STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555021	A. BUILDING _____ B. WING _____	C 06/19/2025

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THE GROVE POST ACUTE	12332 GARDEN GROVE BLVD. GARDEN GROVE, CA 92843

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the concurrent Recertification, Relicensing, and Abbreviated Surveys for Facility Reported Incident (FRI) Number: CA00966665. The survey team entered the facility on 6/16/25 at 0730 hours. The facility identified the census as 89. The survey final sample size was 19. FOR FRI NUMBER: CA00966665, NO DEFICIENCIES WERE IDENTIFIED. GLOSSARY AND DEFINITIONS: % - Percent Abrasion - a shallow wound or scrape that occurs when the top layer of skin (epidermis) is rubbed or scraped away Acute - present or experienced to a severe or intense degree. Advance Healthcare Directives - a legal document that states a person's wishes about receiving medical care if that person is no longer able to make medical decisions ADON - Assistant Director of Nursing AM - morning Aspiration - injalation of foreign objects into the airway and/or lungs BIMS - Brief Interview for Mental Status (assessment used to gauge a person's cognitive functioning) CAUTI - Catheter-Associated Urinary Tract Infection	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 8/06/25

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.

8/6/25 POC Accepted

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F 000	Continued From page 1	F 000		

CDC - Centers for Disease Control and Prevention
Chronic respiratory failure- a condition where the lungs can't adequately exchange oxygen and carbon dioxide over an extended period
CMS - Centers for Medicare and Medicaid Services
CNA - Certified Nursing Assistant
Dementia - a general term for the loss of cognitive functions like memory, language, and reasoning, severe enough to interfere with daily life
DM - diabetes mellitus a chronic metabolic disorder characterized by persistent high blood sugar levels
DON - Director of Nursing
DSD - Director of Staff Development
DSS - Dietary Services Supervisor
DVT - Deep Vein Thrombosis (condition where a blood clot forms in a deep vein)
EBP - Enhanced Barrier Precaution (an isolation precaution for residents with implanted devices such as central catheter, foley catheter, and gastrostomy tube)
EHR - Electronic Health Record
Facility Assessment - a document describing resident population and needs to determine staff and other resources necessary to competently care for residents
FDA - Food and Drug Administration
G-tube - Gastrostomy tube
H&P - History and Physical
hr - hour
Hypoxia- low levels of oxygen in body
Indwelling urinary catheter - a flexible tube inserted into the bladder to drain urine
IP - Infection Preventionist/Prevention
IV - intravenous
Lethargy - a state of weariness that involves

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F 000	Continued From page 2 diminished energy, mental capacity, and motivation Lipohypertrophy - a condition where fatty tissue accumulates in an abnormal way, typically at the site of injections LVN - Licensed Vocational Nurse MAR - Medication Administration Record MDS - Minimum Data Set (a standardized assessment tool) Meal ticket - used to identify the resident's diet, allergies, and food preferences Mechanically altered diet - the texture of the diet was altered mg - milligram(s) mg/dl - milligram(s) per deciliter ml - milliliters(s) mmHg - milliliter(s) of mercury Nasal Cannula - flexible tube to deliver oxygen into the nose Neurogenic bladder - bladder dysfunction caused by nerve damage NH - Nursing Home Osteoporosis - a disease that weakens bones, making them more likely to break Oxygen saturation level - measurement of how much oxygen is being carried by red blood cells in your blood, expressed as a percentage oz - ounce(s) P&P - Policy and Procedure PCV15 - Pneumococcal Conjugate Vaccine (a vaccine which protects against 15 types of pneumococcal bacteria) PCV20 - Pneumococcal Conjugate Vaccine (a vaccine which protects against 20 types of pneumococcal bacteria) PM - afternoon/evening POLST - Physician Order for Life Sustaining Treatment (a medical order that allows patients to specify their end-of-life treatment preferences)	F 000		

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F 000	Continued From page 3 PPSV23 - Pneumococcal Polysaccharide Vaccine (a vaccine which protects against 23 types of pneumococcal bacteria) QSO memo - Quality, Safety, and Oversight (a memorandum issued by the CMS), essentially providing guidance and instructions to state survey agencies and CMS locations regarding healthcare facility compliance and quality standards; it outlines policies related to patient safety and quality of care within healthcare facilities regulated by CMS) RN - Registered Nurse SBAR - Situation, Background, Assessment, and Recommendation (a communication framework used to structure conversations, especially in healthcare, to ensure clear and concise information exchange) SLP - Speech Language Pathologist SSA - Social Service Assistant SSD - Social Services Director Urostomy - a surgically created opening in the abdomen that allows urine to bypass the bladder and exit the body USDA - United States Department of Agriculture UTI - Urinary Tract Infection (a condition associated with invasion by disease causing microorganisms of some part of the urinary tract)	F 000		
F 558 SS=B	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:	F 558		

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F 558	Continued From page 4 Based on observation, interview, and medical record review, the facility failed to provide the reasonable accommodations to meet the needs of two of 19 final sampled residents (Residents 1 and 28). * The facility failed to ensure Residents 1 and 28's bed remote control was within the residents' reach. This failure had the potential to negatively impact the residents' psychosocial well-being or result in a delay to receive care. Findings: 1. On 6/16/25 at 0818 hours, during the initial tour of the facility, Resident 28's bed remote control was observed to be placed at the foot of the bed that was not within Resident 28's reach. Resident 28 was observed to be sleeping during the initial tour. Medical record review for Resident 28 was initiated on 6/16/25. Resident 28 was admitted to the facility on 8/26/21, and readmitted on 2/2/25. Review of Resident 28's H&P examination dated 2/4/25, showed Resident 28 had no capacity to understand and make decisions. On 6/16/25 at 0825 hours, an observation on Resident 28's call light and bed remote control and concurrent interview was conducted with CNA 2. Resident 1's call light was observed to be within reach of Resident 28's left hand; however, Resident 28's bed remote control was still placed at the foot of the bed. CNA 2 was asked how Resident 1 was using her call light and bed remote control. CNA 2 stated Resident 28 was able to verbalize her needs by using her call light	F 558	F 558 • How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The bed remotes for residents 1 and 28 were placed within reach of each resident. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. On 6/24/25, the Director of Staff Development (DSD) conducted an audit of residents to ensure that bed remotes were accessible to all residents, unless contraindicated for safety. No additional residents were observed with bed remotes out of reach. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. An in-service for facility staff was initiated on 6/23/25 by the Director of Staff Development (DSD) regarding ensuring bed remotes are kept within reach of residents, unless contraindicated for safety. Inservices completed by 7/10/25. ON 7/7/25 the maintenance department started installing clips on the bed remotes to ensure they are within reach of residents, unless contraindicated for safety reasons. Completion date: 7/10/25. The assistant director of nursing or designee will monitor 10 random residents(alert) from each station 3x/week 3 x months to ensure their bed remotes are within reach. • How the facility plans to monitor its performance to make sure that solutions are sustained. The POC is integrated into the QA system. The DON/designee will provide a summary trend analysis of the findings to the facility's monthly QAPI Committee x 3 months or until such time consistent substantial compliance has been achieved as determined by the committee. Date of compliance: 7/10/25	

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F 558	Continued From page 5 and use her bed remote control in adjusting her position of comfort. CNA 2 was asked further what the facility's process was on placement of the resident's bed remote control. CNA 2 placed Resident 1's bed remote on her left side near her left hand and verified Resident 1's bed remote control should be placed within the resident's reach since Resident 28 knew how to use the bed remote control. On 6/16/25 at 1252 hours, an interview was conducted with LVN 2. LVN 2 was asked on the facility's protocol on the placement of the bed remote control for the residents. LVN 2 stated the bed remote control should be within reach of the residents. LVN 2 was informed on Resident 28's bed remote control which was observed to be placed at the foot of the bed. LVN 2 acknowledged the bed remote control should be placed within reach of the resident. 2. On 6/17/25 at 0756 hours, an observation on Resident 1's bed remote control and concurrent interview was conducted with Resident 1 and the IP. Resident 1's bed remote control was observed to be hanging by Resident 1's left side of the bed. Resident 1 was asked if he would prefer his bed remote control within reach, Resident 1 stated he preferred the bed remote control to be within reach. The IP was asked for the facility's process on the placement of the bed remote control for the residents. The IP verified Resident 1's bed remote control should have been placed within Resident 1's reach. Medical record review for Resident 1 was initiated on 6/16/25. Resident 1 was admitted to the facility on 10/1/01, and readmitted on 5/4/25.	F 558		

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F 558	Continued From page 6 Review of Resident 1's H&P examination dated 5/5/5, showed Resident 1 had the capacity to make decisions. Review of Resident 1's MDS assessment Section C- Cognitive Patterns dated 5/6/25, showed Resident 1's BIMS score was 15, indicating Resident 1's cognition was intact.	F 558		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the	F 578	F - 578 Request/Refuse/Dscntnue Trmnt; Formlte Adv Dir Corrective Action Initiated For Resident/s Resident 52's advance directive status was immediately reviewed on 6/20/25 by SSD. Social Services obtained a copy of the advance directive and placed it into the resident's medical record. Resident 52's POLST form was reviewed and updated to accurately reflect the advance directive information on 6/23. How Potential Other Residents Were Identified and Corrective Action Taken Other residents are at risk for this noted practice Starting on 6/23 through 7/7/25, the Social Services Director (SSD) initiated an audit of all current resident medical records to ensure advance directives were accurately documented, present in charts, and consistent with resident or representative decisions. Measures/Systemic Changes Initiated to Prevent Future Recurrence On 6/25/25, all admissions and Social Services staff were re-educated by the DON regarding facility policy and procedures for obtaining, maintaining, and documenting advance directives upon admission, including immediate follow-up processes.	

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F 578	Continued From page 7 time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview, medial record review, and facility P&P review, the facility failed to obtain and/or maintain the copies of the advance directive in the medical record for one of two final sampled residents (Resident 52) reviewed for advance directives. This failure had the potential for the resident's decisions regarding their healthcare and treatment not being honored. Findings: Review of the facility's P&P titled Residents' Rights Regarding Treatment and Advance Directives revised 12/2022 showed on admission, the facility will determine if the resident has executed an advance directive. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff. Medical record review for Resident 52 was initiated on 6/16/25. Resident 52 was admitted to the facility on 10/22/24. Review of Resident 52's Advance Directive	F 578	A standardized admission checklist was implemented to verify the presence and accurate documentation of advance directives during each admission. findings will be reported at daily stand up for follow up Social Services will check new admits for follow-up documentation and the maintenance of advance directive copies on a weekly basis Monitoring Plans to Ensure Solutions are Achieved and Integrated into QA System. The POC is integrated into the QA system. The SSD will provide a summary trend analysis of the findings to the facility's monthly QAPI Committee x 3 months or until such time consistent substantial compliance has been achieved as determined by the committee. Date of compliance: 7/7/25	

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F 578	Continued From page 8 Acknowledgement form dated 10/22/24, showed Resident 52 had executed an advance directive. Review of Resident 52's H&P examination dated 10/23/24, showed Resident 52 had no capacity to understand and make medical decisions. Review of Resident 52's Physician Orders for Life-Sustaining Treatment (POLST) dated 10/31/24, showed Section D - Information and Signatures of the advance directive information was left blank. Review of Resident 52's medical record failed to show a copy of Resident 52's advance directive was maintained in the resident's medical record. Further review of Resident 52's medical record failed to show documented evidence the facility attempted to obtain a copy or follow up regarding Resident 52's advance directive. On 6/19/25 at 0948 hours, a concurrent interview and medical record review was conducted with the SSD and SSA. The SSA stated prior to April 2025 their admissions did the Advance Directive Acknowledgement form, and the Social Services department did not see the forms. The SSD verified the Social Services department was now responsible for the residents' advance directives. The SSD stated they did not have documentation of the follow up or a record of Resident 52's advance directive. On 6/19/25 at 1601 hours, an interview was conducted with the Administrator, DSS, and DON, The Administrator, DSS, and DON acknowledged the findings.	F 578		
F 585 SS=D	Grievances	F 585		

