care of, revised date 2/18, the ?P&P indicated, .1. Nail care includes daily cleaning and regular trimming. 3. Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments. 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. 6. Stop and report to the nurse supervisor if there is evidence of ingrown toenails, infections, pain, or if nails are too hard or too thick to cut with ease.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure pharmaceutical services were being met according to facility's policy and procedures when:1. Emergency medication kit was opened on 4/13/26 and had not been replaced by the pharmacy for over two months. This failure resulted in medication not being available in the e-kit (emergency medication container) and had the potential not to meet the needs of the residents during emergencies.2. Resident 75's medication brought by the family was not verified by the facility's licensed pharmacist. Resident 75's medication bottle of Lamotrigine (an antiepileptic medication uses to treat epilepsy [a seizure -a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements, behaviors, sensations, or states of awareness]) 200 mg (milligrams -metric unit of measurement, used for medication dosage and/or amount) was stored in the medication cart and was available for use.This failure had the potential for medication error and had the potential to result in the administration of unverified medications, placing Resident 75 at risk of receiving unnecessary or inappropriate treatment. Findings:1. During a concurrent observation and interview on 6/18/26 at 10:17 a.m. with the Director of Staff Development (DSD), in medication room [ROOM NUMBER], the refrigerator e-kit was checked. The refrigerator e-kit had a red lock and white slip inside the container. The refrigerator e-kit indicated, .Brand Name (insulin lispro-a fast-acting type of insulin [one of many hormones that helps the body turn the food we eat into energy] one vial QTY (Quantity) 1. The e-kit slip indicated, .Name of Drug: insulin lispro injection Date: 4/13/26 E-kit Opened. The DSD stated the refrigerator e-kit had a red lock which indicated that the e-kit was open. The DSD stated the e-kit slip was opened on 4/13/26. The DSD stated licensed nurses will fax to the pharmacy the completed e-kit slip for replacement. The DSD stated an opened e-kit should be replaced by the pharmacy the following day or within 72 hours. The DSD stated it was more than two months and had not been replaced. The DSD stated she would notify the pharmacy.During an interview on 6/18/26 at 1:26 p.m. with the Director of Nursing (DON), the DON stated it was her expectation for the pharmacy to replace opened e-kit with 48 hours. The DON stated licensed nurses were checking the medication room including the medication fridge daily and stated, it was missed. The DON stated maintaining complete e-kits was important to ensure medications were available during emergencies.During a review of facility's P&P titled, Emergency Pharmacy Service and Emergency Kits, the P&P indicated, Emergency pharmacy service is available on a 24-hour basis. Emergency needs for medication are met by using the facility's approved emergency medication supply or by special orders from the provider pharmacy. An emergency supply of medications, including emergency drugs, antibiotics, controlled substances and products for infusion is supplied by the provider pharmacy in limited quantities in portable, sealed containers, in compliance with applicable state regulations. G. As soon as possible, the nurse records the medication use on the medication order form and notifies the pharmacy for replacement of the kit by transmitting the entire order for the resident and indicating that the first dose was used from the kit. The nurse flags the kit with a red color-coded lock to indicate need for replacement of kit. K. If exchanging kits, opened kits are replaced with sealed kits within 72 hours of opening. If replacing used medications, the replacement doses are added to the kit within 72 hours of opening. 2.During a medication storage observation on 6/18/26 at 2:46 p.m. in the hallway of nursing station 200, medication cart 200 was checked. Resident 75's medication bottle indicated, Lamotrigine 200 mg Take 3 tablets by mouth daily.QTY (Quantity):90.During a concurrent interview and record review on 6/18/26 at 3:02 p.m. with Licensed Vocational Nurse (LVN) 6, Resident 75's medication bottle of Lamotrigine 200 mg was checked. LVN 6 stated Resident 75's medication bottle of Lamotrigine 200 mg was from outside pharmacy and was brought in by the family. LVN 6 stated she cannot validate if Resident 75's medication bottle of Lamotrigine 200 mg (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was verified by the facility's licensed pharmacist. LVN 6 stated licensed nurses should document Resident 75's progress notes when medications are brought in by the family. LVN 6 stated it is important for licensed nurses to ensure the medications are verified by licensed pharmacist before administering. LVN 6 stated medications brought by the family should be verified before administration to ensure the medication bottle contained the right medication as written on the medication label. LVN 6 stated Resident 75 has an active order of Lamotrigine 200 mg.During a concurrent interview and record review on 6/19/2026 1:30 p.m. with LVN 8, Resident 75's medication bottle of Lamotrigine 200 mg was checked and counted. Resident 75's medication bottle indicated, Lamotrigine 200 mg Take 3 tablets by mouth daily.QTY (Quantity):90. LVN 8 stated Resident 75's medication bottle of Lamotrigine 200 mg contained 27 tablets. LVN 8 stated Resident 75's medication bottle of Lamotrigine 200 mg was not from the facility's pharmacy. LVN 8 stated that medications brought by family should not be used and should be returned to the family. During an interview on 6/19/26 at 2:10 p.m. with the DON, the DON stated it was her expectation for all licensed nurses to follow the P&P for medications brought to the facility by the resident or family to prevent medication errors. The DON stated the facility discouraged the use of medications brought by the family unless the medications were verified by the facility's licensed pharmacist. The DON stated medications brought by the family or resident should be verified by the facility's licensed pharmacist prior to administration to ensure the right medication was being administered to the resident. The DON stated medications brought by the family should be kept in the medication room and should not be stored in the medication cart. The DON stated medications stored in medication carts are available for use.During a review of Resident 75's Order Summary Report dated 6/19/26, indicated, . [Brand Name] 200 mg (Lamotrigine) Give 1 tablet by mouth three times a day for Seizure Disorder (abnormal electrical activity in the brain).During a review of Resident 75's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 6/19/26, the AR indicated Resident 75 was admitted to the facility on [DATE] with diagnosis of epilepsy.During a review of Resident 75's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 4/9/26, the MDS section C indicated Resident 75 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 7 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 75's cognition was severely impaired.During a review of facility's P&P titled, Medications Brought to the Facility by the Resident/Family. The facility shall ordinarily not permit residents and families to bring medications into the facility. 1. Residents and families must report to the nursing staff any medications that they want to bring or have brought into the facility. 3. If a medication is not otherwise available and/or it is determined to be essential to the resident's life, heath, safety, or well-being to be able to take a medication brought in from outside, the Director of Nursing Services and nursing staff, with support of the attending Physician and Consultant and Pharmacist, shall check to ensure that: a. State law and regulations allow such use; .d. The contents of each container have been verified by a licensed pharmacist. 5. Medications brought into the facility that are not approved for the resident's use shall be returned to the family. If the family does not pick up those medications within thirty (30) days, the facility may destroy the in accordance with established policies.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications used were labeled and stored in accordance with professional standards when:1. A [Brand name] topical gel ointment (a topical gel ointment for external use only to relieve joint pain, stiffness and swelling 1.7 oz [ounce - unit of measurement]) with no medication label and no opened date was stored with other liquid and oral medication in front medication cart 300.This failure had the potential for cross contamination (a transfer of harmful bacteria from one object to another) and improper storage of medication.2. Resident 122's [Brand name] Ophthalmic Solution (an eye drops to lubricate, soothe dry burning or irritated eyes) had no open date and no used by date.This failure had the potential for Resident 122 to be administered expired medications had the potential to experience a negative outcome including decreased effectiveness of medication.3. Resident 19's [Brand name] (a nasal spray to treat both seasonal and year-round allergy symptoms) was labeled only with a resident's room number.This failure had the potential for Resident 19 to be administered expired medications had the potential to experience a negative outcome including decreased effectiveness of medication.4. Resident 75's medication of Ondansetron Hydrochloride (a medication used to prevent nausea [a queasy or unsettled feeling in the stomach that creates an urge to vomit) and vomiting) 4 mg (milligrams -metric unit of measurement, used for medication dosage and/or amount) had an expiration date of 6/9/26 and was available for use.This failure resulted in medication errors when Resident 75 received an expired medication on 6/18/26 and had the potential to experience a negative outcome including decreased effectiveness of medication. Findings: 1. During a concurrent observation and interview on 6/18/26 at 11:10 a.m. with the Registered Nurse (RN) in Station 300, the front medication cart 300 was checked for medication storage and labeling with the RN. On the bottom shelf of the medication cart a [Brand name] topical gel ointment with no medication label and no open date was found stored together with other oral and liquid medications. The RN stated, the [Brand name] topical gel ointment is over-the-counter medication (a medication that can be bought directly from a pharmacy or store without a doctor's prescription) but should still be labeled with an open date and used-by date. The RN stated topical gel ointment should be stored separately from oral and liquid medication to prevent cross-contamination. During an interview on 6/18/26 at 1:40 p.m. with the DON, the DON stated [Brand name] topical gel ointment was an over-the-counter medication but should have been properly labeled with date opened and used-by date to monitor the medication's effectiveness. The DON stated all licensed nurses were expected to label over-the-counter medications with the date opened and the use-by date. The DON stated oral and topical medications, or external medications must be stored separately to prevent cross-contamination and for proper medication storage. During a review of the facility's policy and procedures (P&P) titles, Medication Storage in the Facility, dated March 2018, the P&P indicated, . Orally administered medications are kept separate from externally used medications, such as suppositories, liquids, and lotions. 2. During a concurrent observation and interview on 6/18/26 at 11:25 a.m. with the RN in Station 300, the front medication cart 300 was checked for medication storage and labeling with the RN. Resident (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	122's [Brand name] Ophthalmic Solution had no open date and used by date. The RN stated medication should have been labeled with both the date it was opened and the use-by date. The RN stated dates were important to determine when the medication was first started and when it should be discarded. The RN stated the licensed nurses should always check the date open and the use-by date to avoid medication errors and administering medications past their use-by date. During a review of Resident 122's Order Entry (OE) dated 6/18/26, the OE indicated, [Brand name] Tears Ophthalmic Solution.in both eyes.1 drop.three times a day.dry eyes. During an interview on 6/18/26 at 1:50 p.m. with the DON, the DON stated the expectation for the licensed nurses was to ensure that eye drops were properly labeled with the date opened and the use-by date. The DON stated it was important to check the open date and use-by date to ensure the eye drop was safe and effective to use. During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated February 2023, the P&P indicated, . The medication label includes, at a minimum: a. medication name (generic and/or brand); b. prescribed dose; c. strength; d. expiration date, when applicable; e. resident's name; f. route of administration; and g. appropriate instructions and precautions. 