STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555926	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shadelands Post Acute	2765 Mitchell Dr Walnut Creek, CA 94598

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure adequate supervision was provided for one of three sampled residents (Resident 74) to prevent falls and injuries when Resident 74 with history of unwitnessed falls was found sitting by the foot of her bed with gushing of blood from forehead and two open skin tears.This failure caused Resident 74 to continue to fall and had the potential to result in severe injuries. During a review of Resident 74's admission Record (AR), printed on 5/14/26, AR indicated Resident 74 was admitted to the facility on [DATE], with diagnoses that included abnormalities of gait and mobility (ability to move, walk or change position easily and freely), hemiplegia and hemiparesis affecting left side (stroke), lack of coordination, cognitive communication deficit.During a review of Resident 74's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 12/22/25, the MDS indicated Resident 74's ability to see in adequate light with glasses was severely impaired, no vision or sees only light, colors, or shapes; eyes do not appear to follow objects. MDS indicated Resident 74 was dependent on the assistance of two or more helpers to walk at least 10 feet in room, corridor, or similar space. MDS indicated Resident 74 used a walker and wheelchair for mobility. MDS indicated Resident 74 was dependent with toileting hygiene, helper does all the effort. MDS indicated Resident 74 had impairment on one side of the upper (shoulder, elbow, wrist, hand) and lower extremities (hip, knee, ankle, foot). MDS indicated Resident 74's Basic Interview of Mental status (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) score was 03 which indicated severely impaired mental status. The BIMS score indicated Resident 74 was unable to recall the correct year, month, and day of the week. During a concurrent interview and record review on 5/13/26 at 9:32 a.m. with Assistant Director of Nursing (ADON), Resident 74's fall risk assessments and progress notes were reviewed. The fall risk assessments dated 11/23/25, 12/15/25 and 2/10/26 indicated a score of 20, 20 and 22, respectively indicating Resident 74 was at high risk for falls. Further review of Resident 74's progress notes indicated that Resident 74 had the following unwitnessed falls:On 12/20/25 at 14:30 (2:30 PM) Resident 74 had unwitnessed fall. Staff found her lying down on the floor. Resident 74 complained of pain left arm.On 1/14/26 at 23:57 (11:57 PM), Resident 74 had unwitnessed fall, she was found lying on the floor. Resident 74 complained of left hip pain.On 2/10/26 at 16:02 (4:02 PM), Resident 74 had a fall in her room, combative rolled herself over the bed onto fall matt and crawled towards bathroom.On 2/24/26 at 22:25 (10:25 PM), Floor nurse found Resident 74 on top of her floor mattress.On 3/8/26 at 01:35 (1:35 AM), Resident 74 was found sitting on top of the fall mattress by the foot of the bed. Resident 74 was noted with gushing of blood to her forehead and two open skin tears. Resident 74 was transferred to emergency department (ED) for further evaluation.During an interview on 5/14/2026 at 8:42 a.m. with Licensed Vocational Nurse (LVN 1), LVN 1stated Resident 74 was at high risk for falls. LVN1 stated Resident 74 was placed in room opposite the nurses' station. LVN 1 stated when Resident 74's daughter was present at facility Resident 74 was (continued on next page)

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

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cooperative with care. LVN 1 stated Resident 74 became agitated couple of time got out of bed wanting to go home, looking for her daughter, need to find her belongings. LVN 1 said sometimes nurses are attending to other residents, Certified Nursing Assistants (CNAs) are on the floor answering call lights in other residents' room as much as possible. LVN 1 stated it was hard to coordinate to have someone monitor permanently at all times. LVN 1 stated Resident 74's daughter asks if facility could provide one-one-sitter, so we explain that family provide sitters. LVN 1 stated that Resident 74's daughter was concern about finance.During an interview on 5/14/26 at 9:36 a.m. with Certified Nursing Assistant (CNA1), CNA 1 stated Resident 74 rolls off the side of bed. CNA1 said staff kept eye on Resident 74. CNA1 said sometimes there was no staff at the nurse's station to monitor and at that time Resident 74 will slide down. CNA1 stated sometimes CNAs are doing rounds, nurse doing wounds. supervisor care meeting with other residents and there may be no staff at the nurse's station to watch.During a concurrent interview and record review on 5/13/26 at 4:56 p.m. with Director of Nursing (DON) and Assistant Director of Nursing (ADON) Resident 74's fall care plans dated 2/24/26 and 2/27/26 were reviewed. Resident 74's fall care plan indicated Resident 74's falls are related to impaired safety judgement, impulsive behavior, decreased mobility and failure to follow safety precautions. Resident 74's fall care plan interventions included frequent rounding added to fall rounds. DON stated Resident 74 was monitored hourly with rounds. DON stated Resident 74 was moved to a room closer to nurses' station and monitored with frequent rounding. DON could not provide documentation to support hourly and frequent rounding's to fall rounds was provided for Resident 74.During a review of the facility's policy and procedure (P&P) titled, Falls-Clinical Protocol, revised March 2018, the P&P indicated; Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling.