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F 585	Continued From page 9 CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone	F 585	F- 585 Grievance Corrective Action Initiated For Resident/s On 6/18/25, the Social Services Director (SSD) met with Resident 53 to follow up on her grievance, documented her concerns in full, and ensured her satisfaction with the facility's investigation and action. On 6/18/25 Resident 53's grievance form was immediately updated to include the omitted allegation regarding the CNA being too rough and a documented resolution, including whether the resident was satisfied. How Potential Other Residents Were Identified and Corrective Action Taken On 6/25/25, the SSD initiated a review of all active grievance logs from the past 30 days to ensure complete documentation, follow-up, and resident satisfaction were recorded appropriately. No other unresolved grievances were identified. Measures/Systemic Changes Initiated to Prevent Future Recurrence On 7/10/25, the DON/designee re-educated facility staff - IDT (Social services, activities, and DSD), including CNAs and Licensed nurses, on the grievance reporting process, emphasizing the importance of thorough documentation and prompt follow-up per the facility's P&P. The grievance tracking tool will be checked by the social services director to ensure all grievances include: Full resident concern details, Steps taken to investigate, Final determination and corrective actions, Confirmation of resident satisfaction and resolution date	

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F 585	Continued From page 10 number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not	F 585	The Administrator will review all grievance on a weekly basis for follow up and resolution on a timely basis Resident Council agendas will now include a follow-up item to verify that concerns voiced are addressed and documented thoroughly by department heads and verified by administrator on a monthly basis Monitoring Plans to Ensure Solutions are Achieved and Integrated into QA System. The SSD will provide a summary trend analysis of the findings to the facility's monthly QAPI Committee x 3 months or until such time consistent substantial compliance has been achieved as determined by the committee. Date of Compliance: 6/25/25	

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F 585	Continued From page 11 confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to determine whether a resident's grievance allegation was resolved in accordance with the facility's P&P for one of 19 final sampled residents (Resident 53). * Resident 53 stated on 5/9/25, she sustained a skin abrasion to her thigh after a CNA changed her soiled adult brief. Resident 53 stated she sustained the abrasion form a towel the CNA used to clean her. Resident 53 stated the CNA was too rough and hard with the towel when cleaning her. Resident 53 stated the facility failed to address her concern (after having informed the facility on 5/9/25) thus she informed the facility again during a resident council meeting held on 6/12/25. Resident 53 stated the facility has yet to address her concern. * The facility failed to determine whether Resident 53's allegation the CNA was too rough and hard	F 585		

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F 585	Continued From page 12 with the towel when cleaning her, was resolved in accordance with the facility's P&P for grievances. These failures posed the risk for the resident's grievance not being thoroughly addressed, investigated, documented, and resolved. Findings: Review of the facility's P&P titled Resident and Family Grievances revised 2/22/23, showed the social services designee has been designated as the facility's grievance official. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form. The grievance official will keep the resident appropriately apprised of the progress towards resolution of the grievances. The grievance official may issue a written decision on the grievance to the resident at the conclusion of the investigation. The written decision will include at a minimum: A summary of the pertinent findings or conclusions regarding the resident's concern. A statement as to whether the grievance was confirmed or not confirmed. Any corrective action taken or to be taken by the facility as a result of the grievance. The facility will make prompt efforts to resolve grievances. Medical record review for Resident 53 was initiated on 6/16/25. Resident 53 was admitted to the facility on 7/1/22. Review of Resident 53's H&P examination dated 4/25/25, showed Resident 53 had the capacity to understand and make decisions. On 6/16/25 at 1327 hours, an interview was	F 585		

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F 585	Continued From page 13 conducted with Resident 53. Resident 53 stated on 5/9/25, she sustained a skin abrasion to her thigh after a CNA changed her soiled adult brief. Resident 53 stated she sustained the abrasion form a towel the CNA used to clean her. Resident 53 stated the CNA was too rough and hard with the towel when cleaning her. Resident 53 stated she reported the incident to facility staff on 5/9/25, and no longer wished for this particular CNA to provide care for her. Resident 53 stated the facility failed to address her concern, therefore she again voiced her concern during a resident council meeting held on 6/12/25. Resident 53 stated the facility had not followed up with her and she would like the facility to follow up with her specific concern. On 6/18/25 at 0916 hours, an interview and concurrent facility record review was conducted with the facility's Grievance Official, the SSD. The SSD stated Resident 53 informed her of a grievance on 5/9/25, and she documented Resident 53's grievance on the facility's grievance form. The SSD stated Resident 53 informed her that a CNA caused a skin tear while cleaning her with a towel, during an adult brief change. The SSD stated Resident 53 informed her the CNA was not gentle and cleaned her hard. Review Resident 53's Grievance form dated 5/9/25, showed the SSD documented that a CNA changed Resident 53's adult brief and Resident 53 alleged the CNA caused open skin on Resident 53's left groin. The Grievance form failed to show the SSD documented Resident 53's allegation that the CNA was not gentle and cleaned Resident 53 hard. The SSD stated Resident 53's concern specific to the allegation the CNA was not gentle and cleaned Resident 53	F 585		

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F 585	Continued From page 14 hard should have been included and documented on the Grievance form. Additionally, the SSD stated Resident 53's allegation the CNA was not gentle and cleaned her hard should have been addressed with Resident 53 and a determination made as to whether Resident 53 was satisfied with the facility's investigation, outcomes, and facility interventions. The SSD stated this information should then be documented on Resident 53's Grievance form. The SSD verified the Grievance form section titled Complainant (Resident 53) Satisfied, and Date (Grievance) Resolved were both blank. The SSD stated Resident 53 again voiced her concern during a resident council meeting conducted on 6/12/25. The SSD stated Resident 53's concern was documented on the facility's Department Response Resident Council Concerns Form dated 6/12/25. A review of the Department Response Resident Council Concerns Form dated 6/12/25, was then conducted with the SSD. Documentation showed Resident 53 again voiced her concern specific to the CNA. The facility documented Resident 53 stated a CNA was rough in handling Resident 53 during an adult brief change. Further review of the form showed the department's written response to Resident 53's allegation. The department's response showed documentation specific to whether Resident 53 was to be compensated for a skin tear. However, the department response failed to show a response specific to Resident 53's allegation that the CNA was rough in handling her during an adult brief change. The SSD verified the findings. The SSD stated Resident 53's allegation a CNA was rough in handling her during an adult brief change	F 585		

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F 585	Continued From page 15 should have been addressed, and the department's response and resolution documented. Further review of the Department Response Resident Council Concerns Form dated 6/12/25, showed a section as to if the allegation was resolved to Resident 53's satisfaction, with a Yes or No option available, however, this section was blank. The SSD verified the findings.	F 585		
F 605 SS=D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2), 483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or	F 605		

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F 605	Continued From page 16 convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 605	F605 - Right to be free from chemical restraint. *How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.* The facility will ensure that non-pharmacological interventions will be attempted prior to administration hypnotic medication. For resident 1, documentation of non-pharmacological interventions used will be documented in the medication administration record (MAR) starting on 6/17/25. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.* An audit of residents using hypnotic medication was completed on 7/2/25. No other resident uses hypnotic medication.	

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F 605	Continued From page 17 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of five final sampled residents (Resident 1) reviewed for unnecessary medications was free from the unnecessary psychotropic medications. * The facility failed to ensure the non-pharmacological interventions were implemented prior to to the administration of the temazepam (a sedative medication used to relieve difficulty of falling asleep) to Resident 1.	F 605	*What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.* The medical records department/designee will audit the medical records of the residents on hypnotic medication weekly to identify if non-pharmacologic interventions were provided prior administration. Findings will be reported to DON for follow up. Inservice to licensed nurses initiated on 6/23/25 regarding psychotropic medication including providing non-pharmacological interventions. Completion date by 7/10/25. *How the facility plans to monitor its performance to make sure that solutions are sustained.* The POC is integrated into the QA system. The DON/designee will provide a summary trend analysis of the findings to the facility's monthly QAPI Committee x 3 months or until such time consistent substantial compliance has been achieved as determined by the committee. Date of compliance: 7/10/25	

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F 605	Continued From page 18 This failure had the potential to negatively affect the resident's well-being and had the potential for adverse effects from the psychotropic medications. Findings: Review of the facility's P&P titled Use of Psychotropic Medication(s) dated 3/17/25, showed it is the intent of this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint. 6. The indications for initiating, maintaining or discontinuing medication(s), as well as use of non-pharmacological approaches, will be determined by evaluating the resident's physical, behavioral, mental, and psychosocial signs and symptoms in order to identify and rule out any underlying medical conditions, including the assessment of relative benefits and risks, and the preferences and goals for treatment. 6. Nonpharmacological interventions must be attempted unless clinically contraindicated to minimize the need for psychotropic medications, use the lowest possible dose, or discontinue the medication. Medical record review for Resident 1 was initiated on 6/16/25. Resident 1 was admitted to the facility on 10/1/01, and readmitted on 5/4/25. Review of Resident 1's H&P examination dated 5/5/5, showed Resident 1 had the capacity to make decisions.	F 605		

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F 605	Continued From page 19 Review of Resident 1's Order Summary dated 6/17/25, showed the following physician's orders: - dated 5/6/25, to administer temazepam 30 mg capsule by mouth at bedtime for insomnia manifested by inability to sleep. - dated 5/6/25, to monitor for side effects related to use of psychotropic medications. - dated 5/20/25, to monitor inability to sleep and record the number of hours of sleep every shift for insomnia. Review of Resident 1's care plan revised 5/5/25, showed a care plan problem addressing Resident 1 was on sedative/hypnotic therapy (temazepam) related to insomnia which included the following interventions: - to administer sedative/hypnotic medications as ordered by physician and monitor/document the side effects. - to evaluate other factors potentially causing insomnia, for example, environment (excessive heat, cold, or noise), lighting, inadequate physical activity, facility routines, caffeine/medications and attempt to modify and control these external factors before initiating hypnotic therapy. - to precede or accompany hypnotic use by other interventions to try to improve sleep. Review of Resident 1's MAR for May 2025 showed the following hours of sleep every shift for insomnia: - On 5/6, 5/17, 5/22, 5/23, 5/24, and 5/31/25, had seven hours of sleep during the night shift. - On 5/6, 5/8, 5/10, 5/11, 5/14, 5/15, 5/16, 5/17, 5/24, 5/26, 5/30 and 5/31, one hour of sleep	F 605		

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F 605	Continued From page 20 during the evening shift. - On 5/7, 5/8, 5/9, 5/10, 5/11, 5/12, 5/13, 5/15, 5/16, 5/18, 5/19, 5/20, 5/21, 5/25, 5/26, 5/27, 5/28, 5/29, and 5/30/25, had six hours of sleep during the night shift. - On 5/7, 5/11, 5/13, 5/15, 5/22, 5/23, 5/25, 5/26, 5/27, 5/29, 5/30, 5/31/25, had one hour of sleep during the day shift. - On 5/7, 5/9, 5/12, 5/13, 5/20, 5/21, 5/22, 5/23, 5/27, 5/28, and 5/29/25, had two hours of sleep during the evening shift. - On 5/8, 5/9, and 5/16/25, zero hour of sleep during the day shift. - On 5/10, 5/12, 5/14, 5/17, 5/18, 5/19, 5/21, 5/24, and 5/28/25, had two hours of sleep during the day shift. - On 5/14/25, had five hours of sleep during the night shift. - On 5/18, 5/19 and 5/25/25, zero hour of sleep during the evening shift. - On 5/20/25, no documentation on the hour(s) of sleep, during the day shift. Review of the the chart codes and follow-up codes in the MAR for May 2025 showed the following: - OBA for Group Observed-All, - OBI for Observed Individual, - OBP for Group Observed -Partial, - 1, for Drug refused, - 2 for hold/see progress notes / Treatment refused, - 3 for vital signs outside parameters of administration and for hospitalized - checkmark for administered, - I for ineffective, - E for effective, - U for unknown, and - H for on hold by physician.	F 605		

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F 605	Continued From page 21 Review of Resident 1's MAR for May 2025 showed the "X" marks from 5/6 to 5/31/25, for NPI (nonpharmacological interventions) for temazepam 30 mg capsule by mouth at bedtime for insomnia as manifested by inability to sleep. The MAR chart codes and prompt legends showed no "X" for documentation. Further review of the MAR showed no documentation of the nonpharmacological interventions were provided prior to the administration of the temazepam medication. Review of Resident 1's Licensed Progress Notes for 5/2025 failed to show documentation nonpharmacological interventions were implemented prior to the administration of Resident 1's temazepam medication. On 6/18/25 at 0940 hours, an interview and a concurrent medical record review for Resident 1 was conducted with RN 1. RN 1 was asked what was the "X" mark on the NPI (nonpharmacological intervention box documented by the licensed nurses in the MAR on the physician order for Resident 1's temazepam. RN 1 was also asked to show any documentation of the nonpharmacological interventions implemented prior to the administration of temazepam medication to Resident 1. RN 1 verified she did not know what the "X" mean as it was not in the MAR chart code, and she was not able to show any documentation of the nonpharmacological interventions were implemented for the administration of the temazepam medication.	F 605		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j)	F 641		

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F 641	Continued From page 22 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and facility P&P review, the facility failed to ensure the MDS was coded accurately for one of 19 final sampled residents (Resident 399). This failure had the potential for the resident to not receive individualized plans of care to address the resident's individual care needs.	F 641	F641 – Accuracy of Assessments *How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:* On 6/18/2025, The MDS Coordinator modified the Admission/5day MDS assessment with ARD of 6/6/2025 to reflect the dialysis status for Resident 399. *How the Facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:* All residents that are on Dialysis could be affected by the deficient practice. On 6/18/2025, the MDS Coordinator conducted an audit of the MDS assessments of all residents that have dialysis to ensure that the MDS assessments are coded accurately to reflect resident's dialysis status. Out of 2 residents, 1 was modified and transmitted to reflect accurate coding in resident's dialysis status and the other 1 MDS assessment was coded accurately.	