3. During a concurrent observation and interview 6/18/26 at 2:43 p.m. with Licensed Vocational Nurse (LVN) 6 in Station 200, the back medication cart 200 was checked for medication storage and labeling with LVN 6. Resident 19's [Brand name] was labeled only with resident's room number. LVN 6 stated [Brand name] should have been properly labeled with the resident's name, room number, date opened and used by date. LVN 6 stated it was important to properly label medications to avoid medication errors and cross-contamination. During a review of Resident 19's Order Summary Report (OSR) dated 6/18/26, the OSR indicated, . [Brand name] Allergy Relief Nasal Suspension.1 spray in both nostrils one time a day for nasal congestion one spray in each nostril. During an interview on 6/18/26 at 3:15 p.m. with the DON, the DON stated all licensed nurses should have used patient identifiers (a specific pieces of medication healthcare providers use to verify the resident's identity such as full name and date of birth) and checked whether medications were properly labeled with resident's name, room number, date opened and used by date during medication administration. The DON stated the failure to label medications correctly could contribute to medication errors and cross-contamination. During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated February 2023, the P&P indicated, . The medication label includes, at a minimum: a. medication name (generic and/or brand); b. prescribed dose; c. strength; d. expiration date, when applicable; e. resident's name; f. route of administration; and g. appropriate instructions and precautions. 4.During a medication storage observation on 6/18/26 at 2:25 p.m. in the hallway of nursing station 200, medication cart 200 was checked. Resident 75's medication card indicated, Ondansetron HCL (Hydrochloride) 4 mg tablet Give 1 tablet by mouth every 6 hours as needed for nausea and vomiting.QTY (Quantity):16 .12/9/25. EXP (Expiration): 6/9/26. During a concurrent interview and record review on 6/18/26 at 2:55 p.m. with LVN 6, Resident 75's medication card for Ondansetron HCL 4 mg was reviewed. The medication card indicated, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ondansetron HCL 4 mg tablet Give 1 tablet by mouth every 6 hours as needed for nausea and vomiting.QTY (Quantity):16 .EXP (Expiration): 6/9/26. LVN 6 stated Resident 75's medication Ondansetron had expired on 6/9/26. LVN 6 stated she administered the expired medication to Resident 75 today (6/18/26). LVN 6 stated she did not check the expiration date prior to administering the medication to Resident 75. LVN 6 stated she should check the expiration date before administering the medication. LVN 6 stated expired medication should be removed from the medication cart for destruction. LVN 6 stated expired medication may not be as effective. During a concurrent interview and record review on 6/19/26 at 9:35 a.m. with the Minimum Data Set Nurse (MDSN), Resident 75's Electronic Medication Administration Record (EMAR, a daily electronic documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 6/2026 was reviewed. The EMAR indicated, Ondansetron HCL 4 mg tablet Give 1 tablet by mouth every 6 hours as needed for nausea and vomiting Ordered Date: 12/9/25. initialed GM 0830. The MDSN stated the medication Ondansetron HCL 4 mg was administered by LVN 6 on 6/18/26 at 8:30 a.m. During a concurrent interview and record review on 6/19/26 at 9:38 a.m. with the MDSN, Resident 75's care plan dated 1/15/26, indicated Resident 75 is at risk for nausea and vomiting related to medication side effects. During a review of Resident 75's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 6/19/26, the AR indicated Resident 75 was admitted to the facility on [DATE] with diagnosis of encounter for surgical aftercare following surgery on the circulatory system, hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebral infarction (the blood supply to part of the brain is blocked or reduced), type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), essential (primary) hypertension (abnormally high blood pressure [the amount of force the heart uses to pump blood through the arteries] that is not the result of a medical condition), and nausea and vomiting. During an interview on 6/19/26 at 11:15 a.m. with the DON, the DON stated it was her expectation for all licensed nurses to follow the facility's policy and procedures (P&P) for Medication Labeling and Storage and Medication Administration to ensure no expired medications were stored in the medication cart and medication room to prevent medication errors such as administration of expired medication. The DON stated licensed nurses should check expiration dates of medication before administering the medication to prevent medication errors. The DON stated expired medication has less effectiveness. During a review of facility's P&P titled, Medication Labeling and Storage, dated 2/2023, the P&P indicated, . Medication Storage. 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 3. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. During a review of facility's P&P titled, Administering Medications, dated 4/2019, the P&P indicated, . Medications are administered in a safe and timely manner, and as prescribed. 12. The expiration/beyond use date on the medication label is checked prior to administering.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an effective infection prevention and control program to provide a safe and sanitary environment for three of seven sampled residents (Residents 21, 97, and 8) when:1. Licensed Vocational Nurse (LVN) 5 did not wear appropriate personal protective equipment (PPE- specialized clothing, equipment, and supplies worn by healthcare workers to protect residents and themselves from potential infectious hazards) when LVN 5 accessed Resident 21's gastrostomy tube (GT, a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) on 6/16/26. Resident 21 was on enhanced barrier precaution (EBP- measures used in healthcare settings to prevent the spread of infections) due to presence of GT. 2. Certified Nursing Assistant (CNA) 5 did not wear appropriate PPE when CNA 5 provided direct care to Resident 97 who was on EBP on 6/18/26. 3. CNA 5 and CNA6 left two used PPE (gowns) at the foot of Resident 8's bed after transferring Resident 8 from bed to the wheelchair on 6/16/26. Resident 8 was on EBP due to presence of surgical wound.These failures had the potential to cause cross contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another) to other residents and staff potentially causing health complications, and facility outbreak of infection (a sudden increase or clustering of disease cases beyond what's normally expected in a specific time, place, or population, often involving common exposure).Findings: 1. During a concurrent observation and interview on 6/16/26 at 10:09 a.m. with Resident 21, in Resident 21's room, Resident 21 was self-propelling her wheelchair from the bathroom to her bed. Resident 21 was pleasant, clean, and well groomed. Resident 21 was alert and oriented to person, time, place and situation or event. Resident 21 stated her stomach was growling and was showing her GT. During a concurrent observation and interview on 6/16/26 at 10:09 a.m. with Resident 21, in Resident 21's room, Resident 21 was lying in her bed, awake. Resident 21 stated she was still waiting for the nurse to give her formula feeding in her tube. Resident 21 stated she cannot have oral food and only gets her food through her GT. During an observation on 6/16/26 at 10:37 a.m. with LVN 5, outside Resident 21's room, LVN 5 was preparing the GT formula on top of the medication cart. LVN 5 went inside Resident 21's room with the GT formula, and the privacy curtains were pulled around the bed. LVN 5 did not wear PPE.During a concurrent observation and interview on 6/16/26 at 10:50 a.m. with LVN 5, in Resident 21's room, LVN 5 came out of the room and opened the computer on top of the medication cart. LVN 5 stated she administered Resident 21's enteral feeding and did not wear a PPE. LVN 5 stated she should wear a PPE including a gown when she accessed Resident 21's GT to protect her from infection. LVN 5 stated Resident 21's name had a yellow triangle sign beside her name which indicated Resident 21 was on EBP.During a concurrent interview and record review on 6/17/26 at 11:35 a.m. with the Unit Nurse Manager (UNM), Resident 21's care plan for EBP dated 5/15/26 was reviewed. The care plan for EBP indicated, Patient meets criteria for enhanced barrier precautions. Goal. Patient will allow enhanced barrier precautions for duration of meeting criteria and will have no [NAME] avoidable complications related to infection. Interventions. Gloves and Gowns worn in extended high contact resident care activities. The UNM stated Resident 21 had a stoma opening (surgically created opening on the abdomen) related to the GT. The UNM stated licensed nurses should wear gowns and gloves when accessing GT to prevent the spread and transmission of an infection. The UNM Resident 21's care plan for EBP should be followed and implemented by staff.During an interview on 6/18/26 at 10:03 a.m. with the Infection Preventionist (IP), IP stated it was her expectation for all staff to follow the facility's policy and procedures (P&P) for EBP to prevent cross contamination and spread of infection. The IP stated it was her expectation for licensed nurses and CNAs to wear appropriate PPE during high contact activities such as brief change, linens change, and accessing the GT, and wound care to protect residents and staff from acquiring and transmitting bacteria. The IP stated the use of (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anberry Post Acute	1000 West Yosemite Avenue Merced, CA 95341

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PPE was important to prevent cross contamination. During an interview on 6/19/2026 at 11:01 a.m. with the Director of Nursing (DON), the DON stated it was her expectation for all staff to follow and implement the facility's P&P for EBP to prevent cross contamination and prevent the spread of an infection. The DON stated licensed nurses should wear appropriate PPE such as gowns and gloves when accessing the GT to protect residents from acquiring an infection and prevent the staff from transmitting an infection.During a review of Resident 21's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 6/19/26, the AR indicated Resident 21 was admitted to the facility on [DATE] with diagnosis encounter for surgical aftercare following surgery of digestive system, and gastrostomy status (refers to the presence of a surgically created artificial opening in the stomach).During a review of facility's P&P titled, Enhanced Barrier Precaution, dated 8/2022, the P&P indicated, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents. 3. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing, Bathing/showering, Transferring; Providing hygiene; Changing linens; Changing briefs or assisting with toileting; Device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator); Wound care: any skin opening requiring a dressing.During a review of the professional reference (PR), found on https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html an article titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 7/12/22, the PR indicated, . [Multi Drug Resistant organisms] (MDROs - germs which have become resistant to medications) may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds . are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs).Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, Wound care: any skin opening requiring a dressing. 