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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 an observation, interview and record review, the facility failed to observe infection control practices when residents dirty clothing were not bagged properly when transported to the laundry.This failure had the potential for spread of infections among residents at the facility. During a concurrent observation and interview on 5/13/26 at 3:19 p.m. with Environmental Services Director (ES), three mesh bags of residents dirty clothing were observed on the floor in the laundry room. ES stated resident's dirty clothing should be covered with a plastic bag when transported to the laundry room to prevent spread of infection.During an interview on 5/14/26 at 9:18 a.m. with Certified Nursing Assistant (CNA3), CNA 3 stated that residents dirty clothing are place in a plastic bag then hamper when transported to the laundry. During an interview on 5/14/26 at 10:45 a.m. with CNA 2, CNA 2 stated she received training of how to transport resident's personal dirty clothing to the laundry. CNA 2 stated dirty personal clothing are placed in a plastic bag and then placed in a mesh laundry bag before transported to the laundry to prevent spread of infection. CNA 2 stated she cared for resident in room [ROOM NUMBER] and placed the dirty clothing in the laundry. CNA 2 stated it must have been an oversight on her part that the dirty personal clothing was not first placed in a plastic bag. CNA stated she was sorry about the incident.During an interview on 5/14/26 at 8:23 a.m. with Licensed Vocational Nurse/Infection Preventionist (IP), IP stated residents' dirty clothes need to be in a plastic bag and placed in meshed bags when transported to laundry to prevent spread of infection. During a review of the facility's policy and procedure (P&P) titled, Laundry and Bedding, Soiled, dated January 2026, the P&P indicated, Soiled laundry/bedding shall be handled, transported and processed according to best practices fotr infection prevention and control

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the implementation of its antibiotic use protocols for one of nine sampled residents (Resident 25), that address unnecessary or inappropriate antibiotic use.This failure had the potential for residents to receive unnecessary antibiotics and risk of development of antibiotic-resistant organisms. During a review of Resident 25's Nurse's Note (NN), dated 4/11/26, The NN indicated Resident 25's daughter stated Resident 25's had frequent urination throughout the night. Resident 25's daughter called the facility and spoke with supervisor. MD was notified of Resident 25's symptoms and Urine test /Culture & Sensitivity (UA/C/S) was ordered.During a review of Resident 25's Lab Results Report (LR), dated 4/14/26 and 4/20/26, the LR indicated Resident 25 UA/CS, collected on 4/11/26 and 4/17/26, final result indicated urogenital flora was isolated. During a concurrent interview and record review on 5/13/2026 at 2:02 p.m. with Licensed Vocational Nurse/ Infection Preventionist (IP), facility's monthly antibiotic stewardship/surveillance log (ATB), April and May 2026 were reviewed. The April 2026's ATB log indicated Resident 25 was admitted to facility on 3/17/26. ATB log indicated that on 4/11/26, Resident 25 had urinary frequency and was prescribed Macrobid oral capsule 100mg twice a day for 5 days for urinary tract infection (UTI). Further review of ATB log indicated Resident 25's use of Macrobid for UTI did not meet McGeer's Criteria. (McGeer criteria are standardized, evidence-based definitions used to identify and track infections in nursing homes and long-term care facilities). ATB logs indicated a number of residents use of antibiotics did not meet Mcgreer's criteria. IP stated nurses' do not have or use criteria when receiving orders for antibiotics. IP stated she use McGreer criteria after residents are started on antibiotic medication. IP stated facility did not follow antibiotic stewardship program with Resident 25's use of antibiotics for UTI. IP stated Resident 25's order for antibiotics should have been discontinued when LR showed it was urogenital flora. IP stated there are a number of residents on April 2026's ATB logs use of antibiotics that did not meet McGeer's criteria for infection and not consistent with antibiotic stewardship.During an interview on 5/14/26 at 8:52 a.m. with Licensed Vocational Nurse (LVN1), LVN1 stated nurses do not use criteria when communicating residents suspected infection signs and symptoms or receiving antibiotic medication orders with physician. LVN 1 stated when order for antibiotics is received nurses' call and inform family. LVN 1 stated families want residents' to be address with antibiotics and families sometimes insist. LVN 1 stated she was aware of the criteria, but we do not have or use [NAME] to crosscheck. LVN 1 stated she notified IP when physician ordered antibiotic for residents for follow up. During an interview on 5/14/26 at 8:23 a.m. with IP, IP stated that she did not know if the nurses use [NAME] to communicate with physician when order for antibiotics is received. During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship, dated December 2016, the P&P indicated, Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. When a nurse calls a physician / prescriber to communicate a suspected infection, he or she will have the following information available: a. Signs and symptoms.b. When symptoms were first observed.c. Resident's hydration status.d. Current medication list. e. Allergy information. f. Infection type.g. Any order for warfarin and result of last INR. h. Lat creatinine clearance or serum creatinine, if available [NAME]. Time of the last antibiotic dose.