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F 641	Continued From page 23 Findings: Review of the facility's P&P titled Conducting an Accurate Resident Assessment dated 9/2/22, showed all the residents received an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas. Medical record review for Resident 399 was initiated on 6/18/25. Resident 399 was admitted to the facility on 6/4/25. Review of Resident 399's Admission MDS assessment dated 6/6/25, showed under Section O, Special Treatments, Procedures, and Programs showed Resident 399 was not coded for hemodialysis. Review of Resident 399's Order Summary Report dated 6/17/25, showed a physician's order dated 6/5/25, for Resident 399's hemodialysis schedule on Mondays, Wednesdays, and Fridays at a contracted dialysis facility. On 6/18/25 at 1241 hours, an interview and concurrent medical record review for Resident 399 was conducted with the MDS Coordinator. The MDS Coordinator verified the above findings and stated she coded the MDS assessment incorrectly. On 6/19/25 at 1612 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.	F 641	*What measures will be put in place or what systematic changes will you make to ensure that the deficient practice does not recur:* On 6/18/2025, the MDS Consultant provided an In-service to the MDS Coordinator and MDS staff regarding dialysis and MDS coding per RAI Manual. MDS coding accuracy per RAI Manual was emphasized during the In-service. *How the Facility plans to monitor its performance to make sure the solutions are sustained and to ensure deficient practice will not recur:* The MDS Coordinator will conduct quarterly and annual audits of residents who have dialysis to ensure that MDS assessments accurately reflect the resident's dialysis status. Any findings will be corrected and reported to the Director of Nursing (DON) and will be presented at the Monthly facility Quality Assurance meeting for further discussion and action plans as appropriate.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656	Date of compliance: 7/2/2025	

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F 656	Continued From page 24 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656	F656 Develop/Implement Comprehensive Care Plan Corrective action for residents found to have been affected by this deficiency: -Residents 40, 27, and 96 nutrition care plans were updated by the Dietary Supervisor (DS) and Assistant Director of Nursing (ADON) on 6/18/25. Specifically, Resident 40's care plan addresses the shrimp food allergy, and for Residents 27 and 96, their dietary preference for Korean food. Corrective action for residents that may be affected by this deficiency: - The DS and ADON audited the nutrition care plans on 6/18/25 and completed on 7/9/25, to ensure all care plans capture food allergies and preferences for Korean food. -The Director of Nursing (DON) and ADON in-serviced nursing, the RD and DS utilizing P&P "Comprehensive Care Plans" initiated on 6/23/25 and completed on 7/9/25, emphasizing the importance of ensuring all nutrition care plans address food allergies and cultural food preferences. Measures that will be put into place to ensure that this deficiency does not recur: -The RD, DS, ADON, or trained designee will conduct nutrition care plan audits weekly X 3 months to ensure care plans address food allergies and food preferences.	

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F 656	Continued From page 25 requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and medical record review, the facility failed to ensure the comprehensive care plan was developed for one of 19 final sampled residents (Resident 40) and two nonsampled residents (Residents 27 and 96). * The facility failed to develop a care plan specific to Residents 27 and 96's preference for Korean food and the residents were subsequently served American food. * The facility failed to develop a care plan problem to address Resident 40's food allergies to shrimp. These failures placed the residents at risk for not being provided appropriate, consistent, and individualized care. Findings: 1. Medical record review for Resident 27 was initiated on 6/16/25. Resident 27 was admitted to the facility on 5/8/19, and readmitted on 4/20/22. Review of Resident 27's Nutrition Progress Note dated 6/2/25 at 1716 hours, showed Resident 27 preferred Korean food for lunch and dinner. On 6/17/25 at 1320 hours, an observation was conducted of Resident 27. Resident 27 was	F 656	Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: - The DS, RD, or ADON will report their findings regarding Comprehensive Care Plans to the QA committee for discussion and further recommendations. The QA will continue monitoring for at least 3 months or until substantial compliance is achieved. Date of compliance: 7/9/25	

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F 656	Continued From page 26 observed lying in bed asleep. Resident 27's lunch tray was observed on a bedside table adjacent to Resident 27's bed. Resident 27's lunch tray was observed with pureed food items from the American menu (pureed Dijon pork cutlet, pureed orzo with vegetables, and pureed seasoned beets). 2. Medical record review for Resident 96 was initiated on 6/16/25. Resident 96 was admitted to the facility on 5/31/25. Review of Resident 96's Nutrition Progress Note dated 6/2/25 at 1454 hours, showed Resident 96 preferred Korean food at lunch and dinner. On 6/17/25 at 1246 hours, an observation was conducted of Resident 96. Resident 96 was observed in the dining room eating lunch. Resident 96's lunch tray was observed with pureed food items from the American menu (pureed Dijon pork cutlet, pureed orzo with vegetables, and pureed seasoned beets). Resident 96's lunch ticket showed Resident 96 preferred Korean Food. On 6/17/25 at 1555 hours, an interview and concurrent medical record review was conducted with the DSS. The DSS verified Residents 27 and 96 received American pureed food for lunch today (6/17/25) rather than Korean pureed food for lunch in accordance with the residents' food preferences. The DSS then reviewed Residents 27 and 96's care plans and verified the facility failed to develop a care plan specific to Residents 27 and 96's preference for Korean food. Cross reference to F806, examples #2 and #3. 3. Medical record review for Resident 40 was	F 656		

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F 656	Continued From page 27 initiated on 6/17/25. Resident 40 was admitted to the facility on 4/7/25. Review of Resident 40's Admission Record dated 4/7/25, showed Resident 40 had a food allergy to shrimp. Review of Resident 40's plan of care failed to show documented evidence a care plan problem was developed to address Resident 40's food allergy to shrimp. On 6/18/25 at 1347 hours, an interview and concurrent medical record review for Resident 40 was conducted with LVN 4. LVN 4 verified Resident 40 had a food allergy to shrimp. LVN 4 verified and acknowledged there was no plan of care formulated to address Resident 40's allergy to shrimp. On 6/19/25 at 1612 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.	F 656		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 690		

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F 690	Continued From page 28 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and medical record review, the facility failed to provide the appropriate care and services to prevent UTI for one of one final sampled resident (Resident 68) reviewed for urinary catheter or UTI. * Resident 68 had an indwelling urinary catheter (an indwelling catheter used to drain urine from the bladder) and a history of recurrent UTIs. The facility failed to ensure proper positioning of Resident 68's urinary drainage bag to prevent urine from flowing back into the bladder. This failure posed the risk for Resident 68 to develop a CAUTI.	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI • How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The resident's indwelling catheter bag was checked on 6/19/25 by the ADON for proper positioning and the bag was not touching the floor at the time. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. An audit of residents with indwelling urinary catheter was completed on 6/23/25 by the infection prevention and control nurse. 1 other resident identified with indwelling urinary catheter. Positioning for the collection bags were checked. The collection bags were not touching the floor. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. In-service was initiated on 6/23/25 provided by DSD to the staff regarding catheter care. In-service will be completed by 7/11/25 regarding proper positioning and catheter care. I.P. to observed residents with indwelling catheter 3x/week x 3 months if the collection bags are touching the floor and for proper positioning. Findings will be addressed immediately. • How the facility plans to monitor its performance to make sure that solutions are sustained. The POC is integrated into the QA system. The DON/designee will provide a summary trend analysis of the findings to the facility's monthly QAPI Committee x 3 months or until such time consistent substantial compliance has been achieved as determined by the committee. Date of compliance: 7/11/25	

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F 690	Continued From page 29 Findings: Review of the CDC's Guideline for Prevention of Catheter-Associated Urinary Tract Infections dated 6/2009 under the section titled Proper Techniques for Urinary Catheter Maintenance, showed to keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor. Medical record review for Resident 68 was initiated on 6/16/25. Resident 68 was readmitted to the facility on 1/7/25. Review of Resident 68's SBAR Communication Form dated 6/9/25, showed Resident 68 had a change in condition related to being sleepier than usual. The physician was notified and recommended for the IV fluids, blood tests, and urinalysis test. Review of Resident 68's Nurses Progress Note dated 6/11/25, showed Resident 68 was seen by her physician and the physician had ordered IV antibiotics for seven days for UTI. Review of Resident 68's Order Summary Report dated 6/19/25, showed a physician's order dated 5/7/25, for an indwelling urinary catheter for neurogenic bladder. On 6/17/25 at 1637 hours and 6/18/25 at 1615 hours, Resident 68 was observed lying in bed with a urinary catheter tubing attached to a urinary drainage bag. The urinary drainage bag was observed lying on the floor. On 6/18/25 at 1622 hours, a concurrent observation and interview was conducted with	F 690		

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F 690	Continued From page 30 LVN 3. LVN 3 verified the findings. LVN 3 verified the urinary drainage bag should not be touching the floor and proceeded to elevate Resident 68's bed. LVN 3 stated the floor was dirty and the bag should not be touching the floor for infection prevention. On 6/19/25 at 0915 hours, an interview was conducted with RN 1. RN 1 stated Resident 68 had frequent UTIs. RN 1 acknowledged the findings. RN 1 stated the urinary drainage bag should be above the floor to prevent infections.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the physician's order for the oxygen therapy was followed for one of one final sampled resident reviewed for oxygen therapy (Resident 70). This failure had the potential to affect the respiratory health and well-being of Resident 70. Findings: Review of the facility's P&P titled Oxygen Administration revised 5/20/24, showed the	F 695		

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F 695	Continued From page 31 oxygen was administered under orders of a physician, except in case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control. Medical record review for Resident 70 was initiated on 6/17/25. Resident 70 was admitted to the facility on 5/27/25. Review of Resident 70's H&P examination dated 5/27/25, showed Resident 70 had the capacity to understand and make decisions. Review of Resident 70's Order Summary Report showed the following orders dated 6/3/25: - to administer oxygen via nasal cannula at 2 liters per minute, may titrate up to four liters per minute, if oxygen saturation level less than 92% every shift for acute and chronic respiratory failure with hypoxia; and, - to monitor oxygen saturation level in room air every shift. Review of Resident 70's MAR dated 6/1 to 6/18/25, showed an order dated 6/3/25, to monitor the oxygen saturation in room air every shift. The MAR also showed Resident 70 had an oxygen saturation level in room air ranging from 84% to 97%. On 6/18/25 at 0945 hours, Resident 91 was observed in his room sitting in the wheelchair at the left side of his bed. Resident 91 stated his roommate (Resident 70) was supposed to be receiving oxygen; however, Resident 70 removed his oxygen most of the time and he was wondering if that was ok for Resident 70 to remove his oxygen.	F 695	F 695 Respiratory/Tracheostomy Care and Suctioning • How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. A change of condition assessment was initiated on 6/18/25 regarding resident's non-compliance with oxygen therapy by the charge nurse. A careplan for residents non-compliance with oxygen therapy was put in place on 6/18/25 by the charge nurse. The resident was asked to keep the nasal canula however he insisted on taking it off when he feels "fine." The order for the continuous oxygen was changed to as needed on 6/18/25 per resident preference. His oxygen saturation level was checked on 6/18/25 at 1710 and it was 93% on supplemental oxygen via nasal canula. His oxygen saturation level will continue to be checked every shift. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. An audit of the residents on oxygen therapy was done on 6/30/25 by the IP nurse. 3 other resident identified with orders for continuous oxygen therapy. The residents were checked for compliance to oxygen therapy and there was no other issue identified. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. IP nurse/designee will monitor residents on continuous oxygen therapy for compliance 3x/week x 3 months. Findings will be addressed immediately and reported to DON for follow up. In-service to licensed nurses on on respiratory care and oxygen management was initated on 6/23/25 by DON/designee and will be completed by 7/11/25.	