2.During a concurrent observation and interview on 6/18/26 at 8:50 a.m. with Resident 97 and CNA 5, in Resident 97's room, Resident 97 was lying on one side bed, awake, alert and oriented to person, places, and situation. Resident 97 stated she had a bowel movement and was looking for CNA 5. CNA 5 stated she will get her supplies and she will change Resident 97's brief and linen.During a concurrent observation and interview on 6/18/26 at 8:55 a.m. with CNA 5, outside of Resident 97's room, CNA 5 was holding linens, a gown and went inside Resident 97's room without wearing appropriate PPE. During a concurrent observation and interview on 6/18/26 at 9:02 a.m. with CNA 5, in Resident 97's room, CNA 5 was walking out of the room holding a clear plastic bag. CNA 5 stated the clean plastic bag containing Resident 97's soiled and dirty brief. CNA 5 stated she provided brief change and linen change for Resident 97. CNA 5 stated Resident 97 had a bowel movement. CNA 5 stated she did not notice the yellow triangle sign at the door which indicated Resident 97 was on EBP. CNA 5 stated she should have checked prior to entering her room. CNA 5 stated she should have worn a gown when she provided brief and linen change to Resident 97 to prevent cross contamination and spread of infection.During an interview on 6/18/26 at 10:03 a.m. with the IP, the IP stated it was her (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expectation for all staff to follow the facility's policy and procedures (P&P) for EBP to prevent cross contamination and spread of infection. The IP stated it was her expectation for licensed nurses and CNAs to wear appropriate PPE during high contact activities such as brief changes, linen changes, accessing GT, and wound care to protect residents and staff for acquiring and transmitting the bacteria. The IP stated the use of PPE was important to prevent cross contamination. During an interview on 6/19/2026 at 11:01 a.m. with the DON, the DON stated it was her expectation for all staff to follow and implement the facility's P&P for EBP to prevent cross contamination and prevent the spread of an infection. The DON stated CNAs should wear appropriate PPE such as gowns and gloves when providing brief changes and linen changes to protect residents and staff from acquiring and transmitting an infection.During a review of Resident 97's AR dated 6/12/26, the AR indicated Resident 97 had an admitting diagnosis of encounter for orthopedic aftercare following surgical amputation and acquired absence of left leg above the knee .During a review of Resident 97's care plan for EBP dated 6/13/26, indicated, . is on Enhanced Barrier Precaution related to left AKA (Above the Knee Amputation - A surgical procedure where the leg is removed above the knee joint) Goal Resident will remain free from new or secondary infections.During a review of facility's P&P titled, Enhanced Barrier Precaution, dated 8/2022, the P&P indicated, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents. 3. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing, Bathing/showering, Transferring; Providing hygiene; Changing linens; Changing briefs or assisting with toileting; Device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator); Wound care: any skin opening requiring a dressing.During a review of the professional reference (PR), found on https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html an article titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 7/12/22, the PR indicated, . [Multi Drug Resistant organisms] (MDROs - germs which have become resistant to medications) may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds . are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs).Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, Wound care: any skin opening requiring a dressing. 3. During an observation on 6/16/26 at 9:43 a.m. with Resident 8, in Resident 8's room, two crumpled pale-yellow gowns were lying at the foot part of Resident 8's bed. Resident 8 was not in the room. During a concurrent observation and interview on 6/16/26 at 10:01 a.m. with CNA 6, in Resident 8's room, CNA 6 was pointing her finger on two crumpled pale-yellow gowns lying at the foot part of Resident 8's bed. CNA 6 stated CNA 5 and her used those two gowns when care was provided to Resident 8 today (6/16/26). CNA 6 stated the two used gowns should not be left at Resident 8's bed. CNA 6 stated the two used gowns should be bagged using a clear transparent bag and disposed in soiled linen room to prevent infection.During a concurrent observation and interview on 6/16/26 at 10:06 a.m. with CNA 5, in Resident 8's room, CNA 5 was pointing her finger on two crumpled pale-yellow gowns lying at the foot part of Resident 8's bed. CNA 5 stated CNA 6 assisted her in transferring Resident 8 from bed to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wheelchair this morning (6/16/26). CNA 5 stated used gowns should not be left at the resident's bed and should be placed in clear plastic bag and disposed in soiled linen room to prevent infection. During a concurrent observation and interview on 6/17/26 at 9:42 a.m. with Resident 8, in Resident 8's room, Resident 8 was lying in bed, alert and orientated to names, time, places, and situation, pleasant, clean, and well groomed. Resident 8 stated he had spinal surgery and came to the facility for therapy. Resident 8 stated he needed help getting out of bed with the use of a sit to stand machine. Resident 8 stated two CNAs transferred him from bed to wheelchair with the use of machine yesterday morning (6/16/26).During a concurrent interview and record review on 6/18/26 at 10:03 a.m. with the IP, the facility's in-service (a professional development or training program provided to employees while they are actively employed) for Enhanced Barrier Precautions dated 5/12/26 and 6/12/26 were reviewed. The Inservice indicated, . Dispose of PPE appropriately after use. The IP stated it was her expectation for all CNAs to follow proper disposal of PPE after use. The IP stated CNAs should not leave the used PPE on resident's bed. The IP stated the used PPE was dirty and contaminated (soiled, stained, or infected by contact) and should be bagged using a clear plastic bag and disposed of in the soiled linen immediately to prevent the spread of infection.During an interview on 6/19/2026 at 11:01 a.m. with the DON, the DON stated it was her expectation for all staff to follow and implement the facility's P&P for EBP to prevent cross contamination and the risk of spreading an infection. The DON stated CNAs should not leave used PPE on resident's bed. The DON stated the used PPE were dirty and contaminated and should be disposed immediately after use to prevent cross contamination and spread of infection. During a review of Resident 8's AR, dated 6/19/26, the AR indicated Resident 8 was admitted to the facility on [DATE] with diagnosis of Fusion of Spine.During a review of Resident 8's Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) dated 6/15/26. Resident 8 had a BIMS score of 15 (a score of 13-15 cognitively intact, 8-12 moderately impaired, 0-7 severe impairment), which indicated Resident 8 was cognitively intact.During a review of Resident 8's care plan for EBP with revision date of 6/8/26, indicated, Patient meets criteria for enhanced barrier precautions Goal Patient will allow enhanced barrier precautions for duration of meeting criteria and will have no [NAME] avoidable complications related to infection.During a review of facility's P&P titled, Enhanced Barrier Precaution, dated 8/2022, the P&P indicated, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents. 3. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing, Bathing/showering, Transferring; Providing hygiene; Changing linens; Changing briefs or assisting with toileting; Device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator); Wound care: any skin opening requiring a dressing.During a review of the professional reference (PR), found on https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html an article titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 7/12/22, the PR indicated, . [Multi Drug Resistant organisms] (MDROs - germs which have become resistant to medications) may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds . are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs).Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, Wound care: any skin opening requiring a dressing.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop a baseline care plan for one of seven residents (Resident 97) when Resident 97 did not have a baseline care plan initiated within 48 hours of admission on [DATE] for end stage renal disease (ESRD -a condition where the kidneys can no longer function and hemodialysis treatment (a medical treatment that uses a machine to clean a person's blood by removing waste products and excess water). This failure had the potential to result in Resident 97's hemodialysis needs to go unmet, which placed Resident 97 at risk for complications associated with ESRD which could compromise Resident 97's overall health. Findings:During a concurrent observation and interview on 6/17/2026 9:51 a.m. with Resident 97, in Resident 97's room, Resident 97 was lying on bed, awake, alert and oriented to person, places, and situation. Resident 97 stated she is receiving dialysis treatment.During a concurrent interview and record review on 6/17/26 at 11:35 a.m. with the Unit Nurse Manager (UNM), Resident 97's Clinical admission dated 6/12/26, and current care plan report were reviewed. The Clinical admission indicated, .Diagnosis: End Stage Renal Disease (ESRD).A. Hemodialysis: Yes. The care plan report did not include a care plan for diagnosis of ESRD and hemodialysis. The UNM stated there was no care plan for diagnosis of ESRD and hemodialysis. The UNM stated Resident 97's care plan for diagnosis of ESRD and hemodialysis should be developed within 72 hours from readmission date of 6/12/26. The UNM stated Resident 97's care plan should reflect the necessary care and treatment which include hemodialysis. The UNM stated licensed nurses and Minimum Date Set Nurse (MDSN) were responsible in developing and reviewing residents' care plan. During a concurrent interview and record review on 6/19/26 at 9:31 a.m. with the MDSN, Resident 97's care plan report dated 6/12/26 to 6/18/26 were reviewed. The care plan report indicated, .The resident needs dialysis renal (kidney) failure Date initiated: 6/17/26 Created date 6/17/26. Goal The resident will have no signs and symptoms (s/sx) of complications from dialysis. at risk for fluid overload or potential for fluid overload related to CKD (Chronic Kidney Disease) hemodialysis.Fluid Restriction. Date initiated: 6/19/26 Created date 6/19/26.Goal: will remain free of signs and symptoms of fluid overload. Interventions: Monitor/document/report to MD PRN s/sx of fluid overload: Anorexia, Anxiety, Mood/behavior changes, Confusion, Edema (swelling), Nausea/vomiting, Shortness of breath, difficulty breathing (Dyspnea), Increased respirations (Tachypnea), Difficulty breathing when lying flat (Orthopnea), Congestion, Cough, Fatigue, Jugular Venous Distention (JVD), Sudden weight gain. The MDSN stated baseline care plan should be developed within 72 hours from admission or readmission of residents to the facility. The MDSN stated care plan for hemodialysis related to renal failure and risk for fluid overload was developed beyond 72 hours. The MDSN stated residents' care plan should reflect current plan of care based on assessment and physician's orders. During an interview on 6/19/2026 at 2:10 p.m. with the Director of Nursing (DON), the DON stated it was her expectation for all licensed nurses and Interdisciplinary Team (IDT) to follow the facility's policy and procedures (P&P) for baseline care plans to ensure necessary care and treatment were being implemented to the residents. The DON stated baseline care plans should be developed within 48 hours from residents' admission or readmission to the facility. The DON stated baseline care plan should be individualized or person-centered based on residents' assessment and needs. The DON stated Resident 97's care plan for diagnosis of ESRD and hemodialysis should be developed when Resident 97 was re-admitted to the facility on [DATE] to prevent unrecognized complications related to diagnosis of ESRD and hemodialysis treatment. During a review of Resident 75's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 6/19/26, the AR indicated Resident 75 was admitted to the facility on [DATE] with diagnosis of encounter for orthopedic aftercare following (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	surgical amputation, acquired absence of left leg above the knee, and ESRD.During a review of Resident 97's Order Summary Report dated 6/19/26, indicated a diagnosis of ESRD.During a review of facility's P&P titled, Care Plans - Baseline,' dated 3/2022, the P&P indicated, A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. 1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative; b. Physician orders. 3. A comprehensive care plan may be used in place of the baseline care plan providing the comprehensive care plan is developed within 48 hours of the resident's admission and meets the requirements of a comprehensive assessment.