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure four of nine sampled residents (Residents 3, 9, 24) were offered appropriate pneumococcal (PNA- a disease that can cause infection in the lung) vaccination series.This failure had the potential to place Residents 3, 9, 24 and 34 at risk to be infected and spread of pneumococcal infection.During a review of Resident 3's admission Record (AR), printed on 5/13/26, AR indicated Resident 3 was admitted to the facility on [DATE], with diagnoses that included dementia (memory loss). During a concurrent interview and record review on 5/13/2026 at 2:02 p.m. with Licensed Vocational Nurse/ Infection Preventionist (IP), Resident 3's Immunization Record (IR). was reviewed. IR indicated Resident 3 had pneumococcal PPSV23 vaccine in 10/28/16. IP stated she did not know the time interval of when to recommend pneumococcal vaccine after the last dose. IP stated she was not aware of Center for Disease Control and Prevention (CDC) recommendations for use of pneumococcal vaccine series.During a review of Resident 9's admission Record (AR), printed on 5/14/26, AR indicated Resident 9 was admitted to the facility on [DATE], with diagnoses that included anemia (blood condition where body does not have enough healthy blood cells to carry oxygen to the body tissue).During a concurrent interview and record review on 5/13/2026 at 2:02 p.m. with Licensed Vocational Nurse/ Infection Preventionist (IP), Resident 9's Immunization Record (IR). was reviewed. IR indicated Resident 9 refused pneumococcal PPSV23 vaccine. IR indicated Resident 9 had no history of other pneumococcal vaccine. IP stated she did not know of the CDC recommendations for use of pneumococcal vaccine series. During a review of Resident 24's admission Record (AR), printed on 5/13/26, AR indicated Resident 24 was admitted to the facility on [DATE], with diagnoses anemia (blood condition where body does not have enough healthy blood cells to carry oxygen to the body tissue).During a concurrent interview and record review on 5/13/2026 at 2:02 p.m. with Licensed Vocational Nurse/ Infection Preventionist (IP), Resident 24's Immunization Record (IR). was reviewed. IR indicated Resident 24 refused pneumococcal PPSV23 vaccine. IR indicated Resident 24 had no history of other pneumococcal vaccine. IP stated she did not know of the CDC recommendations for use of pneumococcal vaccine series.During a review of Resident 34's admission Record (AR), printed on 5/13/26, AR indicated Resident 34 was admitted to the facility on [DATE], with diagnoses sepsis (The body's extreme life-threatening response to an infection).During a concurrent interview and record review on 5/13/2026 at 2:02 p.m. with Licensed Vocational Nurse/ Infection Preventionist (IP), Resident 34's Immunization Record (IR). was reviewed. IR indicated Resident 34 refused pneumococcal PPSV23 vaccine. IR indicated Resident 34 had no history of other pneumococcal vaccine. IP stated she did not know of the CDC recommendations for use of pneumococcal vaccine series.According to CDC pneumococci vaccination recommendations for patient characteristics Age: ˆ50 years, PPSV23: no prior doses, PCV13: no prior doses, risk factor not applicable. Give one dose of PCV15, PCV20, or PCV21. If PCV20 or PCV21 is used, their pneumococcal vaccinations are complete. If PCV15 is used, follow with one dose of PPSV231 to complete their pneumococcal vaccinations. The recommended interval between PCV15 and PPSV23 is at least 1 year. Footnotes: If PPSV23 was inadvertently given before PCV15, one dose of PCV15, PCV20, or PCV21 should be given at least 1 year after PPSV23.{Reference:https://www2a.cdc.gov/vaccines/m/pneumo/agegroup.html}A review of the facility's policy and procedure (P&P) titled, Pneumococcal Vaccine, dated 2001, indicated, Administration of the pneumococcal vaccines are made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 74), was provided information necessary to obtain an informed consent prior to the administration of Trazodone (an antidepressant medication used for treatment of major depressive disorder in adults), when the physician (MD1) did not inform Resident 74's responsible party (RP) in advance of the use, risks, and benefits of Trazodone. This failure had the potential to deny residents and surrogate decision maker information needed to make an informed decision. During a review of Resident 74's admission Record (AR), printed on 5/14/26, AR indicated Resident 74 was admitted to the facility on [DATE], with diagnoses that included hemiplegia and hemiparesis affecting left-dominant side (stroke), cognitive communication deficit, depression (mood disorder) and anxiety disorder (fear or worry that interferes with daily life). AR indicated RP was Resident 74's responsible party.During a review of Resident 74's admission Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 12/22/25, the MDS indicated Resident 74's Basic Interview of Mental status (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status), score was 03 and indicated severely impaired mental status. The