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F 695	Continued From page 32 On 6/18/25 at 0952 hours, during an observation and concurrent interview with Resident 70. Resident 70 was observed sitting in the wheelchair on the patio of the facility. Resident 70 was observed with portable oxygen tank at the back of his wheelchair. The oxygen tubing was observed connected to the portable oxygen tank and the portable oxygen tank was observed to be turned off. The nasal cannula was observed on the patio table and was not in Resident 70's nose. Resident 70 stated he did not need oxygen so he turned his oxygen off. Resident 70 stated he turned his oxygen off almost every day, for the most part of the day; and he was fine. On 6/18/25 at 1001 hours, an observation for Resident 70 and concurrent interview was conducted with RN 1. RN 1 verified the above observation. RN 1 was observed checking the oxygen saturation level for Resident 70 which showed 92%. RN 1 stated the facility was in the process of removing the oxygen administration for Resident 70, and Resident 70 was ok without the continuous oxygen administration if Resident 70 did not want the oxygen on. RN 1 was not observed educating Resident 70 about the risks and benefits of the oxygen administration. RN 1 was observed further assisting Resident 70 to administer the continuous oxygen at 2 liters per minute. On 6/18/25 at 1005 hours, an interview and concurrent medical record review for Resident 70 was conducted with RN 1. RN 1 verified the physician's order for the oxygen and stated Resident 70 had an order for continuous oxygen administration. RN 1 also verified Resident 70's oxygen saturation level in room air was ranging	F 695	• How the facility plans to monitor its performance to make sure that solutions are sustained. The POC is integrated into the QA system. The IP/designee will provide a summary trend analysis of the findings to the facility's monthly QAPI Committee x 3 months or until such time consistent substantial compliance has been achieved as determined by the committee. Date of compliance: 7/11/25	

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F 695	Continued From page 33 from 84% to 97%. RN 1 further stated Resident 70 should have received continuous oxygen administration. On 6/18/25 at 1304 hours, an interview and concurrent medical record review for Resident 70 was conducted with the DON. The DON was informed and acknowledged the above findings.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and facility's P&P review, the facility failed to provide the adequate and appropriate pain management for one of one final sampled resident reviewed for pain management (Resident 49). * The facility failed to ensure an accurate pain level was assessed and documented prior to the administration of the pain medication for Resident 49. * The facility failed to ensure non-pharmacological interventions were provided prior to the administration of the pain medication for Resident 49. These failures had the potential for Resident 49 to not receive the appropriate pain management.	F 697		

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F 697	Continued From page 34 Findings: Review of the facility's P&P titled Pain Management dated 3/17/25, showed the facility will use pain assessment tool, which is appropriate for Resident's cognitive status, to assist staff in consistent assessment of a resident's pain. Under the section pain management and treatment showed non-pharmacological intervention will include but are not limited to: - Environmental comfort measures (e.g., adjusting room temperature, smoothing linens, comfortable seating, assistive devices or pressure redistributing mattress and positioning) - Loosening any constrictive bandage, clothing or device. - Applying splinting for example (e.g., pillow or folded blanket). - Physical modalities (e.g., cold compress, warm shower bath, message, turning and repositioning). - Exercises to address stiffness and prevent contractors as well as restorative nursing program to maintain joint mobility. - Cognitive/behavioral interventions (e.g., music, relaxation, technique, activities, diversion, spiritual and comfort support, teaching the resident coping techniques and education about pain) a. Medical record review for Resident 49 was initiated on 6/17/25. Resident 49 was admitted to the facility on 7/31/23. Review of Resident 49's MDS assessment dated 4/9/25, showed Resident 49 had moderate cognitive impairment.	F 697	F 697 Pain management • How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Pain assessment on resident 49 was done on 6/23/25 by ADON. The resident had a pain level of 7/10 on 6/22/25 at 1535 and she was given Tramadol which was effective. Follow up pain level was 0/10. Documentation of non-pharmacological intervention was initiated on 6/17/25 by the charge nurse. 1:1 training with LVN who made the error was done on 6/23/25 by ADON on pain management and providing non-pharmacological interventions prior to administration of medication. Inservice with licensed nurses on pain management and providing non-pharmacological interventions prior to administration of medication initiated on 6/23/25 by DON/Designee and will be completed by 7/10/25. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. An audit of all residents with tramadol was done by the DON/designee on 7/3/25. We found 2 other residents on tramadol. No errors were found with the pain assessment and non-pharmacological interventions were attempted prior to administration of medication. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Medical records director/designee will conduct an audit of residents on tramadol to check if non-pharmacological interventions were provided prior to administration of medications. Medical records director/designee will also validate if the initial pain level is being documented. These audits will be done 3x/week x 3 months. Any significant findings will be reported to DON/designee for follow up.	

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F 697	Continued From page 35 Review of Resident 49's Order Summary Report showed a physician's order dated 6/16/25, for tramadol HCL (pain medication) oral tablet 50 mg one tablet by mouth every six hours as needed for moderate to severe pain. Review of Resident 49's MAR dated 6/1 to 6/30/25, showed an order dated 6/16/25, for tramadol 50 mg one tablet by mouth as needed for moderate to severe pain. The MAR showed Resident 49 received the above medication on 6/17/25 at 0846 hours, and the pain level was "0" (on a pain scale of 0 to 10, with 0 which meant no pain, and 10 which meant the worst possible pain). Further review of Resident 49's medical record failed to show if the pain level was assessed and accurately documented prior to the administration of the above pain medication. b. Review of Resident 49's Physician's Order dated 2/26/25, showed an order for tramadol 50 mg one tablet by mouth every six hours as needed for moderate to severe pain. Review of Resident 49's MAR dated 6/1 to 6/30/25, showed an order dated 2/26/25, for tramadol 50 mg one tablet by mouth as needed for moderate to severe pain. The above physician's order for tramadol was discontinued on 6/16/25. Further review of Resident 49's MAR showed the medication was administered on the following dates and times with documented pain level: - on 6/1/25 at 0831 hours, for a pain level of 5; and at 1641 hours, for a pain level of 6; - on 6/5/25 at 0824 hours, for a pain level of 7; - on 6/5/25 at 0442 and 1200 hours, for a pain	F 697	• How the facility plans to monitor its performance to make sure that solutions are sustained. The POC is integrated into the QA system. The IP/designee will provide a summary trend analysis of the findings to the facility's monthly QAPI Committee x 3 months or until such time consistent substantial compliance has been achieved as determined by the committee. Date of compliance: 7/10/25	

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F 697	Continued From page 36 level of 7; - on 6/9/25 at 0400 hours, for a pain level of 8; - on 6/10/25 at 0857 hours, for a pain level of 7; - on 6/14/25 at 0913 hours, for a pain level of 7; and, - on 6/15/25 at 1015 hours. for a pain level of 7. Further review of Resident 49's MAR failed to show if non-pharmacological interventions were provided to the resident prior to the administration of the pain medication for the above dates and times. On 6/18/25 at 1009 hours, an interview and concurrent medical record review for Resident 49 was conducted with RN 1. RN 1 stated moderate to severe pain meant for pain level of 4-10, on a pain scale of 0 to 10, with 0 meant no pain and 10 meant the worst possible pain. RN 1 verified the above findings and stated the staff should have assessed and documented the accurate pain level prior to the administration of pain medication to Resident 49 on 6/17/25 at 0846 hours. In addition, RN 1 stated the staff should have provided non-pharmacological interventions prior to the administration of the pain medication to Resident 49 for the above dates and times. On 6/18/25 at 1304 hours, an interview and concurrent medical record review for Resident 49 was conducted with the DON. The DON verified and acknowledged the above findings.	F 697		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 755		

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F 755	Continued From page 37 them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and facility P&P review, the facility failed to provide the pharmaceutical services to meet the resident's needs as evidenced by: * The facility failed to ensure the injection sites for the subcutaneous medication administration for four of 19 final sampled residents (Resident 49, 52, 59, and 82) and one nonsampled resident	F 755	F 755 Pharmacy services – Insulin injection sites not rotated. 5 residents affected. IV and oral e-kit were not replaced within 72 hours. • How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The five identified residents were checked by DSD and ADON. Skin assessments done on 6/20/25. No lipodystrophy (lypohypertrophy) noted on all 5 sample residents. Skilled nursing pharmacy was called and asked to replace the IV and oral emergency kits on 6/16/25. IV e-kit and oral e-kit were delivered on 6/16/26. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. An audit of residents with insulin injections was done by DSD on 7/3/25. Identified 4 residents with insulin injection sites not rotated. 1:1 training with the nurses who made the errors will be completed by 7/4/25 by DON/designee on proper administration of insulin. All new e-kits were delivered by Skilled Nursing Pharmacy on 6/16/25 and replaced by the ADON. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Med records will check documentation of insulin injection sites during weekdays x 3 months. Findings will be reported to DON for follow up. Inservice for replacement of e-kit in for all licensed nurses on 7/2/25. Inservice for rotating insulin injection sites initiated on 6/20/25 by DON/designee and will be completed by 7/11/25. ADON/designee will check iv and oral e-kits daily Monday to Friday weekly x 3 months.	

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F 755	Continued From page 38 (Resident 50) were rotated consistently. This failure had the potential to negatively affect the residents' health condition and well-being. * The facility failed to ensure the emergency kit for intravenous medications and oral medications were refilled replaced within 72 hours as per the facility's P&P. This failure had the potential for negative health outcomes for residents who needed medications from the emergency kits. Findings: 1. According to the FDA Highlights of Prescribing Information for Lantus (long-acting insulin) revised 5/2019, under Dosage and Administration, showed to rotate injection sites to reduce the risk of lipodystrophy (the loss of local fat deposits as a complication of repeated insulin injections into the same subcutaneous tissue). Medical record review for Resident 52 was initiated on 6/16/25. Resident 52 was admitted to the facility on 10/22/24. Review of Resident 52's H&P examination dated 10/23/24, showed Resident 52 had no capacity to understand and make medical decisions. Review of Resident 52's Order Summary Report dated 6/19/25, showed a physician's order dated 1/1/25, to administer Lantus SoloStar subcutaneous solution pen-injector 100 unit/ml (insulin glargine) 15 units subcutaneously in the evening for diabetes mellitus. Review of Resident 52's Medication Administration Records for May and June 2025 showed Resident 52 was administered the Lantus	F 755	• How the facility plans to monitor its performance to make sure that solutions are sustained. The POC is integrated into the QA system. The IP/designee will provide a summary trend analysis of the findings to the facility's monthly QAPI Committee x 3 months or until such time consistent substantial compliance has been achieved as determined by the committee. Date of compliance: 7/11/25	

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F 755	Continued From page 39 insulin daily from 5/1/25 through 6/18/25, and the injection sites used to administer the insulin injections were not consistently rotated. For example, Resident 52 received the Lantus insulin at the same site on the left arm on the following dates: - from 5/1 through 6/13/25 at 2000 hours - on 6/15 and 6/16/25 at 2000 hours 2. Medical record review for Resident 49 was initiated on 6/16/25. Resident 49 was readmitted to the facility on 12/27/24. Review of Resident 49's H&P examination dated 2/26/25, showed Resident 49 did not have the capacity to understand and make medical decisions. Review of Resident 49's Order Summary Report dated 6/19/25, showed a physician's order dated 3/5/25, to administer Lantus subcutaneous solution 100 unit/ml (insulin glargine) 15 units subcutaneously at bedtime for diabetes mellitus. Review of Resident 49's Medication Administration Records for May and June 2025 showed Resident 49 was administered the Lantus insulin daily from 5/1/25 through 6/18/25, and the injection sites used to administer the insulin injections were not consistently rotated. For example, Resident 49 received the Lantus insulin at the same site as follows: - on 5/1 and 5/2/25 at 2100 hours, the insulin was injected into the right arm; - from 5/3 to 5/7/25 at 2100 hours, the insulin was injected into the left arm; - from 5/12 to 5/14/25 at 2100 hours, the insulin was injected into the right arm; - on 5/18 and 5/19/25 at 2100 hours, the insulin	F 755		