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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 and record review, the facility failed to develop and implement a comprehensive person-centered care plan (CP) for one of seven sampled residents (Resident 3) when Resident 3 did not have a comprehensive CP implemented for Resident 3's depression medication. This failure had the potential for Resident 3's medication side effects and adverse reactions to go unnoticed and undetected by nursing staff.During a review of Resident 3's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 6/18/26, the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnosis of displaced intertrochanteric fracture of right femur-subsequent encounter for closed fracture with routine healing (a broken right thigh bone), unspecified fracture of the lower end of left radius (a broken left wrist) subsequent encounter for closed fracture with routine healing, type 2 diabetes mellitus (when the body cannot use insulin properly and/or does not make enough insulin) without complications, depression unspecified (a serious mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities), post-traumatic stress disorder unspecified (PTSD-when a person is suffering from trauma-related symptoms), anxiety disorder unspecified (when a person experiences fear that disrupts their daily life).During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 5/15/26, the MDS section C indicated Resident 3 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 3 was cognitively intact.During a review of Resident 3's facility document titled, Order Summary Report (OSR), dated 6/18/26, the OSR indicated, .PARoxetine HCL Tablet 20 mg Give 1 tablet by mouth one time a day for depression.Administer with 40 mg dose to equal 60 mg total dose.PARoxetine HCL Tablet 40mg Give 1 tablet by mouth one time a day for depression.Administer with 20 mg dose to equal 60 mg total dose.During an interview on 6/18/26 at 1:54 p.m. with Licensed Vocational Nurse (LVN) 6, LVN 6 stated there was always an admission nurse when residents got admitted who input medications, CP, and all orders into the electronic health record (EHR). LVN 6 stated the admission nurse then provided hand off report to the nurse on the floor that would be caring for the newly admitted resident. LVN 6 stated all new admits got a CP including a CP for medications. LVN 6 stated she saw an anti-anxiety CP, sedative (a substance or medicine that calms the brain and body) CP, hypnotic (a prescription or over-the-counter sleep aid) CP, anticoagulant (a medication that stops or slows down the body's process of making blood clots) CP, and was looking in the EHR but could not find a CP relating to Resident 3's antidepressant medication. LVN 6 stated there was not a CP and there should be a CP to monitor side effects. LVN 6 stated a CP was important so staff knew that Resident 3 was on that medication, for resident safety, and because CP's helped to guide the care provided.During an interview on 6/18/26 at 3:24 p.m. with the Director of Nursing Services (DNS), The DNS stated her expectation was that CP's for medications such as antianxiety, psychotropic (any prescription drug or chemical substance that alters how the brain works and changes your mood, thoughts, feelings, or behavior) medications, and antidepressant medications should have a CP indicating monitoring for side effects and adverse reactions of those medications for which the resident is currently on. The DNS stated it was important to have an individualized CP to ensure residents' health and safety were being met and stated it was also important for CP's to be implemented to guide the care that was being provided. The DNS stated her expectation was for comprehensive CP's to be created and (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anberry Post Acute	1000 West Yosemite Avenue Merced, CA 95341

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	implemented within 21 days after admission.During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P 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.the comprehensive, person-centered care plan is developed no more than 21 days after admission.The comprehensive, person-centered care plan. reflects currently recognized standards of practice for problem areas and conditions.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 5Number of residents cited: 2Based on observation, interview, and record review, the facility failed to provide services that met professional standards of quality for two of five sampled residents (Resident 9 and Resident 25) when Licensed Vocational Nurse (LVN) 1 and LVN 3 did not follow physician order to administer Apixaban (medication used to prevent and treat blood clots) medication with food to Resident 9 and Resident 25 during medication pass on 6/18/26.These failures to follow proper medication administration had the potential to result in reduced effectiveness of treatment or harm to Resident 9 and Resident 25.During a concurrent observation and interview on 6/18/26 at 7:53 a.m. with LVN 1 outside of Resident 25's room, LVN 1 observed preparing Resident 25's medications including Apixaban. LVN 1 entered Resident 25's room and administered medications without food. Resident 12 was lying in bed watching TV and breakfast tray was on top of the over the bed table untouched. Resident 25 took her medications without food.During a review of Resident 12's AR dated 6/18/26, the AR indicated Resident 25 was admitted to the facility on [DATE] with diagnoses which included surgical after care following surgery on the digestive system, fracture (broken) of left femur (thigh bone) and muscle weakness.Review of Resident 25's Order Summary Report, dated 6/18/26 indicated, .Apixaban Oral Tablet five [5] milligram [MG-unit of measurement] (Apixaban) Give one [1] tablet by mouth two times a day.take with food. Order Date: 11/26/25. Start Date: 11/27/26.During an interview on 6/18/26 at 3:35 p.m. with LVN 2 and LVN 4 in the nursing station 300, LVN 2 and LVN 4 stated during medication administration, the practice was to compare medication order with the medication bubble pack direction to ensure direction was followed. LVN 2 and LVN 4 stated medication with instructions to administer with food had to be followed because it could lead to an upset stomach and affects medication absorption in the stomach.During a concurrent interview and record review on 6/18/26 at 4:04 p.m. with LVN 1, LVN 1 reviewed Resident 25's clinical record titled, Order Summary Report, dated 6/18/26 and stated Resident 25's apixaban order was to administer with food. LVN 1 stated she did not administer Resident 25's apixaban medication with food and she should have. LVN 1 stated she did not follow the physician order to administer medication with food which could cause an upset stomach, diarrhea, or constipation.During a concurrent observation and interview on 6/18/26 at 4:26 p.m. with LVN 3, LVN 3 prepared Resident 9's medications including apixaban. LVN 3 administered Resident 9's medications through Resident 9's gastrostomy tube (G- tube, soft, flexible tube placed directly into the stomach through a small, permanent opening in the belly). LVN 3 flushed Resident 9's G-tube with water and did not connect the feeding formula.During a concurrent interview and record review on 6/18/26 at 4:45 p.m. with LVN 3, LVN 3 reviewed Resident 9's EMAR dated 6/1/26-6/30/26 for apixaban medication order and stated the medication indicated to administer medication with food. LVN 3 stated she administered Resident 9's apixaban without food and she should have. LVN 3 stated she did not compare the medication directions from the bubble pack (blister pack-specialized packaging method that organizes patient medications by day). LVN 3 stated administering medication without food could cause an upset stomach and irritation of the stomach linings. During an interview on 6/19/26 at 1:40pm. with the Director of Nursing Services (DNS), the DNS stated licensed nurses were expected to follow medication administration rights (medication administration steps healthcare professionals follow to ensure patient safety when giving medication), to check the medication label, MAR and physician orders prior to administering medications.During a review of facility's policy and procedure (P&P) titled, Administering Medications, revised date 4/19, the P&P indicated, .Medications are administered in accordance with prescriber orders. The individual administering medication checks the label THREE [3] times to verify the right of the resident, right medication, right dosage, right time and right method [route] of administration before giving the medication.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that the administration of enteral nutrition (delivers specialized liquid formulas directly to the stomach) was consistent with physician's orders for one of seven sampled residents (Resident 21) when Resident 21's enteral nutrition was administered by Licensed Vocational Nurse (LVN) 5 for almost three hours past the prescribed time of administration on 6/16/26. Resident 21 was NPO (nothing by mouth).This failure resulted in Resident 21 receiving her enteral feeding (also referred to as tube feeding is the delivery of nutrients through a feeding tube directly into the stomach) late and had the potential risk of receiving inadequate nutrition and experience unrecognized decline in health conditions which could compromise Resident 21's overall health.Findings:During a concurrent observation and interview on 6/16/26 at 10:09 a.m. with Resident 21, in Resident 21's room, Resident 21 was self-propelling her wheelchair from bathroom to her bed. Resident 21 was pleasant, clean, and well groomed. Resident 21 was alert and oriented to person, time, place and situation or event. Resident 21 stated her stomach was growling and was showing her gastrostomy tube (GT, a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) Resident 21 stated she did not receive her morning enteral feeding and had been waiting for her formula. Resident 21 stated she should receive her formula feeding for breakfast.During a concurrent observation and interview on 6/16/26 at 10:09 a.m. with Resident 21, in Resident 21's room, Resident 21 was lying in her bed, awake. Resident 21 stated she was still waiting for the nurse to give her formula feeding in her tube. Resident 21 stated she cannot have oral food and only gets her food through her GT.During a concurrent observation and interview on 6/16/2026 at 10:31 a.m. with LVN 5, in front of Resident 21's room, LVN 5 was at her medication cart. LVN 5 stated Resident 21's GT feeding was scheduled at 8:00 a.m. LVN 5 stated Resident 21's GT feeding was late, . started on the other side.I am behind. During an observation on 6/16/26 at 10:37 a.m. with LVN 5, outside Resident 21's room, LVN 5 was preparing the GT formula on top of the medication cart. LVN 5 went inside Resident 21's room with the GT formula, and the privacy curtains were pulled around the bed.During a concurrent observation and interview on 6/16/26 at 10:50 a.m. with LVN 5, in Resident 21's room, LVN 5 came out of the room and opened the computer on top of the medication cart. LVN 5 stated she administered Resident 21's enteral feeding.During a concurrent interview and record review on 6/17/26 at 11:35 a.m. with the Unit Nurse Manager (UNM), Resident 21's Electronic Medication Administration Record (EMAR - a daily electronic documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 6/2026 was reviewed. The EMAR indicated, Enteral Feed Order every 4 hours related to GASTROSTOMY STATUS. Brand