BIMS score indicated Resident 74 was unable to recall the correct year, month, and day of the week. MDS indicated Resident 74 was unable to recall recent information with cueing. MDS indicated Resident 74 had clear speech, make self-understood and understand others. During a review of Resident 74's Order Summary Report (OSR), dated 12/19/25 OSR indicated MD1 prescribed Trazodone oral tablet 50 mg give one tablet by mouth at bedtime for depression manifested by inability to sleep.During a review of Resident 74's Medication Administration Record (MAR), dated 1/1/26 to 1/31/26, MAR indicated Resident 74 was administered Trazodone 50 mg one tablet by mouth at bedtime from 1/1/26 through 1/14/26.During a review of Resident 74's Interdisciplinary team note (IDT), dated 1/16/26, the IDT indicated that IDT met with Resident 74's RP to discuss care concerns. IDT indicated Trazodone medication was discussed. IDT indicated RP was not happy and stated that Resident 74 will never consent to a psychotropic medication like Trazadone and RP started to cry. IDT indicated MD 1 gave order to discontinue Trazodone. IDT (Interdisciplinary Team, a group of individuals representing different departments of the facility a professional discipline that work together to provide the greatest benefit to the resident which included the resident, the resident's family and/or representative, whenever possible, develops and implements approaches to care that are both clinically and appropriate and person - centered.During an interview on 5/14/26 at 11:25 a.m. with MD1, MD1 stated that he did not obtain informed consent for use of Trazodone from Resident #74's responsible party. MD 1 stated he did not speak with RP prior to prescribing Trazodone for Resident 74. MD1 stated Resident 74's RP did not want Resident 74 to be administered trazodone. MD1 stated that the facility process was that nurses communicate medication needs with residents and RPs and when there was need for clarification physician will talk to resident/family. During a concurrent interview and record review on 5/14/26 at 11:32 a.m. with Assistant Director of Nursing (ADON), Resident 74's Informed Consent-Psychoactive Medication (IC), dated 12/19/25 was reviewed. The IC indicated a licensed nurse has verified the resident or resident representative has given informed consent verbally or via phone. ADON stated she completed the informed consent form because she assumed MD1 had obtained informed consent from Resident 74's responsible party. ADON stated she did not remember whether it was Resident 74's RP or son that ADON called for verbal consent. During a concurrent interview and record review on 5/14/26 at 12:01 p.m. with Director of Nursing (DON), Resident 74 IDT documentation dated 1/16/26, physician order and MAR were reviewed. IDT indicated MD1 did not provide Resident 74's RP information necessary to obtain an informed consent prior to the prescribing (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and nursing administration of Trazodone. DON stated she was aware that informed consent was not obtained prior to administration and use of trazodone. DON stated facility had provided in-service training to the nurses and MD. During a review of the facility's policy and procedure (P&P) titled, Psychoactive/Psychotropic Medication Use, dated 4/2025, the P&P indicated, The prescribing clinician will obtain informed consent from the resident (or, as appropriate, the resident representative) for use of a psychotropic medication.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview and record review, the facility failed to ensure appropriate pain assessment was performed for one of eight sampled residents (Resident 18) when Resident 18, who was able to communicate verbally, was assessed for pain by facility staff using the Pain Assessment in Advanced Dementia (PAINAD, is an observational tool used to assess pain in patients with severe cognitive impairment who cannot verbally communicate their pain).This failure resulted in Resident 18 to receive pain medication without appropriate pain assessment.During a review of Resident 18's admission Record, dated 5/14/26, the admission Record indicated Resident 18 was admitted in the facility on 5/4/26 with an admission diagnosis of metabolic encephalopathy (a change in how your brain works due to an underlying condition), chronic diastolic heart failure (a condition when the heart's left fluid-filled chamber becomes thick and stiff and does not fill with enough blood between beats) and pleural effusion (an abnormal buildup of excess fluid between the layers of the thin selective barrier that line the lungs and chest cavity).During a record review of Resident 18's Minimum Data Set (MDS, an assessment used to guide plan of care) dated 4/29/26, the MDS indicated Resident 18 had the ability to make himself understood (express ideas and wants) and had the ability to understand (clear comprehension) of others' verbal content. The MDS also indicated, Resident 18's Brief Interview for Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information) score was 14 out of 15, indicating cognitively intact status. A score of 8-12 indicated moderate cognitive impaired status and a score of 0-7 indicated severe cognitive impaired status.During a review of Resident 18's Nursing-Daily Skilled Charting Form, dated 5/12/26, indicated Resident 18 was able to communicate well verbally and was