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F 755	Continued From page 40 was injected into the right arm; - on 5/20 and 5/21/25 at 2100 hours, the insulin was injected into the left arm; - on 5/24 and 5/25/25 at 2100 hours, the insulin was injected into the right arm; - on 5/30 and 5/31/25 at 2100 hours, the insulin was injected into the left arm; - on 6/1 and 6/2/25 at 2100 hours, the insulin was injected into the left arm; - on 6/4 and 6/5/25 at 2100 hours, the insulin was injected into the left arm; and - from 6/13 to 6/16/25 at 2100 hours, the insulin was injected into the left arm. On 6/19/25 at 0902 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified the insulin injection sites were not rotated for Residents 49 and 52. RN 1 stated they rotated the administration sites for the insulin based on the previous shift and would choose a different site. RN 1 stated they rotated the sites to prevent lipohypertophy (a skin condition where fat or scar tissue forms under the skin due to repeated injections in the same area. This condition can affect the absorption of insulin). 3. Medical record review for Resident 59 was initiated on 6/17/25. Resident 59 was admitted to the facility on 3/7/25. Review of Resident 59's Order Summary Report dated 6/18/25, showed a physician's order dated 5/30/25, to administer insulin lispro injection as per sliding scale if the blood sugar level result was 151 to 200 mg/dl, 2 units of insulin subcutaneously before meals and at bedtime. If blood sugar below 70 mg/dl, to follow hypoglycemic protocol. Another physician's order dated 6/28/25, showed to administer lantus (long	F 755		

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F 755	Continued From page 41 acting) insulin 5 units subcutaneously at bedtime for DM. Review of Resident 59's Location of Administration Report for May and June 2025 for Resident 59's insulin medication injection showed the injection sites were not rotated on the following dates and times: - on 5/28/25 at 2046 hours, the lantus insulin medication was administered subcutaneously to the right lower quadrant of the abdomen. - on 5/29/25 at 2100 hours, the lantus insulin medication was administered subcutaneously to the right lower quadrant of the abdomen. - on 5/30/25 at 0648 hours, the insulin lispro medication was administered subcutaneously to the right lower quadrant of the abdomen. - on 5/30/25 at 1645 hours, the insulin lispro medication was administered subcutaneously to the right lower quadrant of the abdomen. - on 5/30/25 at 2100 hours, the insulin lispro medication was administered subcutaneously to the right lower quadrant of the abdomen. - on 6/2/25 at 2039 hours, the lantus insulin medication was administered subcutaneously to the right lower quadrant of the abdomen. - on 6/3/25 at 2053 hours, the lantus insulin medication was administered subcutaneously to the right lower quadrant of the abdomen. - on 6/4/25 at 2143 hours, the lantus insulin medication was administered subcutaneously to the left lower quadrant of the abdomen. - on 6/5/25 at 2026 hours, the lantus insulin medication was administered subcutaneously to the left lower quadrant of the abdomen. - on 6/16/25 at 2025 hours, the lantus insulin medication was administered subcutaneously to the left upper quadrant of the abdomen. - on 6/17/25 at 2111 hours, the lantus insulin	F 755		

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F 755	Continued From page 42 medication was administered subcutaneously to the left upper quadrant of the abdomen. - on 6/4/25 at 1628 hours, the insulin lispro medication was administered subcutaneously to the right lower quadrant of the abdomen. - on 6/4/25 at 2143 hours, the insulin lispro medication was administered subcutaneously to the right lower quadrant of the abdomen. - on 6/8/25 at 1623 hours, the insulin lispro medication was administered subcutaneously to the right lower quadrant of the abdomen. - on 6/8/25 at 2034 hours, the insulin lispro medication was administered subcutaneously to the right lower quadrant of the abdomen. - on 6/11/25 at 1228 hours, the insulin lispro medication was administered subcutaneously to the right lower quadrant of the abdomen. - on 6/11/25 at 1713 hours, the insulin lispro medication was administered subcutaneously to the right lower quadrant of the abdomen. - on 6/11/25 at 2130 hours, the insulin lispro medication was administered subcutaneously to the right lower quadrant of the abdomen. 4. Medical record review for Resident 82 was initiated on 6/18/25. Resident 82 was admitted to the facility on 1/30/25. Review of Resident 82's Order Summary Report dated 6/18/25, showed a physician's order dated 2/9/25, to administer insulin glargine (long acting) subcutaneously 15 units every 12 hours for DM. Review of Resident 82's Location of Administration Report for May and June 2025 for Resident 82's insulin medication injection showed the injection sites were not rotated on the following dates and times: - on 5/2/25 at 0930 hours, the glargine insulin	F 755		

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F 755	Continued From page 43 medication was administered subcutaneously to the right lower quadrant of the abdomen. - on 5/2/25 at 2059 hours, the glargine insulin medication was administered subcutaneously to the right lower quadrant of the abdomen. - on 5/3/25 at 1002 hours, the glargine insulin medication was administered subcutaneously to the right lower quadrant of the abdomen. - on 5/8/25 at 0822 hours, the glargine insulin medication was administered subcutaneously to the left lower quadrant of the abdomen. - on 5/8/25 at 2052 hours, the glargine insulin medication was administered subcutaneously to the left lower quadrant of the abdomen. - on 5/9/25 at 0828 hours, the glargine insulin medication was administered subcutaneously to the right lower quadrant of the abdomen. - on 5/9/25 at 2048 hours, the glargine insulin medication was administered subcutaneously to the right lower quadrant of the abdomen. - on 5/16/25 at 2027 hours, the glargine insulin medication was administered subcutaneously to the left upper quadrant of the abdomen. - on 5/17/25 at 1017 hours, the glargine insulin medication was administered subcutaneously to the left upper quadrant of the abdomen. - on 5/23/25 at 1339 hours, the glargine insulin medication was administered subcutaneously to the right lower quadrant of the abdomen. - on 5/23/25 at 2058 hours, the glargine insulin medication was administered subcutaneously to the right lower quadrant of the abdomen. - on 5/24/25 at 2101 hours, the glargine insulin medication was administered subcutaneously to the left upper quadrant of the abdomen. - on 5/25/25 at 0933 hours, the glargine insulin medication was administered subcutaneously to the left upper quadrant of the abdomen. - on 6/4/25 at 0820 hours, the glargine insulin	F 755		

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F 755	Continued From page 44	F 755		

medication was administered subcutaneously to the left lower quadrant of the abdomen.
- on 6/4/25 at 2047 hours, the glargine insulin medication was administered subcutaneously to the left lower quadrant of the abdomen.
- on 6/5/25 at 0904 hours, the glargine insulin medication was administered subcutaneously to the left lower quadrant of the abdomen.
- on 6/5/25 at 2019 hours, the glargine insulin medication was administered subcutaneously to the left lower quadrant of the abdomen.
- on 6/17/25 at 0813 hours, the glargine insulin medication was administered subcutaneously to the left lower quadrant of the abdomen.
- on 6/17/25 at 2215 hours, the glargine insulin medication was administered subcutaneously to the left lower quadrant of the abdomen.

On 6/18/25 at 1333 hours, an interview and concurrent medical record review for Residents 59 and 82 was conducted with LVN 4. LVN 4 verified Residents 59 and 82 were receiving insulin injections. LVN 4 was asked about things to remember when administering the medications subcutaneously. LVN 4 stated the licensed nurses needed to rotate the injection sites to prevent any complications such as non-absorption of the insulin when administered on the same site. LVN 4 was asked to review the location of administration for insulin injections for Residents 59 and 82 in the MARs for May and June 2025. LVN 4 verified the insulin injections sites were not rotated. LVN 4 acknowledged and stated the injection sites for the insulin administration should have been rotated to prevent any complication.

On 6/19/25 at 1612 hours, an interview was conducted with the DON. The DON was

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F 755	Continued From page 45 informed and acknowledged the above findings. 5. Medical record review for Resident 50 was initiated on 6/16/25. Resident 50 was admitted to the facility on 10/17/21, and readmitted on 5/3/24. Review of Resident 50's Order Summary Report showed a physician's order dated 1/3/24, for insulin glargine 23 units to be administered by subcutaneous injection at bedtime for diabetes. Review of Resident 50's Location of Administration Report for the months of May and June 2025, showed Resident 50's insulin injections sites were not rotated on the following dates and times: - On 5/7/25 at 2100 hours, the insulin glargine was administered subcutaneously to the left lower quadrant of Resident 50's abdomen. - On 5/8/25 at 2100 hours, the insulin glargine was administered subcutaneously to the left lower quadrant of Resident 50's abdomen. - On 5/9/25 at 2100 hours, the insulin glargine was administered subcutaneously to the left lower quadrant of Resident 50's abdomen. - On 5/13/25 at 2100 hours, the insulin glargine was administered subcutaneously to the left lower quadrant of Resident 50's abdomen. - On 5/14/25 at 2100 hours, the insulin glargine was administered subcutaneously to the left lower quadrant of Resident 50's abdomen. - On 5/29/25 at 2100 hours, the insulin glargine was administered subcutaneously to the left lower quadrant of Resident 50's abdomen. - On 5/30/25 at 2100 hours, the insulin glargine was administered subcutaneously to the left lower quadrant of Resident 50's abdomen. - On 6/5/25 at 2100 hours, the insulin glargine was administered subcutaneously to the left lower quadrant of Resident 50's abdomen.	F 755		

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F 755	Continued From page 46 - On 6/6/25 at 2100 hours, the insulin glargine was administered subcutaneously to the left lower quadrant of Resident 50's abdomen. - On 6/7/25 at 2100 hours, the insulin glargine was administered subcutaneously to the left lower quadrant of Resident 50's abdomen. - On 6/8/25 at 2100 hours, the insulin glargine was administered subcutaneously to the left lower quadrant of Resident 50's abdomen. On 6/19/25 at 0910 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified Resident 50's insulin injection sites were not rotated on the above listed dates and times. RN 1 stated the injection sites should have been rotated to prevent lipohypertrophy and skin discomfort. 5. Review of the facility's P&P titled Medication Ordering and receiving from Pharmacy revised on 8/2014 showed in part, the following: L. Before reporting duty, the charge nurse indicates the "opened" status of emergency kit at the shift change report. M. If exchanging kits, when the replacement kit arrives, the receiving nurse gives the used kit to the courier for return to the pharmacy. N. If exchanging kits, the used sealed kits are replaced with the new sealed kits within 72 hours of opening. O. The kits are checked by a pharmacist monthly. P. The Quality Assessment and Assurance Committee and provider pharmacy is responsible for establishing the list of medications to be maintained in the emergency supply, in compliance with any directives from state law regarding the emergency supply. On 6/16/25 at 0944 hours, an inspection of Medication Storage Room A and concurrent	F 755		

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F 755	Continued From page 47 interview was conducted with RN 1. RN 1 was asked for the documentation when the emergency kits for the IV and oral medications were last opened. RN 1 showed the emergency pharmacy logs that included all the items, date and time when the items were used from the emergency kit, and the initial dose(s) of the ordered medications were used from the emergency kits (oral and IV). Review of the log showed the following: - dated 6/9/25 at 0900 hours, one bag of one liter 0.9% normal saline (type of IV fluid) was taken. - dated 6/13/25 at 0900 hours, one tablet of an oral medication Bactrim Double Strength (antibiotic) 800/160 mg was taken. RN 1 was asked when the emergency kits for the IV and oral medications be replaced. RN 1 verified the emergency kits for the IV and oral medications should have been replaced within 72 hours after it was opened.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		

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F 761	Continued From page 48 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure for proper storage, labeling, and disposal of the medications. * The facility failed to ensure the medication cabinets were maintained in a clean and sanitary condition. * The facility failed to ensure the multidose medications were labeled with the expiration date once the medication were taken out from the original box. * The facility failed to ensure multiple packets of Dermaseptin ointment (skin protectant cream) and Dermarite Boarder Gauzes in Treatement Cart A were labeled with an expiration date. These failures had the potential to negatively impact the residents' well-being, and the potential for the medications to lose the stability and effectiveness. Findings:	F 761	F761 Label/Store Drugs and biologicals Corrective Action Initiated For Resident/s On 6/16/25 Medication Room A cabinets were immediately cleaned, disinfected, and the hanger was removed by ADON). On 6/16/25 the bottle of Geri-Tussin with an illegible expiration date was removed and discarded on 6/16/25 from Medication Room B by ADON. On 6/16/25 all Dermaseptin ointment packets and Dermarite bordered gauze without visible expiration dates were removed. New supplies with expiration dates verified from the original box and placed in a clear container with clear expiration dates labeled by the treatment nurse on 6/16/25. How Potential Other Residents Were Identified and Corrective Action Taken Other residents are at risk for this noted practice On 6/17/25 a spot check of medication and treatment rooms, carts, and storage areas was initiated. No additional issues were found during this audit. Systemic Measures to Prevent Recurrence The DON/designee conducted an in-service training on 7/3/25 to all licensed nursing staff on P&P on Medication Storage, labeling and emphasizing with a focus on proper labeling and visibility of expiration dates for all medications and supplies and the importance of a cleaned and sanitary medication. The ADON/designee will conduct weekly audits for four weeks, then monthly for three months to validate that medication storage areas remain clean and free of unnecessary items and to ensure that all medications and treatment supplies are clearly labeled with expiration dates. Any findings will be reported to DON for ff up.	