Name 1.2 (237 ml [Milliliters-used to measure units of liquid volume) 6 cartons/day to provide 1710 kcal (kilocalories - a unit of energy), 79 g (grams- unit of mass) protein, 1146 ml free water -Order Date-06/07/2026.Hours 0000 0400 0800 1200 1600 2000. The UNM stated licensed nurses should follow the prescribed GT feeding administration of every four hours at 12 midnight, 4:00 a.m., 8:00 a.m., 12:00 noon, 4:00 p.m. and 8:00 p.m. to ensure Resident 21 was receiving the required calories and proteins as indicated in the EMAR. The UNM stated a.m. shift nurse should administer the enteral feeding at 8:00 a.m. and when administered beyond the prescribed time was considered late administration and will be close to the next enteral feeding time. The UNM stated there is potential risk of weight loss and feeding intolerance when Resident 21's enteral feeding was not followed according to the physician's order.During an interview on 6/17/26 at 3:10 p.m. with the Director of Nursing (DON) and LVN 5, the DON validated with LVN 5 about the time Resident 21 was administered the GT feeding on 6/16/26. LVN 5 stated she completed administering Resident 21's GT feeding almost 11:00 a.m. on 6/16/26, which was due at 8:00 a.m. LVN 5 stated trial oral intake was started at 12:00 p.m. on (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/16/26 with the speech therapist (ST). The DON stated Resident 21's GT feeding administration was late and will closely monitor Resident 21 for weight loss. The DON stated it was her expectation for all licensed nurses to follow the physician's orders to ensure residents are receiving necessary care and treatment. During a concurrent interview and record review on 6/18/26 at 11:00 a.m. with the Registered Nurse (RN), Resident 21's EMAR dated 6/16/26 was reviewed. The EMAR indicated, Enteral Feed Order Administration Details Scheduled for 0800 Effective date 6/16/26 10:36 a.m. Administered by Name of LVN 5 Documented 6/16/26 at 10:51 a.m. The RN stated Resident 21's enteral feeding was administered late. The RN stated licensed nurses should follow the scheduled time of feeding administration based on physician's order to ensure Resident 21 receives adequate nutrients and to prevent weight loss. During a concurrent interview and record review on 6/18/26 at 12:05 p.m. with the RN, Resident 21's and Order Summary Report dated 5/18/26 was reviewed. The Order Summary Report indicated, Enteral Diet, NPO texture, NPO consistency.Start Date 5/15/26. The RN stated Resident 21 was NPO since 5/15/26 and receiving enteral feeding as the primary source of nutrition. During a review of Resident 21's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 6/19/26, the AR indicated Resident 21 was admitted to the facility on [DATE] with diagnosis encounter for surgical aftercare following surgery of digestive system, gastrostomy status (refers to the presence of a surgically created artificial opening in the stomach), dysphagia (difficulty swallowing) chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), pneumonia (an infection that affects one or both lungs, causing the air sacs of the lungs to fill with fluid), and essential (primary) hypertension (abnormally high blood pressure [the amount of force the heart uses to pump blood through the arteries] that is not the result of a medical condition), and severe protein calorie malnutrition (inadequate intake of food).During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 5/18/26, the MDS section C indicated Resident 23 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 10 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 21 was moderately impaired.During a review of Resident 21's care plan dated 5/18/26, indicated, The resident has a nutritional problem or potential nutritional problem related to diagnosis of gastrostomy status, dysphagia, pneumonia, severe protein calorie malnutrition.underweight.Goal Resident will tolerate tube feeding (TF) with no gastrointestinal (GI) issues; and requires tube feeding related to dysphagia. Goal The resident will maintain adequate nutritional and hydration status.During a review of facility's policy and procedures (P&) titled, Enteral Nutrition, dated 11/2018, the P&P indicated, . Adequate nutritional support through enteral nutrition is provided to residents as ordered. 4. Enteral nutrition is ordered by the provider based on the recommendations of the dietitian. 5. Some examples of potential benefits of using a feeding tube include: a. Addressing malnutrition and dehydration; c. Allowing a resident to gain strength that may allow him or her to return to oral nutrition.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure necessary respiratory care consistent with professional standards of practice was provided for one of seven sampled residents (Resident 92) when there was no physician's order for Resident 92's use of continuous positive airway pressure (CPAP -a non-invasive ventilation machine that involves the administration of air usually through the nose by an external device at a predetermined level of pressure), a comprehensive person-centered care plan was not developed and implemented and the CPAP was not being routinely cleaned by the facility staff. Resident 92 had a diagnosis of Sleep Apnea (a condition that makes you stop breathing while you're sleeping).These failures resulted in Resident 92 not being assessed and monitored by qualified staff for the effectiveness of the CPAP, possible complications or side effects (unwanted undesirable effects) related to CPAP use and had the potential for Resident 92 to experience unrecognized negative outcomes including respiratory infection which could compromise Resident 92's overall health.Findings:During a concurrent observation and interview on 6/16/26 at 10:25 a.m. with Resident 92, in Resident 92's room, Resident 92 was lying in bed, awake, alert and oriented to person, time, place and situation. Resident 92 had difficulty hearing and was wearing a hearing aid. Resident 92 was asking for water and pointing to a machine at bedside table, and stated, for my CPAP. Resident 92's CPAP mask and tubing were laying on the head part of the bed. Resident 92 stated he applied his own CPAP but was not able to clean it. Resident 92 stated that his CPAP machine, mask, and tubing were not cleaned for two weeks, and stated, should be cleaned once a week. Resident 92 stated his wife is coming tomorrow (6/17/26) to clean his CPAP machine (a device that pumps mild air pressure through a hose and mask to keep airway open while sleeping, primarily treating obstructive sleep apnea).During a concurrent interview and record review on 6/17/26 at 11:35 a.m. with the Unit Nurse Manager (UNM), Resident 92's admission Record (a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), undated, Order Summary Report, dated 6/2026, care plan report, undated, consultation/clinic referral, dated 6/3/26 were reviewed. The admission Record indicated Resident 92 was admitted to the facility on [DATE] with diagnosis of sleep apnea. The Order Summary Report did not include an order for CPAP. The care plan report does not contain a care plan for CPAP use. The consultation/clinic referral indicated, . doing well with CPAP. Continue use.signed FNP (Family Nurse Practitioner). The UNM stated Resident 92 went to an appointment for a pulmonologist (a medical specialist who diagnoses and treats diseases of the respiratory system, including the lungs, airways, and breathing muscles) consult on 6/3/26 and had an order to continue use of the CPAP. The UNM stated the pulmonologist order was not carried out by the licensed nurses and a care plan for use of CPAP was not developed and implemented. The UNM stated the pulmonologist order for Resident 92 to continue CPAP use should be carried out due to Resident 92 having sleep apnea. The UNM stated the care plan for Resident 92's CPAP use should be developed and implemented to properly assess and monitor Resident 92's CPAP use and to provide necessary respiratory care and treatments. The UNM stated night shift nursing staff were responsible in cleaning Resident 92's CPAP machine and the machine should be cleaned to prevent infection.During an interview on 6/18/26 at 3:13 p.m. with the family member (FM), in Resident 92's room, the FM stated she is Resident 92's wife. The FM stated she cleaned the CPAP mask and tubing with the use of vinegar yesterday (6/17/26). The FM stated she brought Resident 92's personal CPAP machine from home when he was admitted to the facility.During an interview on 6/18/26 at 3:26 p.m. with the Director of Nursing (DON), the DON stated Resident 92's physician's order to continue use of CPAP should be carried out by the licensed nurses for continued care. The DON stated Resident 92's use of CPAP should be care planned to ensure monitoring of side effects and proper care is being implemented when applying the CPAP and cleaning of CPAP (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	equipment and supplies. The DON stated the CPAP mask, and tubing should be cleaned weekly to prevent the risk of respiratory infection. The DON stated Resident 92 was referred to facility's Respiratory Therapist yesterday (6/17/26).During a review of Resident 92's AR, dated 6/19/26, the AR indicated that Resident 92 have a diagnosis of congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), chronic atrial fibrillation (an irregular heartbeat), hyperlipidemia (a condition where fats build up in the arteries, increasing the risk of a stroke [a condition when a blood vessel that carries oxygen and nutrients to the brain is either blocked or ruptures]or heart attack [a condition with the blood flow that brings oxygen to the heart is severely reduced or blocked]), morbid (severe) obesity (a serious health condition that results from an abnormally high body mass due to excess calories).During a review of facility's policy and procedures (P&P) titled, CPAP/BIPAP Support, dated 3/2025, the P&P indicated, Purpose. 1. To provide the spontaneously breathing resident with continuous positive airway pressure with or without supplemental oxygen. 2. To improve arterial oxygenation (PaO2) in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease. 3. To promote resident comfort and safety. Preparation. 2. Review the resident's medical record to determine his/her baseline oxygen saturation. respiratory, circulatory and gastrointestinal status. 3. Review the physician's order to determine the oxygen concentration and flow. 4. Review and follow manufacturer's instructions for CPAP machine setup. General Guidelines. 4. CPAP may be appropriate for improving arterial oxygenation in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/ obstructive lung disease. 6. Side effects associated with CPAP may include: a. Claustrophobia; b. Sleep disturbances; c. Discomfort upon exhaling; d. Headaches; e. Dry mouth; f. Sore throat; g. Nosebleeds; and/or h. gastrointestinal distension. 7. Complications associated with CPAP may include: a. Tension pneumothorax; b. Skin breakdown around the mask; c. Aspiration; and/or d. Diminished cardiac output. Steps in the Procedure. 1. Explain the procedure to the resident. 3. Explain possible side effects of CPAP and instruct to report any discomfort to the nurse. 5. Connect filter to air flow outlet. 7. Position the exhalation port of the mask away from the resident's face and free from obstruction. 8. Set mode, CPAP. 13. Monitor the oxygen saturation of the resident. General Guidelines for Cleaning 2. These guidelines are for single-resident use cleaning. 4. Machine cleaning: Wipe machine with warm, soapy water and rinse at least once a week and as needed. 