responsive.During an observation on 5/12/26 at 4:30 p.m. outside Resident 18's room, Resident 18 was observed requesting pain medication from Licensed Vocational Nurse (LVN) 3. LVN 3 was observed asking Resident 18 where his pain was. Resident 1 was heard saying both knees. LVN 3 was not heard asking Resident 1 for his pain level.During medication administration observation on 5/12/26 at 4:31 p.m., LVN 3 was observed preparing and administering one medication to Resident 18. This medication included one tablet of tramadol 50 milligram (mg).During an observation on 5/12/26 at 4:32 p.m., LVN 3 observed documenting Resident 18's pain level using the Pain Assessment in Advanced Dementia (PAINAD, is an observational tool used to assess pain in patients with severe cognitive impairment who cannot verbally communicate their pain)During a review of Resident 18's Order Summary Report, dated 5/4/26, Resident 18 was prescribed with one tablet of tramadol 50 mg every six hours as needed for moderate-severe pain (4-10 pain).During a review of Resident 18's Medication Administration Note, dated 5/12/26 at 4:32 p.m., LVN 3 documented that Resident 18 had knee pain (both knees) without a pain level.During a concurrent interview and record review on 5/13/26 at 4:49 p.m. with LVN 3, Resident 18's Medication Administration Record (MAR), dated May 2026 was reviewed. The MAR indicated, on 5/12/26, for the 4:32 p.m. administration time of one tablet of tramadol 50 mg, the pain level of Resident 18 was zero. LVN 3 stated, she did not ask Resident 18 for his pain level. LVN 1 stated, she had based her pain assessment of Resident 18 on his reaction.During a review of facility's policy and procedure titled Pain Assessment Using Numeric and PAINAD Scale, dated 3/25, indicated, Purpose: To ensure pain is identified, evaluated, treated, monitored, documented. Pain Assessment Tool Selection: Use the Numeric Pain Scale when the resident can reliably self-report: 0=no pain, 1-3=mild pain, 4-6=moderate pain, 7-10=severe pain. Use the PAINAD Scale when the resident cannot reliably self-report. PAINAD scores five observed category: breathing, negative vocalization, facial expression, body language, and consolability.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility failed to ensure controlled medication (those with high potential for abuse and addiction) were fully accounted when random controlled medication use audit for one of three residents (Resident 1) did not reconcile. The controlled medication was signed out of the controlled drug record (CDR, an inventory sheet that keeps record of the usage of controlled medications) but not documented on the Medication Administration Record (MAR) to indicate the medication was given to the resident.This failure resulted in inaccurate accountability and had the potential for misuse or diversion (illegal distribution or abuse of prescription drugs or their use for purpose not intended by the prescriber) of controlled medications.During a review of Resident 1's admission Record, dated 5/13/26, the admission Record indicated Resident 1 was admitted in the facility on 5/6/26 with an admission diagnosis of osteomyelitis of cervical vertebra (rare infection of the bones of the neck), acute respiratory failure with hypoxia (a life-threatening medical emergency where the lungs cannot adequately transfer oxygen to the bloodstream) and pneumonia (an infection that inflames the air sacs in one or both lungs, causing them to fill with fluid or pus).During a review of Resident 1's Order Summary Report, dated 5/6/26, the Order Summary Report indicated Resident 1 had an order for oxycodone (a controlled medication) 10 milligram (mg) one tablet by mouth every four hours as needed for pain.During a review of Resident 1's CDR for oxycodone, dated 5/6/26, the CDR indicated one amount of oxycodone 10 mg was used at 3:55 p.m.During a concurrent interview and record review on 5/13/26 at 2:19 p.m. with the Assistant Director of Nursing (ADON), Resident 1's Medication Administration Record (MAR), dated May 2026 was reviewed. The MAR indicated, on 5/6/26, there was no licensed staff initials in the box for Resident 1's one tablet of oxycodone 10 mg to demonstrate the medication was given. The ADON stated, Resident 1's one tablet of oxycodone 10 mg was not documented as given in the MAR. The ADON stated, the expectation from staff was to document in the MAR after the medication was taken out of the packaging and was signed in the CDR to know that the medication was given.During a review of the facility's policy and procedure titled, Controlled Substances, dated 11/22, indicated, Dispensing and Reconciling Controlled Substances: 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up., 2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. records of personnel access and usage; b. medication administration records .During a review of the facility's policy and procedure titled, Administering Medication, dated 12/22, indicated, 19. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility had a 7.69% error rate when two medication errors out of 26 opportunities were observed during the medication administration for two of eight sampled residents (Residents 18 and 59) when:1. Resident 18 received tramadol (medication used to treat pain) with a pain level of zero (no pain).2. Resident 59 did not receive polyethylene glycol (an over-the-counter medication used to treat occasional constipation) as ordered.These failures resulted in Resident 18 and 59 receiving medication not in accordance with the prescriber's orders.1. During a review of Resident 18's admission Record, dated 5/14/26, the admission Record indicated Resident 18 was admitted in the facility on 5/4/26 with an admission diagnosis of metabolic encephalopathy (a change in how your brain works due to an underlying condition), chronic diastolic heart failure (a condition when the heart's left fluid-filled chamber becomes thick and stiff and does not fill with enough blood between beats) and pleural effusion (an abnormal buildup of excess fluid between the layers of the thin selective barrier that line the lungs and chest cavity).During a record review of Resident 18's Minimum Data Set (MDS, an assessment used to guide plan of care) dated 4/29/26, the MDS indicated Resident 18 had the ability to make himself understood (express ideas and wants) and had the ability to understand (clear comprehension) of others' verbal content. The MDS also indicated, Resident 18's Brief Interview for Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information) score was 14 out of 15, indicating cognitively intact status. A score of 8-12 indicated moderate cognitive impaired status and a score of 0-7 indicated severe cognitive impaired status.During a review of Resident 18's Nursing-Daily Skilled Charting Form, dated 5/12/26, indicated Resident 18 was able to communicate well verbally and was responsive.During an observation on 5/12/26 at 4:30 p.m. outside Resident 18's room, Resident 18 was observed requesting pain medication from Licensed Vocational Nurse (LVN) 3. LVN 3 was observed asking Resident 18 where his pain was. Resident 1 was heard saying both knees. LVN 3 was not heard asking Resident 1 for his pain level.During medication administration observation on 5/12/26 at 4:31 p.m., LVN 3 was observed preparing and administering one medication to Resident 18. This medication included one tablet of tramadol 50 milligram (mg).During an observation on 5/12/26 at 4:32 p.m., LVN 3 was observed documenting Resident 18's pain level using the Pain Assessment in Advanced Dementia (PAINAD, is an observational tool used to assess pain in patients with severe cognitive impairment who cannot verbally communicate their pain)During a review of Resident 18's Order Summary Report, dated 5/4/26, Resident 18 was prescribed with one tablet of tramadol 50 mg every six hours as needed for moderate-severe pain (4-10 pain).During a review of Resident 18's Medication Administration Record (MAR), dated 5/12/26, Resident 18's pain level was zero at 4:32 p.m. when one tablet of tramadol 50 mg was administered.During a review of Resident 18's Medication Administration Note, dated 5/12/26 at 4:32 p.m., LVN 3 documented that Resident 18 had knee pain (both knees) without a pain level.During a concurrent interview and record review on 5/13/26 at 4:49 p.m. with LVN 3, Resident 18's Medication Administration Record (MAR), dated May 2026 was reviewed. The MAR indicated, on 5/12/26, for the 4:32 p.m. administration time of one tablet of tramadol 50 mg, the pain level of Resident 18 was zero. LVN 3 stated, she did not ask Resident 18 for his pain level. LVN 1 stated, she had based her pain assessment of Resident 18 on his reaction.2. During a review of Resident 59's admission Record, dated 5/12/26, the admission Record indicated Resident 59 was admitted in the facility on 4/18/26 with an admission diagnosis of displaced midcervical fracture of right femur (the thighbone is broken in the middle of the neck and the bone fragments are misaligned), acute post hemorrhagic anemia (a condition where a rapid, massive loss of blood quickly depletes the body's cells responsible for transporting oxygen from the lungs to the body's tissues) and essential hypertension (persistently high blood pressure without a single identifiable medical cause).During medication administration observation on 5/12/26 at 8:23 a.m., LVN 4 was observed preparing five of (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 59's medications. These medications included half tablet of atenolol (medication used to treat high blood pressure) , one capsule of stool softener (medication used to treat constipation), one tablet of losartan (medication used to treat high blood pressure), 17 grams (gm) of polyethyleyne glycol (medication to treat constipation) and one enoxaparin (medication used to prevent and treat blood clot) injection. LVN 4 mixed 17 gm powder of polyethylene glycol into a clear plastic cup halfway filled with water.During an observation on 5/12/26 at 8:32 a.m. in Resident 59's room, LVN 4 gave Resident 59's five prepared medications. Resident 59 was then observed drinking approximately half of the water mixed with polyethylene glycol. Resident 59 was then heard saying he did not want to drink all of the water from the clear plastic cup. LVN 4 was then observed taking the clear plastic cup with water outside Resident 59's room.During a review of Resident 59's Order Summary Report, dated 4/17/26, Resident 59 was prescribed with 17 gm of polyethylene glycol one time a day for bowel management, hold for loose stool, dissolve 17 gm into 4-8 oz of water or juice.During a concurrent observation and interview on 5/12/26 at 2:09 p.m. with LVN 4, one clear plastic cup had 5 ounces (oz) mark at the bottom. LVN 4 stated mixing Resident 