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F 761	Continued From page 49 Review of the facility's P&P titled Medication Storage in the facility revised on 1/2025 showed in part, the medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized. N. Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures. O. Medication storage conditions are monitored on a routine basis and corrective action taken if problems are identified. On 6/16/25 at 0944 hours, an inspection of Medication Storage Room A and concurrent interview was conducted with RN 1. Medication Storage Room A's two cabinets were observed to be dusty and with a hanger. RN 1 acknowledged the medication storage cabinets in Medication Storage Room A should always be maintained clean and sanitary for infection prevention and control. On 6/16/25 at 1028 hours, an inspection on Medication Storage Room B and concurrent interview was conducted with RN 1. A bottle of geri-tussin (an expectorant liquid medication used to relieve chest congestion, thins and loosens mucus) was observed to have an illegible expiration date. When asked, RN 1 verified she could not read the expiration date and stated the significance of legible expiration dates on the medications was for the residents' safety and the expiration dates should be readable. 3. Review of the facility's P&P titled Medication Storage dated 1/2025 showed outdated,	F 761	Monitoring Plans to Ensure Solutions are Achieved and Integrated into QA System. The POC is integrated into the QA system. The DON/designee will provide a summary trend analysis of the findings to the facility's monthly QAPI Committee x 3 months or until such time consistent substantial compliance has been achieved as determined by the committee. Date of compliance: 7/3/25	

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F 761	Continued From page 50 contaminated, or deteriorated medication and those in containers that are cracked, soiled, or without secure closure are immediately removed from stock, dispose disposed off according to procedure for medication disposal, and reorder from the pharmacy if a current order exists. On 6/17/25 at 0846 hours, an inspection of Treatment Cart A was conducted with LVN 5. Multiple packets of Dermaseptin ointments and Dermarite Boarder Gauzes, each packaged in separate plastic, were observed without the expiration date. LVN 5 verified the observation and stated multiple staff including other treatment nurses, LVNs, used Treatment Cart A. LVN 5 stated the staff should have labeled the multiple Dermaseptin ointments and Dermarite Boarder Gauzes with an expiration date when they were removed from the original box stored in the medication room. On 6/18/25 at 1304 hours, the DON was informed and acknowledged the above findings.	F 761		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's	F 803		

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F 803	Continued From page 51 reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure 87 of 89 residents who received food from the kitchen received the proper diets and portion sizes when the facility's menus were not followed. * The facility failed to ensure Resident 65 received the pureed green beans as per the menu. * The facility failed to ensure the kitchen staff served the correct portion sizes as per the menu and menu spreadsheet. * The facility failed to prepare the Korean menu puree and failed to serve the Korean menu puree to the residents who preferred to eat Korean food. * The facility failed to provide the American menu for Resident 79 when she was served pureed kimchi instead of pureed bread.	F 803	F803 Menus Meet Resident Nds/Prep in Adv/Followed Corrective action for residents found to have been affected by this deficiency: -DS provided Resident 65 with the pureed green beans that were found missing from the meal tray, immediately on 6/16/25. -DS in-serviced dietary staff on 6/17/25, including the Lead Cook and Cook 2 on P&P "Standardized Menus" and "Food Preparation Guidelines", emphasizing the importance of following recipes, using proper measuring utensils, and correct portion sizes according to the menu spreadsheets, to ensure residents receive adequate nutrition by providing all food items on the menu, including both the American and cultural Korean menus. -DS conducted resident satisfaction surveys and visited all residents on a puree textured diet, or who were not served the correct food items, initiated on 6/17/25 and completed on 7/7/25, including Residents 79 and 40, and residents who preferred the Korean menu, including Residents 27 and 96, to ensure residents are content with the meals provided. Corrective action for residents that may be affected by this deficiency: -DS, RD, or trained designee will conduct daily round audits during food preparation 3 times per week X 3 months to ensure all standardized menus and spreadsheets are followed.	

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F 803	Continued From page 52 * The facility failed to prepare the Korean menu puree and failed to serve the Korean menu puree for two nonsampled residents (Residents 27 and 96) who preferred to eat Korean food. * The facility failed to ensure the menus were followed. Resident 40 was served with carrots not included in the menu for the day. These failures had the potential for the residents' nutritional needs not being met. Findings: Review of the facility's document titled Diet Type Report dated 6/16/25, showed 87 of 89 residents in the facility received food prepared in the kitchen. The Diet Type Report showed 20 of the 87 residents received a pureed diet. Review of the facility's document titled Resident Diet Information dated 6/19/25, showed 14 of the 20 residents in the facility were on a pureed diet and preferred the Korean menu. Review of the facility's P&P titled Standardized Menus revised 12/2022 showed the facility shall provide nourishing, palatable meals to meet the nutritional needs of the residents based on the Recommended Daily Allowances (RDA) of the Food and Nutrition Board of the National Research Council, of the National Academy of Sciences, standardized cycle menus are planned in advance and utilized. 1. Review of the facility's document titled Daily Spreadsheet, Parsley - Spring 2025 Week 1 Monday - Day 2, showed the following menu for Monday lunch for the pureed diet:	F 803	-DS, RD, or trained designee will conduct test tray and tray line audits, 3 times per week X 3 months, ensuring both the American and Korean menus and spreadsheets are followed, including all pureed foods and cultural food preferences. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: -DS or RD will report their findings regarding standardized menus and food preparation compliance to the QA committee for discussion and further recommendations. The QA will continue monitoring for a minimum of 3 months or until substantial compliance is achieved. Date of compliance: 7/7/25	

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F 803	Continued From page 53 - Pureed baked chicken; - Pureed potatos O'Brien; - Pureed whole green beans; and - One soft puree or slurry of bread or roll with margarine or butter. On 6/16/25 at 1237 hours, during the dining observation, Resident 65 was observed in the dining room with her lunch meal in front of her with RNA 2 providing assistance with the resident's feeding. Resident 65's meal tray was observed without the pureed whole green beans. Resident 65's meal ticket showed the resident was to be served a pureed diet and did not indicate Resident 65 should not receive the pureed green beans as per the menu. RNA 2 verified Resident 65 did not receive the pureed green beans. On 6/16/25 at 1242 hours, the DSS was summoned to the dining room and observed Resident 65's meal. The DSS verified the findings and stated she would need to ask the cook about the green beans and proceeded to leave. The DSS shortly came back to the dining room and provided Resident 65 a portion of pureed green beans. 2. Review of the facility's document titled Daily Spreadsheet, Korean Menu - Spring 2025 Week 1 Tuesday - Day 3, showed the following: - Dak bulgogi (Korean BBQ chicken) regular portion, 2 oz (1/4 cup); - Stir fried cabbage regular portion, to be served with a #8 scoop. On 6/17/25 at 1145 hours, during the lunch tray line observation, the Lead Cook used a #8 scoop (1/2 cup) to serve the dak bulgogi regular portion.	F 803		

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F 803	Continued From page 54 Cook 2 was observed to use a #12 scoop (1/3 cup) serving the stir fried cabbage regular portion. On 6/17/25 at 1315 hours, a concurrent observation and interview was conducted with the DSS. The DSS was informed and acknowledged the incorrect portion sizes were served for the dak bulgogi and stir fried cabbage regular portions. 3. Review of the facility's document titled Daily Spreadsheet, Korean Menu - Spring 2025 Week 1 Tuesday - Day 3, showed the following menu for Tuesday lunch for the pureed diet: - Pureed spinach doenjang soup - Pureed kimchi - Pureed dak bulgogi (Korean BBQ chicken) - Pureed steam white rice; and - Pureed stir fried cabbage. On 6/17/25 at 1145 hours, a trayline observation was conducted in the kitchen. The pureed foods on the Korean menu, including the pureed dak bulgogi (Korean BBQ chicken), pureed steamed white rice, and pureed stir fried cabbage were not observed to be prepared. On 6/17/25 at 1309 hours, a concurrent observation and interview was conducted with the Lead Cook. The Lead Cook stated he used the American menu for all the pureed meals and verified the Korean Menu pureed items were not prepared. The Lead Cook stated he served a pureed bread for the American menu and a pureed kimchi for the Korean menu puree. On 6/17/25 at 1315 hours, an interview was conducted with the DSS. The DSS stated the kitchen staff were communicated the resident's	F 803		

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F 803	Continued From page 55 preferences for American menu or Korean menu on the meal ticket. The DSS was informed and acknowledged the findings. The DSS stated she was not aware the Korean menu puree, aside from the puree kimchi, was not prepared. On 6/17/25 at 1555 hours, a follow-up interview was conducted with the DSS. When asked why the Korean menu puree was not prepared, the DSS stated the cook made a mistake. 4. Review of the facility's document titled Daily Spreadsheet, Parsley - Spring 2025 Week 1 Tuesday - Day 3, showed the following menu for Tuesday lunch for the pureed diet: - Pureed Dijon pork cutlet; - Pureed orzo with vegetables; - Pureed seasoned beets; and - Soft puree or slurry, one bread or roll with margarine or butter. On 6/17/25 at 1232 hours, an observation of the lunch meal service was conducted in the facility's dining room. Resident 79's meal tray was observed. Resident 79's meal ticket showed she did not have any preferences. Resident 79's meal tray was observed with the American menu puree (pureed Dijon pork cutlet, pureed orzo with vegetables, and pureed seasoned beets) and pureed kimchi. On 6/17/25 at 1309 hours, a concurrent observation and interview was conducted with the Lead Cook. The Lead Cook stated he used the American menu for all the pureed meals. The Lead Cook stated he served a pureed bread for the American menu and a pureed kimchi for the Korean menu puree.	F 803		

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F 803	Continued From page 56 On 6/17/25 at 1315 hours, an interview was conducted with the DSS. The DSS stated the kitchen staff were communicated the resident's preferences for American menu or Korean menu on the meal ticket. The DSS was informed and acknowledged Resident 79 should have been served the pureed bread and not the pureed kimchi. 5. Review of the facility's document titled Daily Spreadsheet, Korean Menu - Spring 2025 Week 1 Tuesday - Day 3, showed the following menu for Tuesday's (6/17/25) lunch for the pureed diet: - Pureed spinach doenjang soup - Pureed kimchi - Pureed dak bulgogi (Korean BBQ chicken) - Pureed steam white rice; and - Pureed stir-fried cabbage. a. Medical record review for Resident 27 was initiated on 6/16/25. Resident 27 was admitted to the facility on 5/8/19, and readmitted on 4/20/22. Review of Resident 27's Order Summary Report showed a physician's order dated 9/16/24, for a regular diet pureed texture. Review of Resident 27's Nutrition Progress Note dated 6/2/25 at 1716 hours, showed Resident 27 preferred Korean food for lunch and dinner. On 6/17/25 at 1320 hours, an observation was conducted of Resident 27. Resident 27 was observed lying in bed asleep. Resident 27's lunch tray was observed on a bedside table adjacent to Resident 27's bed. Resident 27's lunch tray was observed with pureed food items from the American menu (pureed Dijon pork cutlet, pureed orzo with vegetables, and pureed	F 803		