5 Humidifier (if used); a. Use clean, distilled water only in the humidifier chamber. B. Clean humidifier weekly and air dry. C. To disinfect, place vinegar-water solution (1:3) in clean humidifier. Soak for 30 minutes and rinse thoroughly. 6. Filter cleaning: a. Rinse washable filter under running water once a week to remove dust and debris. Replace filter at least once a year. b. Replace disposable filters monthly. 7. Masks, nasal pillows and tubing: Clean daily by placing in warm, soapy water and soaking/agitating for 5 minutes. Mild dish detergent is recommended. Rinse with warm water and allow it to air dry between uses. 8. Headgear (strap): Wash with warm water and mild detergent as needed. Allow to air dry. Documentation. Document the following in the resident's medical record: 1. General assessment (including vital signs, oxygen saturation, respiratory, circulatory and gastrointestinal status) prior to procedure; 2. Time CPAP was started and duration of the therapy; 3. Mode and settings; 5. How the resident tolerated the procedure; and 6. Oxygen saturation during therapy. Reporting. 2. Notify the physician if the resident experiences any adverse consequences, including (but not limited to) respiratory distress and marked change in vital signs.During a review of facility's P&P titled, Care Plans, Comprehensive Person- Centered, dated 3/2022, the P&P 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. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physical, mental, and psychosocial well-being, including: d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions. 8. Services provided for or arranged by the facility and outlined in the comprehensive care plan are: a. provided by qualified persons;.11. 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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident's entire medication regimen was monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being for three of ten sampled residents (Resident 8, Resident 2 and Resident 24) when:1.Resident 8 was not being monitored for anticoagulant (medication that prevents blood clots from forming) side effects as indicated on Resident 8's care plan. Resident 8 was receiving Rivaroxaban (a blood thinner that treats or prevents blood clots) for Deep Vein Thrombosis (DVT) prophylaxis preventive measures used to stop the formation of dangerous blood clots in deep veins, primarily in the legs) and Atrial Fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). This failure resulted in Resident 8 not being monitored for possible complications or side effects (unwanted undesirable effects that are possibly related to a drug) of anticoagulant by qualified staff and had the potential for Resident 8 to experience unrecognized negative outcomes including bleeding, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, and sudden changes in mental status.2. Resident 2's ticagrelor (antiplatelet medicine that acts like a slippery shield for the blood, keeping platelets from sticking together to form dangerous clots) did not have adequate indication for use.This failure had the potential for Resident 2 to go unmonitored for serious side effects of the medication prescribed. 3. No non-pharmacological (non-medications strategies) interventions were started for Resident 2 and Resident 24's before the use of psychotropic medications (prescription drugs that alter brain chemicals to influence mood, behavior, thoughts, or perception) were ordered and administered. These failures had the potential for Resident 2 and Resident 24 to result in higher doses of psychotropic medications which could lead to more side effects (unintended reactions) of medications. Findings: 1. During a concurrent observation and interview on 6/17/26 at 9:42 a.m. with Resident 8, in Resident 8's room, Resident 8 was lying in bed, alert and orientated to names, time, places, and situation, pleasant, clean, and well groomed. Resident 8 stated he had spinal surgery and came to the facility for therapy. Resident 8 had multiple circular brownish discoloration in right arm. During a concurrent interview and record review on 6/17/26 at 3:00 p.m. with the Unit Nurse Manager (UNM), Resident 8's Order Summary Report and Electronic Medication Administration Record (EMAR - a daily electronic documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 6/2026 were reviewed. The Order Summary Report indicated, Brand Name (Rivaroxaban) 10 mg (milligrams -metric unit of measurement, used for medication dosage and/or amount) Give 1 tablet by mouth in the evening for DV prophylaxis Order date 6/8/26. The EMAR indicated, Brand Name (Rivaroxaban) 10 mg Give 1 tablet by mouth in the evening for DVT prophylaxis Order date 6/8/26. The UNM stated licensed nurses were administering Rivaroxaban to Resident 8 per physician's order and were not monitoring for possible side effects of anticoagulant usage. The UNM stated she cannot locate the monitoring of side effects in Resident 8's EMAR. The UNM stated monitoring for side effects should be completed by licensed nurses every shift and should be documented in Resident 8's EMAR. The UNM stated it was important for licensed nurses to assess and monitor Resident 8 for side effects related to anticoagulant use. The side effects licensed nurse should be monitoring for are bleeding and bruising and should notify the physician for further evaluation and treatment. (continued on next page)

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Anberry Post Acute	1000 West Yosemite Avenue Merced, CA 95341

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/17/26 at 3:15 p.m. with the UNM, Resident 8's care plan for anticoagulant dated 6/8/26 was reviewed. The care plan indicated, .is on anticoagulant therapy related to Atrial Fibrillation Goal: will be free from discomfort or adverse reaction related to anticoagulant use.Interventions: Monitor for side effects and effectiveness every shift. Monitor/document/report PRN adverse reactions of ANTICOAGULANT therapy; blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB, loss of appetite, sudden changes in mental status, significant of sudden changes or v/s (vital signs). The UNM stated Resident 8's care plan should be implemented to ensure Resident 8 is monitored by licensed nurses every shift for possible side effects related to anticoagulant use. During a review of Resident 8's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 6/19/26, the AR indicated Resident 8 was admitted to the facility on [DATE] with diagnosis of Fusion of Spine, Chronic Atrial Fibrillation, Long term (current) Use of Anticoagulants, and Essential Hypertension (HTN-high blood pressure). During a review of Resident 8's Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) dated 6/15/26. Resident 8 had a BIMS score of 15 (a score of 13-15 cognitively intact, 8-12 moderately impaired, 0-7 severe impairment), which indicated Resident 8 was cognitively intact. During an interview on 6/19/26 at 8:42 a.m. with the Director of Nursing (DON), the DON stated it was her expectation for all Licensed Nurses to monitor residents for side effects of anticoagulant use every shift to identify signs and symptoms of bleeding such as bruising, blood in the urine and stool to notify the physician immediately for further treatment and interventions. The DON stated the monitoring of side effects of anticoagulant use should have a physician's order and licensed nurses should be documented in residents' EMAR. The DON stated Resident 8's care plan for anticoagulant use should be followed and implemented by nursing staff to ensure necessary care and treatment is provided. During a review of facility's policy and procedures (P&P) titled, Anticoagulation -Clinical Protocol, dated 11/2018, the P&P indicated, Assessment and Recognition. 1. As part of the initial assessment, the physician and staff will identify individuals who are currently anti-coagulated; for example, those with recent history of deep vein thrombosis (DVT), or heart valve re-placement, atrial fibrillation or those who have had recent joint replacement surgery. a. Assess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications. Monitoring and Follow-Up. 5. The staff and physicians will monitor for possible complications individuals who are being anticoagulated and will manage related problems. a. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria (blood in the urine), hemoptysis (coughing or spitting up blood, or other evidence of bleeding, the nurse will discuss the situation with physician before giving next scheduled dose of anticoagulant. b. The physician will order measures to address any complications, including holding or discontinuing the anticoagulant as indicated. 2. During a concurrent observation and interview on 6/16/26 at 9:58 a.m. during the initial tour in Resident 2's room, Resident 2 was lying in bed watching TV. Resident 2 stated she was in the facility working with therapy. Resident 2 stated she had no concerns; staff are providing her assistance with her activities of daily living (ADL-routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves). (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's admission Record (AR- document containing resident personal information), dated 6/19/26, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses which included encephalopathy (brain disease, damage, or malfunction), atherosclerosis (hardening of the arteries) of native arteries of extremities (limbs parts of the body that stick out from the main trunk) and depression (serious mood disorder that causes persistent sadness and a loss of interest in life). During a review of Resident 2's Order Summary Report (OSR), dated 6/19/26, the OSR indicated, Resident 2 had an active order for . Sertraline (medication used to treat depression) HCL [hydrochloride] 100 MG [milligram-unit of measurement] Give 1 tablet by mouth one time a day for depression.Ticagrelor Oral Tablet 90 MG (Ticagrelor) Give 1 [one] tablet by mouth two times a day for intermittent [stopping and starting] claudication [muscle pain, cramping, or weakness]. During a concurrent interview and record review on 6/18/26 at 3:24 p.m. with LVN 2 and LVN 4, Resident 2's Order Summary Report, for the month of June 2026 was reviewed. LVN 2 and LVN 4 stated Resident 2 was receiving the medication Ticagrelor with the indication of intermittent claudication. LVN 2 and LVN 4 stated the indication for the medication was not appropriate indication and was not sure what it was. LVN 2 and LVN 4 reviewed Resident 2's discharged summary from acute hospital and stated Resident 2 was admitted to the facility with the medication but had no diagnosis or indication. LVN 2 and LVN 4 stated they did not find documentation the medical doctor gave the diagnosis or indication. 