59's 17 gm of polyethylene glycol powder approximately with 2.5 oz of water and not 4-8 oz as order. LVN 4 stated Resident 59 approximately only drank 1.5 oz of water mixed with the medication.During a review of the facility's policy and procedure titled, Administering Medication, dated 12/22, indicated, 3. Medications must be administered in accordance with the orders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review the facility failed to ensure proper medication storage and labeling practices when:1. An afrin nasal spray (an over-the-counter medication that provides relief for nasal and sinus congestion) was unlabeled with Resident 60's name during medication administration observation.2. Resident 60's alvesco inhaler (medication used for the maintenance treatment of asthma) was stored in the medication cart without prescriber's order during the inspection of one of two sampled medication cart.These failures had the potential to result in unsafe medication administration and storage practices.1. During a review of Resident 60's admission Record, dated 5/12/26, the admission Record indicated Resident 60 was admitted in the facility on 4/29/26 with an admission diagnosis of pulmonary embolism without acute cor pulmonale (blood clot that blocks and stops blood flow to a blood vessel in the lung without right-sided heart failure), bacteriuria (presence of bacteria in the urine) and hypothyroidism (common condition where the thyroid gland fails to produce enough hormones, causing the body's metabolism to slow down).During a concurrent medication administration observation and interview on 5/12/26 at 8:48 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 was observed preparing and administering four medications to Resident 60. These medications included one capsule of stool softener (medication used to treat constipation) , one tablet of eliquis (medication used to treat and prevent blood clots), one lidocaine patch (medication used as relief from minor muscle, joint, and nerve pain) and two sprays of afrin nasal spray to both nostrils. The afrin nasal spray bottle and box container was observed without label of Resident 60's name. LVN 4 stated, there should be Resident 60's name on the nasal spray bottle and on the box container.During a review of Resident 60's Order Summary Report, dated 4/30/26, the Order Summary Report indicated Resident 60 had a prescribed order for afrin nasal spray solution two spray into both nostrils one time a day for nasal congestion.During a review of Resident 60's Medication Administration Record (MAR), dated May 2026, the MAR indicated, Resident 60 had a scheduled order to receive afrin nasal spray solution two spray in both nostril on 5/12/26 at 9:00 a.m.During a review of facility's policy and procedure titled, Nasal Spray Administration, dated 11/24, indicated, Purpose: To ensure safe, accurate, and effective administration of nasal spray medications to resident in accordance with physician orders, manufacturer recommendations, infection control standards, and applicable federal and state regulations. Policy: Nasal spray medications shall be handles, stored, administered, . to maintain resident safety and prevent contamination. 6.Storage: Nasal spray medications shall be stored:. Clearly labeled for individual resident use.2. During a concurrent observation and interview on 5/13/26 at 11:08 a.m. with LVN 4, an alvesco inhaler was stored in a zip lock bag inside the third left drawer of the medication cart 2. The zip lock bag had Resident 60's name written in black ink marker. LVN 4 stated, Resident 60's family member brought in the medication. LVN 4 stated, medications stored in the medication cart were for current resident use. During an interview on 5/13/26 at 12:51 p.m. with the Director of Nursing (DON), the DON stated, Resident 60's alvesco inhaler supply cannot be used because there was no active order. The DON stated, the family member will be called to pick up the inhaler. The DON stated, the inhaler was stored in the medication room.During a follow up interview on 5/13/26 at 1:33 p.m. with the DON, the DON stated, Resident 60's inhaler should have been kept in the medication room until the family member picked it up.During a review of Resident 60's Order Summary Report, dated 5/13/26, the Order Summary Report indicated Resident 60 had no active prescribed order for alvesco inhaler.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to employ a full-time registered dietitian, the person designated to serve as the director of food and nutrition services met both the federal and/or state educational qualifications for the position, when facility's dietary manager was also not qualified/certified. This failure had the potential for lack of competency and skill set necessary to carry out all the functions of the food services. During an interview on 5/11/26 at 2:46 p.m. with Dietary Manager (DM), DM stated that he was not a certified dietary manager. DM stated he was currently in school.During an interview on 5/11/26 at 3:06 p.m. with Registered Dietician (RD), RD stated that she was hired to work on part time. RD stated she worked 24 hours a week.During an interview on 5/13/2026 at 1:02 p.m. Administrator (Admin), Admin stated he was aware DM was in school and not certified.During a concurrent interview and record review on 5/14/26 at 8:04 a.m. with Admin, DM's Employee Record (ER), was reviewed. The ER indicated DM was hired 10/3/22 as a DM. Admin stated DM was currently in a training program.