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F 803	Continued From page 57 seasoned beets). On 6/17/25 at 1337 hours, an observation and concurrent interview was conducted with CNA 7. CNA 7 was observed removing Resident 27's meal tray from Resident 27's room. CNA 7 was asked the percentage of food Resident 27 had consumed for lunch. CNA 7 stated Resident 27 had consumed approximately 10% of her lunch. b. Medical record review for Resident 96 was initiated on 6/16/25. Resident 96 was admitted to the facility on 5/31/25. Review of Resident 96's Order Summary Report showed a physician's order dated 5/31/25, for a heart healthy diet with pureed texture. Review of Resident 96's Nutrition Progress Note dated 6/2/25 at 1454 hours, showed Resident 96 preferred Korean food at lunch and dinner. On 6/17/25 at 1246 hours, an observation was conducted of Resident 96. Resident 96 was observed in the dining room eating lunch. Resident 96's lunch tray was observed with pureed food items from the American menu (pureed Dijon pork cutlet, pureed orzo with vegetables, and pureed seasoned beets). Resident 96's lunch ticket showed Resident 96 preferred Korean Food. On 6/17/25 at 1555 hours, an interview and concurrent medical record review was conducted with the DSS. The DSS verified Residents 27 preferred Korean food for lunch and dinner as indication on Resident 27's nutrition progress note dated 6/2/25 at 1716 hours. Additionally, the DSS verified Resident 96 also preferred Korean	F 803		

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F 803	Continued From page 58	F 803		

food for lunch and dinner as indicated on Resident 96's nutrition progress note dated 6/2/25 at 1454 hours. The DSS verified Residents 27 and 96 received the American pureed food for lunch, rather than Korean pureed food for lunch in accordance with the residents' food preferences. The DSS stated the cook made a mistake today and failed to prepare the Korean pureed menu.
6. On 6/16/25 at 1317 hours, a lunch meal observation and concurrent interview for Resident 40 was conducted. Resident 40 was observed in her room eating her lunch. Resident 40's food plate was observed with chopped cooked carrots. Resident 40 did not eat the carrots that were served with the meal. Resident 40 stated her skin got itchy when she ate carrots and which was why she did not like the carrots.

Medical record review for Resident 40 was initiated on 6/17/25. Resident 40 was admitted to the facility on 4/7/25.

On 6/16/25 at 1321 hours, an observation and concurrent interview with LVN 6 was conducted in Resident 40's room. LVN 6 verified Resident 40's meal tray was with cooked carrots and served to Resident 40.

Review of the facility's menu served for the day was provided by the DSS. However, menu did not show the carrots were included for the lunch meal of the residents for the day.

On 6/16/25 at 1534 hours, an interview and concurrent facility document review for Resident 40 was conducted with the DSS. The DSS verified the lunch menu for the day. The DSS was asked if the carrots were part of the lunch menu for the day. The DSS verified there were

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F 803	Continued From page 59 no carrots on the menu for the day. The DSS was asked why Resident 40 was served with carrots for the lunch meal. The DSS stated the cook made a mistake. The DSS further stated the food trays were not checked for accuracy before coming out from the kitchen. On 6/19/25 at 1612 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. Cross reference to F806, sample #4.	F 803		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and medical record review, the facility failed to ensure the food preferences were honored for six of 87 residents who received food prepared in the kitchen. * The facility failed to serve the pureed Korean menu to the residents who had a preference for Korean food (Residents 7, 16, 27, 35, and 96). * The facility failed to ensure the food preferences was honored for Resident 40. Resident 40	F 806	F806 Resident Allergies, Preferences, Substitutes Corrective action for residents found to have been affected by this deficiency: -DS visited Residents 7, 16, 27, 35, 96, and 40 on 7/7/25, ensuring meal satisfaction, updating all food preferences per resident or resident representative. -DS in-serviced all dietary staff initiated on 6/17/25 and completed for all dietary staff on 7/7/25, utilizing P&P "Menus and Adequate Nutrition", emphasizing the importance of honoring all food preferences, including cultural foods, ensuring residents' nutritional adequacy and satisfaction. Measures that will be put into place to ensure that this deficiency does not recur:	

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F 806	Continued From page 60 disliked carrots but was served with carrots on her lunch tray. These failures had the potential to negatively impact the residents' food intake and well-being. Findings: Review of the facility's document titled Diet Type Report dated 6/16/25 showed 87 of 89 residents received food prepared in the kitchen. 1. Review of the facility's document titled Daily Spreadsheet, Parsley - Spring 2025 Week 1 Tuesday - Day 3, showed the following menu for Tuesday lunch for the pureed diet: - Pureed Dijon pork cutlet; - Pureed orzo with vegetables; - Pureed seasoned beets; and - Soft puree or slurry, one bread or roll with margarine or butter. Review of the facility's document titled Daily Spreadsheet, Korean Menu - Spring 2025 Week 1 Tuesday - Day 3, showed the following menu for Tuesday lunch for the pureed diet: - Pureed spinach doenjang soup - Pureed kimchi - Pureed dak bulgogi (Korean BBQ chicken) - Pureed steam white rice; and - Pureed stir fried cabbage. On 6/17/25 at 1145 hours, a trayline observation was conducted in the kitchen. The pureed foods on the Korean menu, including the pureed dak bulgogi (Korean BBQ chicken), pureed steamed white rice, and the pureed stir fried cabbage were not observed to be prepared.	F 806	-DS, RD, or trained designee will conduct test tray and tray line audits, 3 times per week X 3 months, ensuring all food preferences are honored, including all Korean cultural food preferences, and that no foods residents dislike are on the meal trays. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: -DS, or RD will report their findings regarding honoring food preferences and cultural food requests to the QA committee for discussion and further recommendations. The QA will continue monitoring for a minimum of 3 months or until substantial compliance is achieved. Date of compliance: 7/7/25	

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F 806	Continued From page 61 On 6/17/25 at 1232 hours, an observation of the lunch meal service was conducted in the facility's dining room. A meal cart was observed dropped off by the kitchen staff. The ADON and DSD were observed checking the trays in the meal cart. The ADON was observed checking a printout of the physician's diet orders and calling the orders out. The DSD was observed checking the resident tray's meal and meal ticket (used to identify the resident's diet and food preferences for meal service. The following was observed during the lunch meal service: - Residents 7, 16, and 35's meal tickets were observed and showed Residents 7, 16, and 35 preferred Korean food. Residents 7, 16, and 35's meal trays were observed with the American menu puree (pureed Dijon pork cutlet, pureed orzo with vegetables, and pureed seasoned beets) and pureed kimchi. On 6/17/25 at 1309 hours, a concurrent observation and interview was conducted with the Lead Cook in the kitchen. The Lead Cook stated he used the American menu for all the pureed meals and verified the Korean Menu pureed items were not prepared. The Lead Cook stated he served a pureed bread for the American menu and a pureed kimchi for the Korean menu puree. On 6/17/25 at 1315 hours, an interview was conducted with the DSS. The DSS stated the kitchen staff were communicated the resident's preferences for American menu or Korean menu on the meal ticket. The DSS was informed and acknowledged the findings. The DSS stated she was not aware the Korean menu puree, aside from the puree kimchi, was not prepared.	F 806		

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F 806	Continued From page 62 On 6/17/25 at 1555 hours, a follow-up interview was conducted with the DSS. When asked why the Korean menu puree was not prepared, the DSS stated the cook made a mistake. 2. Medical record review for Resident 27 was initiated on 6/16/25. Resident 27 was admitted to the facility on 5/8/19, and readmitted to the facility on 4/20/22. Review of Resident 27's Nutrition Progress Note dated 6/2/25 at 1716 hours, showed Resident 27 preferred Korean food for lunch and dinner. On 6/17/25 at 1320 hours, an observation was conducted of Resident 27. Resident 27 was observed lying in bed asleep. Resident 27's lunch tray was observed on a bedside table adjacent to Resident 27's bed. Resident 27's lunch tray was observed with pureed food items from the American menu (pureed Dijon pork cutlet, pureed orzo with vegetables, and pureed seasoned beets). 3. Medical record review for Resident 96 was initiated on 6/16/25. Resident 96 was admitted to the facility on 5/31/25. Review of Resident 96's Nutrition Progress Note dated 6/2/25 at 1454 hours, showed Resident 96 preferred Korean food at lunch and dinner. On 6/17/25 at 1246 hours, an observation was conducted of Resident 96. Resident 96 was observed in the dining room eating lunch. Resident 96's lunch tray was observed with pureed food items from the American menu (pureed Dijon pork cutlet, pureed orzo with vegetables, and pureed seasoned beets).	F 806		

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F 806	Continued From page 63 Resident 96's lunch ticket showed Resident 96 preferred Korean Food. On 6/17/25 at 1555 hours, an interview and concurrent medical record review was conducted with the DSS. The DSS verified Resident 27 preferred Korean food for lunch and dinner as indication on Resident 27's nutrition progress note dated 6/2/25 at 1716 hours. Additionally, the DSS verified Resident 96 also preferred Korean food for lunch and dinner as indicated on Resident 96's nutrition progress note dated 6/2/25 at 1454 hours. The DSS verified Residents 27 and 96 received American pureed food for lunch today, rather than Korean pureed food for lunch in accordance with the residents' food preferences. 4. On 6/16/25 at 1317 hours, a lunch meal observation and concurrent interview for Resident 40 was conducted. Resident 40 was observed in her room eating her lunch meal. Resident 40's food plate was observed with chopped cooked carrots. Resident 40 did not eat the carrots that were served with the meal. Review of Resident 40's meal ticket on the food tray showed Resident 40 disliked the carrots. On 6/16/25 at 1321 hours, an observation and concurrent interview with LVN 6 was conducted in Resident 40's room. LVN 6 verified Resident 40's meal tray was served with carrots. LVN 6 was asked to review Resident 40's meal ticket on the food tray. LVN 6 verified Resident 40's food preferences, and the resident disliked the carrots. On 6/16/25 at 1321 hours, the DSS was summoned to come to Resident 40's room. The DSS was asked about Resident 40's food tray.	F 806		

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F 806	Continued From page 64 The DSS verified Resident 40 was served with the carrots and the meal ticket showed Resident 40 disliked the carrots. On 6/19/25 at 1612 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. Cross refernces to F803, example #6.	F 806		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one nonsampled resident (Resident 61) observed during the dining observation task received the appropriate mechanically altered diet as ordered by the physician. This failure posed the risk of aspiration and resident's nutritional needs not being met. Findings: Review of the facility's P&P titled Therapeutic Diet Orders revised 11/2024 showed the therapeutic diets, including mechanically altered diets where appropriate, will be based on the resident's	F 808	F808 Therapeutic Diet Prescribed by Physician Corrective action for residents found to have been affected by this deficiency: - DS and RD in-serviced dietary staff immediately on 6/16/25 and completed for all dietary staff on 6/17/25, utilizing P&P "Therapeutic Diet Orders" ensuring that all diet textures are followed according to the physician's orders. -DS audited dinner for Resident 61 on 6/16/25, ensuring the resident's diet order was followed and the correct food items were served. Corrective action for residents that may be affected by this deficiency: -DS, RD, or trained designee will conduct tray line audits at various mealtimes, comparing resident meals with the PCC Diet Type Report, ensuring meal tray accuracy.	