3. During a concurrent observation and interview on 6/16/26 at 10:16 a.m. during initial tour in Resident 24's room, Resident 24 was seated in her wheelchair propelling self out of the bathroom. Resident 24 stated she had surgery on her left knee and now receiving antibiotic (medication to fight bacterial infection) for the bone infection (tiny, harmful germs like bacteria enter the body and begin to multiply). During a review of Resident 24's AR dated 6/18/26, the OSR indicated Resident 24 was re-admitted to the facility on [DATE] with diagnoses which included aftercare following joint replacement surgery infection and inflammatory reaction (body's built-in alarm and defense system) due to internal left knee prosthesis (artificial replacement for a missing or non-functioning body part) and major depressive disorder. During a review of Resident 24's OR dated 6/18/26, the Resident 24 had an active order for . Sertraline HCL Oral Tablet 50 MG . Give one [1] tablet by mouth one time a day for Depression. During an interview on 6/18/26 at 1:38 p.m. with LVN 1, LVN 1 stated non-pharmacological interventions should be initiated for residents receiving psychotropic medications. LVN 1 stated it was important to ensure residents were provided with alternatives to medications like relaxation techniques and participation in activities. LVN 1 stated she was not sure who was responsible in ensuring an order was placed in resident's record. During a concurrent interview and record review on 6/18/26 at 3:44 p.m. with LVN 2 and LVN 4, Resident 2 and Resident 24's Order Summary Report, for the month of June 2026 were reviewed. LVN 2 and LVN 4 stated Resident 2 and Resident 24 had orders for antidepressant medications. LVN 2 and LVN 4 stated there were non-pharmacological interventions and was not sure if it was needed. After consulting with DNS, LVN2 and LVN 4 stated all psychotropic medications should have non-pharmacological interventions. LVN 2 and LVN 4 stated it was important to offer (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	non-pharmacological interventions to help re-direct, distract residents or just someone to talk to. LVN 2 and LVN 4 stated it was the responsibility of licensed nurses to ensure non-pharmacological interventions were initiated. During an interview on 3/19/26 at 1:45 p.m. with the Director of Nursing Services (DNS), the DNS stated Resident 2's ticagrelor medication did not have appropriate diagnosis or indication. The DNS stated she was not sure where the nurse obtained the indication. The DNS stated she did not find documentation the primary doctor gave the diagnosis or indication. The DNS stated her expectation was for licensed nurses to start non-pharmacological interventions as soon as they received order for psychotropic medications. The DNS stated non-pharmacological interventions was to assist with de-escalation techniques to calm residents. The DNS stated non-pharmacological interventions are approaches to deal with residents without using medications. During a review of facility's policy and procedure (P&P) titled, Psychotropic Medication Use, dated 7/22, the P&P indicated, .Residents, families, and and/or the representative are involved in the medication management process. Psychotropic medication management includes: a. indication for use. d. adequate monitoring for efficacy and adverse consequences. 10. Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medication when possible. 11. Residents on psychotropic medications receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, in an effort to discontinue medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety when:1. A box of zucchini was not labelled and dated in the walk-in refrigerator.2. Station 200's nourishment unit refrigerator was observed with a box of pizza brought into the facility that was not properly labeled with the resident's name, room number, date the food was brought in, opened or the use-by date.These failures had the potential for staff to have access to expired foods for residents.1. During concurrent observation and interview on 6/16/26 at 9:31 a.m. with the Kitchen [NAME] (KC) inside the walk-in refrigerator, an unlabeled and undated plastic bin containing zucchini was observed on a metal rack. KC stated all food items inside should be labeled. KC stated, once food or produce is put into another container for use, it should be labeled with received date and use by date. KC stated the kitchen staff missed the labelling of food and produce.During an interview on 6/17/26 at 9:50 a.m. with the Certified Dietary Manager (CDM), CDM stated the plastic bin containing zucchini was unlabeled and undated inside the walk-in refrigerator. CDM stated her expectation was that all food should have a received date and use by date. CDM stated all food such as produce should be labeled and dated. CDM stated it was important to label and put the use by date on food items for quality and to ensure food does not sit in the refrigerator for a long time.During an interview on 6/17/26 at 3:00 p.m. with the Registered Dietician (RD), the RD stated all foods such as produce received in the kitchen should be properly labeled with received date and used by date. RD stated food without labels and dates were thrown away. RD stated food should have been labeled and dated to determine when it needed to be discarded and to prevent unnecessary food waste. RD stated unlabeled and undated food posed a food safety risk because it could spoil and cause foodborne illness.During a review of the facility's policy and procedure (P&P) titled, Food receiving and Storage, dated 11/2022, the P&P indicated, .All foods stored in the refrigerator. labeled and dated (use by date) .2. During an observation on 6/16/26 at 10:21 a.m. in Station 200 Nourishment Unit refrigerator, a box of pizza was observed with a date of 6/6/26.During an interview on 6/17/26 at 10:00 a.m. with the CDM, the CDM stated the kitchen staff were responsible for checking all food items in the nourishment unit refrigerator. The CDM stated kitchen staff should ensure foods are labeled and dated with the received date and the use-by date. The CDM stated the facility staff were also aware that any food brought in by residents and their families from outside sources was required to be labeled and dated with the received date and the use-by date. The CDM stated the facility staff were allowed to accept food brought in by residents or their family members and store it in the nourishment unit refrigerator. The CDM stated food inside the nourishment unit refrigerator without labels and dates, was thrown away. The CDM stated the untouched food, or unconsumed meals could be stored in the nourishment unit refrigerator for up to three days. The CDM stated leftover food is not allowed to prevent cross contamination.During an interview on 6/17/26 at 3:10 p.m. with the RD, the RD stated any outside food stored in the refrigerator on the nourishment unit should have been clearly labeled with the residents' name, room number, the date the food was brought in or opened and the use-by date. The RD stated the facility did not allow any leftover food to be kept or stored in the nourishment unit refrigerator. The RD stated leftovers were not stored in the nourishment unit refrigerator to prevent foodborne illnesses and for resident safety.During a review of the facility's policy and procedure (P&P) titled, Food from Outside Source, dated 12/1/26, the P&P indicated, . Food that does not have a manufacturer's printed date must be thrown out 72 hours from the time it was brought into the facility. The food must be dated by nursing staff with an open date and use by date .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain medical records of residents that are complete and accurately documented in accordance with accepted professional standards and practice for two of 10 sampled residents (Resident 11 and Resident 9) when:1.Resident 11's electronic health record (EHR) contained no documentation of completed ileostomy (a specific type of surgery where the lower part of the small intestine is brought through an opening in the belly to form a stoma [an artificial opening made by a surgeon on the abdomen-belly]) bag changes since 7/3/25.This failure had the potential to disrupt continuity of care, create gaps in the services provided, and lead to miscommunication among staff regarding Resident 11's status.2. Licensed Vocational Nurse (LVN) 1 did not document Resident 9's medications administered in his electronic Medication Administration Record (eMAR-digital medication chart or a smart medicine checklist used by nurse and caregivers) after she administered medications during medication pass on 6/18/26.This failure had the potential for Resident 9 to miss doses of medication, receive double-dosing of medication, delayed medication interventions, and increased risk of life-threatening adverse drug events. 1. During a review of Resident 11's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 6/18/26, the AR indicated Resident 11 was admitted to the facility on [DATE] with diagnoses of spondylosis with myelopathy-cervical region (when age-related wear-and-tear in the neck causes the spinal canal to narrow, resulting in dangerous pressure and injury to the spinal cord), anxiety disorder, muscle spasm, morbid (severe) obesity due to excess calories, chronic pain syndrome (when persistent pain-lasting longer than 3-6 months- causes other widespread problems), ileostomy status (when a person has undergone a surgical procedure where the lowest part of the small intestine is brought through the abdominal wall to create a stoma), and muscle weakness-generalized. The AR indicated under the contacts section of the document that Resident 11 was her own responsible party (RP-indicates that the resident holds the legal, medical, and financial authority over their own care). During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 4/13/26, the MDS section C indicated Resident 11 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 11 was cognitively intact. During a review of Resident 11's facility document titled, Order Summary Report (OSR), dated 6/18/26, the OSR indicated, .Ostomy: Change Ileostomy bag PRN [as needed] if soiled or dislodgement as needed.Ostomy: Ileostomy care as needed. During a review of Resident 11's facility document titled, Treatment Administration Record (TAR), dated 4/1/26-4/30/26, the TAR indicated the following orders, .Ostomy: Change Ileostomy bag PRN if soiled or dislodgement as needed.Ostomy: Ileostomy care as needed. TAR contained no documentation of completed ileostomy bag dressing changes. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 11's facility document titled, TAR, dated 5/1/26-5/31/26, the TAR indicated the following orders, .Ostomy: Change Ileostomy bag PRN if soiled or dislodgement as needed.Ostomy: Ileostomy care as needed. TAR contained no documentation of completed ileostomy bag dressing changes. During a review of Resident 11's facility document titled, TAR, dated 6/1/26-6/30/26, the TAR indicated the following orders, .Ostomy: Change Ileostomy bag PRN if soiled or dislodgement as needed.Ostomy: Ileostomy care as needed. TAR contained no documentation of completed ileostomy bag dressing changes. During a concurrent interview and record review on 6/18/26 at 4:13 p.m. with Licensed Vocational Nurse (LVN) 7, Resident 11's TAR was reviewed. LVN 7 stated Resident 11's ostomy bag was changed as needed when it was full and changed according to doctors' orders. LVN 7 stated ostomy bag changes should be documented on the TAR. LVN 7 reviewed Resident 11's TAR's in the EHR and stated the last documented ostomy bag change was on 7/3/25. LVN 7 stated it was important to document the ostomy care and bag changes to keep track of skin changes or irritation that could occur due to frequent dressing changes and to document the care that was being provided. During a concurrent interview and record review on 6/18/26 at 3:45 p.m. with the Director of Nursing Services (DNS), Resident 11's TAR was reviewed. The DNS reviewed Resident 11's EHR and stated there were current doctor orders for ostomy care PRN. The DNS stated staff should document ileostomy bag changes in the TAR and should be done according to physicians' orders. The DNS stated the floor nurses changed the ostomy bag about every other day or when it was needed and was half full and stated she was unable to locate any staff signatures indicating ileostomy care had been provided. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, dated 7/2017, the P&P indicated, .All services provided to the resident.shall be documented in the resident's medical record.The following information is to be documented in the resident medical record.Treatments or services performed.Documentation of procedures and treatments will include care-specific details, including.The date and time the procedure/treatment was provided.The name and title of the individual(s) who provided the care.The signature and title of the individual documenting. 2.During observation on 6/16/26 at 11:14 a.m. during the initial tour in Resident 9's room, Resident 9 was lying in bed with eyes closed. Resident 9 was observed with head of bed slightly elevated and feeding tube machine (enteral feeding pump-device that pushes liquid food through tubing at a slow, controlled rate) at bedside. Resident 9 did not answer questions asked. During a review of Resident 9's AR, undated, the AR indicated Resident 8 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (paralysis of one entire side of the body) hemiparesis (one-sided muscle weakness), dysphagia (difficulty or discomfort in swallowing), and dementia (a progressive state of decline in mental abilities). During a concurrent interview and record review on 6/18/26 at 8:12 a.m. with LVN 1 during medication administration observation, LVN 1 stated Resident 9 has a gastrostomy tube (G-tube-small feeding tube that goes through the skin of the belly directly into the stomach), and administered his medications at 7 a.m. LVN 1 reviewed Resident 9's eMAR and stated, I forgot to sign the eMAR after I administered his [Resident 9] medications. LVN 1 stated she should have signed the eMAR (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	immediately after administering medications. LVN 1 stated the practice was to sign the eMAR immediately, but she did not. During an interview on 6/18/26 at 4:45 p.m. with LVN 3, LVN 3 stated the practice during medication administration was to document after medication was administered to residents and not prior to administering medication or an hour after. LVN 3 stated it could lead to over medication or under medicating resident and could lead to serious health conditions. During an interview on 6/18/26 at 3:40 p.m. with LVN 2 and LVN 4, they stated medication administration practice was to prepare medication, administer medication then document in the eMAR to avoid medication error. During an interview on 6/19/26 at 1:31 p.m. with the Director of Nursing Services (DNS), the DNS stated she expected licensed nurses to document right away after medication was administered. The DNS stated not documenting immediately could lead to a medication error, duplication of medication or non-administration of medication which could lead to serious health problems for residents. During a review of facility's policy and procedure (P&P) titled, Administering Medications, revised date 4/19, the P&P indicated, .Only person licensed or permitted by this state to prepare, administer and document the administration of medications may do so. Medications are administered in accordance with prescribed orders, including any required time frame. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to educate and offer Covid-19 vaccinations for three of three sampled employees (Certified Nurse Assistant [CNA] 5, CNA 7, and Licensed Vocational Nurse [LVN] 5) when CNA 5, 7, and LVN 5's employee files were reviewed and did not contain documentation that staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccinations or if they were offered the COVID-19 vaccination.This failure had the potential to increase the risk to vulnerable nursing home residents by potentially exposing them to outbreaks and raising the likelihood of severe illness or death.During an interview on 6/19/26 at 9:50 a.m. with the Infection Preventionist (IP), the IP stated the facility did not offer Covid 19 vaccinations for staff because it was no longer mandated for staff to be vaccinated.During a concurrent interview and record review on 6/19/26 at 11:11 a.m. with the Director of Staff Development (DSD), three employee files (CNA 5, CNA 7, and LVN 5) were reviewed. The employee files reviewed did not contain documentation that staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccination or if the COVID-19 vaccination was offered. DSD stated she confirmed with the Administrator (ADM) and stated the facility had not offered the Covid-19 vaccination to staff since 2023 because Covid-19 vaccinations were no longer required.During an interview on 6/19/26 at 2:16 p.m. with CNA 8, CNA 8 stated she had worked at the facility for seven years and could not remember the last time she received information or was offered a COVID-19 vaccination at the facility. CNA 8 stated Covid -19 had not been brought up at the facility in recent years. During a concurrent interview and record review on 6/19/26 at 1:27 p.m. with the Director of Nursing Services (DNS), the policy and procedure (P&P) titled, Coronavirus Disease (COVID-19)-Vaccination of Staff, dated May 2024 was reviewed. The DNS stated COVID- 19 education and vaccination was offered to staff at orientation upon hire and stated facility did not continue to offer the vaccine or provide continuing ongoing education regarding COVID-19 to staff after the initial orientation period. The DNS reviewed the P&P and stated the facility's P&P was not being followed. The DNS stated it was important to provide Covid-19 information and vaccinations to staff so that staff could be informed of the option to get the vaccine and for the protection of residents and other staff members.During a review of the facility's policy and procedure (P&P) titled, Coronavirus Disease (COVID-19)-Vaccination of Staff, dated May 2024, the P&P indicated, Staff are educated about benefits, risks, and potential side effects of the COVID-19 vaccine. Staff are required to adhere to state and local laws and facility practices pertaining to staff COVID-19 vaccination.Staff are offered vaccination against COVID-19.The facility maintains documentation related to staff COVID-19 vaccination that includes, at a minimum.That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine.Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555901	A. Building B. Wing	06/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anberry Post Acute	1000 West Yosemite Avenue Merced, CA 95341

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a safe, functional, and sanitary condition was maintained when four containers (five gallon each) containing chemicals in the dirty area of the laundry room were found covered with thick white foamy substance and the floor directly below the containers also contained the thick white foamy substance. This failure had the potential to affect the health condition of the 105 residents, staff and visitors of the facility, like severe skin burns, eye damage and toxic (poisonous or harmful) respiratory irritation. Findings: During a concurrent observation and interview on [DATE] at 8:22 a.m. with the Laundry Person (LP) in the dirty room area of the laundry room, nine containers were stacked in the corner of the room and four of the containers were covered with a white foamy substance. The LP stated she did not notice the thick white foamy substance covering the containers and was not sure what the white foamy substance was. The LP stated she had never used the chemicals before. The LP stated it was not normal and she was not sure if the white foamy substance was safe. During a concurrent observation and interview on [DATE] at 8:30a.m. with the Housekeeping Director (HD), the HD stated the containers contained liquid sanitizer and were used in the kitchen. The HD stated four of nine containers were covered with a white foamy substance. The HD stated he was made aware of the white foamy substance a few weeks ago by the dietary supervisor. The HD stated the Administrator (ADM) and the Director of Maintenance (DM) were also made aware and had checked on the containers. The HD stated, I thought it was taken care of. The HD stated the white foamy substance was a chemical. The HD stated it should have been taken care of because the chemical could cause chemical reactions and may affect residents and staff members' health if mishandled. During an interview on [DATE] at 9:05 a.m. with the Dietary Services Manager (DSM), the DSM stated she noticed the containers containing chemicals stored in the dirty room of the laundry department about four weeks ago were covered with white foamy substances. The DSM stated she notified the ADM and DM. The DSM stated the chemicals belonged in the kitchen but were no longer used because it was past its expiration date. During an interview on [DATE] at 9:42 a.m. with the DM, the DM stated his main responsibility was to ensure a safe environment for residents and staff and to make sure everything was working properly. The DM stated he remembered the DSM reporting to him about the containers of chemicals stored in the dirty room of the laundry room. The DM stated some of the containers were covered with thick white foamy substances. The DM stated he called the county regional waste and was told they did not take chemicals and was provided with a number to call and might be able to help. The DM stated he called the number provided to him and left message but did not remember receiving any call back. The DM stated he should have followed up more often until the chemicals were picked up. The DM stated it was not safe to store the chemicals for a long time because it could cause chemical reactions creating dangerous vapors (invisible gases) which could affect the health of residents and staff.During an interview on [DATE] at 2:20 p.m. with the ADM, the ADM stated he was made aware of the containers of chemicals stored in the dirty area of the laundry room a month or two months ago and thought the DM took care of it. The ADM stated the chemicals had expired because the company delivered too much. The ADM stated the chemicals were dangerous, could spill and could cause health issues to residents, staff and visitors when not handled properly. The ADM stated the issue of the chemicals should have been safely disposed of when it was first reported to him and the DM. During a review of facility's document titled, Job Description; Maintenance Director, revised date [DATE], the Job Description, indicated, The Maintenance Director is responsible to maintain the facility in good repair at all times, and oversee the Maintenance, Housekeeping and Laundry departments. The interior and the exterior surfaces, fixtures, and mechanical systems are the responsibility of the Maintenance Director. Ensure that all interior (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fixtures in good repair. Ensure that plumbing, electrical, heating, ventilation and air conditioning are maintained. Respond promptly and provide direction for emergency repair requests. Maintain required Material Safety data Sheet [MDSD-chemical cheat sheet. It details exactly how dangerous a material is and how to handle it safely. Oversee the maintenance, housekeeping and laundry departments.During a review of facility's policy and procedure (P&P) titled, Maintenance Service, revised date 12/09, the P&P indicated, .The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Maintaining the building in good repair and free from hazards. The Maintenance Director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner. Maintenance personnel shall follow the established safety regulations to ensure the safety and well-being of all concerned.