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on interview and record review, the facility failed to ensure a binding arbitration agreement (a contract in which parties agree to resolve disputes outside of court) was explained in a manner that was understandable to one of three sampled residents (Resident 25's) family representative (FR 1). This failure had the potential to prevent FR 1 from making an informed decision regarding whether to enter into a binding arbitration agreement.During a review of Resident 25's admission Record, printed 5/14/26, the Record indicated Resident 25 was admitted to the facility in March 2026 with a diagnosis of major depressive disorder. During an interview on 5/13/26, at10:45 a.m., with FR 1, FR 1 stated they completed Resident 25's admission paperwork and signed their binding arbitration agreement. FR 1 stated the facility gave Resident 25's admission paperwork, and the binding arbitration agreement, all together at one time and was told to sign. FR 1 stated the binding arbitration agreement was not explained to them and they did not understand it was optional. FR 1 stated they would not have signed it if they knew it was optional. During an interview on 5/13/26, at 12:37 p.m., with Resident Relations Liaison (RRL), RRL stated during admission, they gave residents the binding arbitration agreement with all the admission paperwork. RL stated it was important to tell residents the binding arbitration agreement was optional and was not a condition of admission because it was their right to choose. During an interview on 5/13/26, at 12:45 p.m., with Clinical Liaison (CL), CL stated it was important to make sure residents, and resident representatives understood they waived their right to a trial when they signed the binding arbitration agreement. CL stated it was important to tell residents the binding arbitration agreement was optional and was not a condition of admission because if they didn't understand they might have been at risk if there were any disputes between the facility and the resident or resident representative. During an interview on 5/13/26, at 4:18 p.m., with RRL, RRL stated when they gave the binding arbitration agreement to FR 1, they did not explain the document line by line. During a review of Resident 25's Binding Arbitration Agreement, dated 4/6/26, the Agreement indicated, FR 1 signed it on 4/6/26. During a review of the facility's policy and procedure (P&P) titled, Binding Arbitration Agreements, revised November 2023, the P&P indicated, Residents (or representatives) are informed of the nature and implications of any proposed binding arbitration agreements so as to make informed decisions on whether to enter into such agreements. The P&P, indicated, it is unambiguously communicated to residents (or representatives) that binding arbitration agreements are optional and not required as a condition of admission or to receive care at this facility. The P&P indicated, The terms and conditions of a binding arbitration agreement are explained to the resident (or representative) in a way that ensures his or her understanding of the agreement, including that the resident may be giving up his or her right to have a dispute decided in a court proceeding (i.e., litigation).

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview and record review, the facility failed to ensure the essential equipment were properly maintained when; Resident 34's bed made loud cranking noise when bed was moved up and down during care. This failure had the potential to cause residents distress or discomfort. During a concurrent observation and interview on 5/12/26 at 10:03 a.m. with Certified Nursing Assistant (CNA 1) and Licensed Vocational Nurse (LVN1), Resident 34's healed wound on buttock was observed. Resident 34's bed made loud cranking noise when remote was operated to bring the bed up and down. Resident 34 stated he can live with the noise. During an interview on 5/12/26 at 10:06 a.m. with CNA 1, CNA 1 stated Resident 34's bed makes loud noise from time to time. CNA 1 stated that the nursing staff are aware that Resident 34's bed made cranking noise and that maintenance department was notified. During an interview on 5/12/26 at 10:09 a.m. with Registered Nurse (RN1) stated that sometimes Resident 34's bed was lubricated. During an interview on 5/12/26 at 10:11 a.m. with Maintenance Supervisor (MS), MS stated he was aware of the cranking noise made by Resident 34's beds. MS stated about half of the resident beds at the facility made cranking noise. MS stated beds are oiled when residents are discharged . MS stated he waited for residents' discharge because he was concern about the smell of the lubricant. MS stated facility had a plan to replace beds that made loud noise when used. During an interview on 5/13/26 at 12:57 p.m. with Administrator (Admin), Admin stated facility was in the process of buying new beds. Admin stated facility plan to replace all residents' beds. During a review of the facility's policy and procedure (P&P) titled, Preventative Maintenance, dated April 2025, the P&P indicated, The facility shall maintain a preventative maintenance program designed to minimize equipment failure, maintain resident safety and comfort, reduce operational disruptions, and ensure compliance with regulatory requirements.