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F 808	Continued From page 65 individual needs as determined by the resident's assessment. Therapeutic diets are provided only when ordered by the attending physician or a registered or licensed dietitian who has been delegated to write diet orders, to the extent allowed by state law. Dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form and/or the appropriate nutritive content as prescribed. Review of the International Dysphagia Diet Standardization Initiative (IDDSI) Complete IDDSI Framework Detailed definitions 2.0 dated 7/2019 for a soft and bite-sized diet (SB6), showed the food can be mashed/broken down with pressure from fork, spoon, or chopsticks and a knife is not required to cut this food. The food is also soft, tender, and moist throughout but with no separate thin liquid. Under the section titled food specific - bread, showed no regular dry bread, sandwiches or toast of any kind. On 6/16/25 at 1209 hours, a lunch meal cart was observed to be dropped off by the kitchen staff for the residents in the dining room. The ADON was observed checking a printout of the physician's diet orders and calling the orders out. The DSD was observed checking the meal and meal ticket on the residents' trays. The ADON stated they made sure the menu matched the diet orders, the texture matched, and any additional directions. On 6/16/25 at 1226 hours, Resident 61 was observed in the dining room being fed by Resident 70. Resident 61's meal ticket showed her diet order was a carbohydrate controlled soft and bite-sized diet (SB6). Resident 61's meal tray was observed with a regular texture slice of bread.	F 808	Measures that will be put into place to ensure that this deficiency does not recur: -Licensed nurses will continue to audit meal trays with the PCC Diet Type Report at all mealtimes before meal trays are provided to the residents. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: -DS, RD, or licensed nurse will report their findings regarding diet order monitoring to the QA committee for discussion and further recommendations. The QA will continue monitoring for a minimum of 3 months or until substantial compliance is achieved. Date of compliance: 6/17/25	

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F 808	Continued From page 66 On 6/16/25 at 1242 hours, an observation of Resident 61 and concurrent interview was conducted with the DSS. The DSS observed, was informed, and acknowledged the above findings. The menu spreadsheet was reviewed and the DSS acknowledged Resident 61 should not have received the regular texture slice of the bread. Medical record review for Resident 61 was initiated on 6/16/25. Resident 61 was admitted to the facility on 2/2/25. Review of Resident 61's Speech Language Pathologist (SLP) Discharge Summary dated 4/24/25, showed a soft and bite-sized diet was recommended for Resident 61. Review of Resident 61's MDS assessment dated 5/3/25, showed Resident 61's cognition was severely impaired. Review of Resident 61's Order Audit Report dated 6/18/25, showed a physician's order dated 3/7/25, for a carbohydrate controlled diet, soft and bite-sized (SB6) texture, thin liquid consistency, plate guard for all meals, bread cleared and screened by the SLP. The order details history section showed the SLP updated the original order on 6/16/25 at 1510 hours, to show on the order that bread was cleared and screened by the SLP. On 6/18/25 at 1326 hours, an interview and concurrent medical record review for Resident 61 was conducted with the SLP. The SLP stated when she evaluated a resident and changed the diet, the change was not active until the	F 808		

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F 808	Continued From page 67 physician's order was written. The SLP stated once she put the physician's order in their EHR, then it was considered active. The SLP was informed and acknowledged the above findings. The SLP verified she did not revise the diet order for Resident 61 until 6/16/25 at 1510 hours, to show Resident 61 was cleared to eat regular bread. The SLP verified Resident 61 should not have been served the regular bread during lunch.	F 808		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitation guidelines were followed when:	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary Corrective action for residents found to have been affected by this deficiency: -The licensed nurse (LVN 2) discarded the unlabeled pieces of banana immediately found by Resident 22's bedside table. Corrective action for residents that may be affected by this deficiency: -Cook 1 discarded the expired container of dry pasta immediately on 6/16/25. The DS discarded the opened mislabeled bottle of oyster sauce and kimchi immediately on 6/16/25. -The multiple pieces of equipment found damaged were discarded immediately by the DS on 6/16/25, including the rubber spatulas, pitcher, and cutting boards.	

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F 812	Continued From page 68 * The facility failed to ensure the foods in the kitchen were properly labeled and dated, and the expired items were thrown out. * The facility failed to ensure the kitchen utensils and equipment were clean and not worn out. * The facility failed to ensure the cutting boards were in sanitary condition. * The facility failed to ensure the refrigerator used to store residents' food from the outside was clean. * The facility failed to ensure the handwashing signage was posted and visible at the handwashing station in the kitchen. * Two pieces of bananas on Resident 22's bedside table were unlabeled and dated. These failures posed the risk for food borne illnesses in highly susceptible resident population of 87 facility residents who received food prepared in the kitchen. Findings: Review of the facility's document titled Diet Type Report dated 6/16/25, showed 87 of 89 residents received food prepared in the kitchen. 1. Review of the facility's P&P titled Date Marking for Food Safety revised 12/2022 showed the facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food. The food shall be clearly marked to indicate the date or date by which the food shall be consumed or	F 812	-DS ensured the resident refrigerator was cleaned immediately, with the brown food residue removed on 6/16/25. -DS posted proper handwashing signage immediately at the handwashing station on 6/17/25. -DS in-serviced dietary staff initiated on 6/16/25 and completed for all dietary staff on 6/17/25, utilizing P&Ps "Date Marking for Food Safety" and "Sanitation Inspection", emphasizing the importance of proper labeling and dating and cleaning of equipment. -The DON, Director of Staff Development (DSD) and DS conducted an in-service with all the dietary and nursing staff initiated on 6/16/25 and completed on 7/9/25, utilizing the P&P "Use and Storage of Food Brought in by Family or Visitors" on proper labeling and dating of outside food, and ensuring food is discarded if not properly labeled and that the resident refrigerator is cleaned following the cleaning schedule. Measures that will be put into place to ensure that this deficiency does not recur: -DS, RD, or trained designee will complete daily kitchen rounds, 5 times per week X 3 months, and the RD will complete their monthly sanitation audit, ensuring proper labeling & dating in all areas, including the resident refrigerator and bedside tables,	

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F 812	Continued From page 69 discarded. The marking system shall include the date of opening, and the date the item must be consumed or discarded or may refer to the food storage charts posted as the use by dates if manufacturer expiration dates are not present. The discard day or date may not exceed the manufacturer's use-by date, or four days, whichever is earliest. The date of opening or preparation counts as Day 1. During an initial tour of the kitchen on 6/16/25 at 0755 hours, the following was observed with Cook 1: - one container labeled dry pasta with a prepared date of 4/15/25, and a use by date of 6/15/25; - one opened bottle of oyster sauce with a prepared date of 6/12/25, and a use by date of 6/12/28; and the manufacturer's expiration date on the bottle showed 2/27/28. The Cook 1 verified the findings. - one container labeled kimchi with a prepared date of 5/15/25, and a use by date of 5/25/25; and - one container labeled chopped kimchi with a prepared date of 5/15/25, and a use by date of 5/25/25. On 6/16/25 at 0846 hours, the DSS was informed and verified the findings. The DSS stated the label was wrong and the kimchi was prepared the day prior. 2. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, for materials that are used in the construction of utensils and food-contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to	F 812	and compliant equipment cleaning, discarding any damaged equipment. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: -DS or RD will report their findings regarding proper labeling & dating, cleaning of equipment and outside food for residents to the QA committee for discussion and further recommendations. The QA will continue monitoring for a minimum of 3 months or until substantial compliance is achieved. Date of compliance: 7/9/25	

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	555021	A. BUILDING _____ B. WING _____	C 06/19/2025

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F 812	Continued From page 70 food and under normal use conditions shall be safe, durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. During an initial tour of the kitchen on 6/16/25 at 0755 hours, the following was observed with Cook 1: - two rubber spatulas with corroded edges; - one rubber spatula with melted handle, coating on the spatula appears brown; and - one small pitcher with a melted bottom. Cook 1 verified the findings. On 6/16/25 at 0846 hours, the DSS was informed of and acknowledged the findings. 3. According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces. Review of the facility's P&P titled Cutting Boards dated 2014 showed cutting boards should be replaced when the boards begin to have breaks, corrosion, open seams, cracks and chipped areas as the boards can no longer be sanitized properly. During an initial tour of the kitchen on 6/16/25 at 0755 hours, the following was observed with	F 812		

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F 812	Continued From page 71 Cook 1: - Two cutting boards heavily marred with chipped areas Cook 1 verified the above findings. On 6/16/25 at 0846 hours, the DSS was informed and acknowledged the findings. 4. According to the USDA Food Code 2022, Section 4-601.11, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, the nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. On 6/16/25 at 0819 hours, an observation of the residents' refrigerator was conducted with RN 1. There was a brown food residue observed on one of the refrigerator shelves. RN 1 verified the findings. 5. According to the USDA Food Code 2022, Section 6-301.14, Handwashing Signage, a sign or poster that notifies food employees to wash their hands shall be provided at all handwashing sinks used by food employees and shall be clearly visible to food employees. On 6/16/25 at 0755 hours, 6/17/25 at 1145 hours, and 6/18/25 at 0848 hours, the handwashing station in the kitchen was observed without a handwashing signage posted or visible. On 6/18/25 at 0917 hours, the handwashing station was observed with the DSS. The DSS stated she had the handwashing signage but did not currently have it posted. The DSS stated it should had been posted.	F 812		

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F 812	Continued From page 72 6. Review of the facility's P&P titled Use and Storage of Food Brought In by Family or Visitors revised on 1/30/25, showed it is the right of the residents of this facility to have food brought in by family or other visitors, however the food must be handled in a way to ensure the safety of the resident ...2. All food items that are already prepared by the family or visitor brought in must be approved per Nursing to ensure is in accordance with the diet order and labeled with content and dated. a. The facility may refrigerate labeled and dated prepared items in the nourishment refrigerator ... d. If not consumed within three days, food will be thrown away by facility staff...5. All items not maintained are subject to being discarded if not removed by the resident and/or resident representative. 6. If any part of this policy is not followed, the facility reserves the right to protect others by not allowing food items to be brought into the facility for a resident. 7. The facility staff will assist residents in accessing and consuming food that is brought in by the residents and family or visitors if the resident is not able to do so on their own. Medical record review of Resident 22 was initiated on 6/16/25. Resident 22 was admitted on 9/25/17, and readmitted to the facility on 2/28/22. Review of Resident 22's H&P examination dated 8/16/24, showed Resident 22 had no capacity to understand and make decisions. Review of Resident 22's Order Summary Report dated 6/17/25, showed a physician order dated 2/21/25, for regular diet soft and bite sized texture, thin consistency, patient screened and cleared for bread by speech language pathologist, gravies to meals, double protein,	F 812		

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F 812	Continued From page 73 fortified meals for breakfast, lunch and dinner, Korean menu. On 6/16/25 at 0914 hours, an observation of Resident 22's bedside table and concurrent interview was conducted with CNA 3. Resident 22's bedside table was observed to have two pieces of bananas in a clear plastic bag that was not labeled with name, date brought and use by date. CNA 3 was asked when the bananas were brought in by the resident's visitor. CNA 3 stated she did not know since when the bananas were brought. CNA 3 verified the bananas were perishable foods and should have been at least dated when it was brought in by the resident's visitor. On 6/16/25 at 1252 hours, an interview was conducted with LVN 2. LVN 2 was informed about the two pieces of bananas in a clear plastic bag on Resident 22's bedside table. LVN 2 was asked when the two pieces of bananas were brought in by Resident 22's visitor. LVN 2 stated she did not know when the two pieces of bananas were brought. LVN 2 verified the two pieces of bananas brought in by Resident 22's visitor should have been dated because the banana was a perishable food. On 6/19/25 at 1604 hours, an interview was conducted with the DON. The DON acknowledged the above findings.	F 812		
F 838 SS=D	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what	F 838		

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F 838	Continued From page 74 resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including	F 838	F838 How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. On 6/24/25, administrator completed the most current version of the Facility Assessment. The assessment was brought to the QA committee for discussion and approval on 6/25/25 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken All residents have potential to be affected by the deficient practice. The administrator will continue to gather feedback from emergency drills, monthly safety meetings, monthly all-staff meetings, and monthly QA for feedback on communication protocol and any necessary changes to Facility assessment and Emergency Operations Plan in the event of an emergency. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Administrator will verify the most recent version of the facility assessment prior to creating the Facility Assessment for 2026 and upcoming years.	

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F 838	Continued From page 75 but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable.	F 838	How the facility plans to monitor its performance to make sure that solutions are sustained. Facility Assessment will be discussed at the monthly QA meeting for feedback from floor staff and department heads to review findings from monthly safety committee/all-staff meetings and learnings from disaster/fire/emergency drills. Date of compliance: 6/25/25	

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F 838	Continued From page 76 (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is not met as evidenced by: Based on interview and facility document review, the facility failed to ensure the Facility Assessment addressed or included the following:	F 838		

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F 838	Continued From page 77 1. Active involvement of required individuals in developing the Facility Assessment; 2. Resources necessary to care for residents including weekends; 3. A plan to maximize recruitment and retention of direct care staff; and 4. A contingency plan for staffing needs. This failure had the potential to not meet the residents' care needs if the assessed population's needs and resources were not comprehensively identified and addressed. Findings: According to the CMS QSO-24-13-NH dated 6/18/24, with an implementation date of 8/8/24, CMS had issued a revised guidance for long-term care facility assessment requirement. The Facility Assessment should address and included the active involvement of the direct care staff in developing the Facility Assessment. Also included the staffing resources necessary to care for the residents, including the weekends; a plan to maximize recruitment and retention of direct care staff member, and a contingency plan for staffing needs for the events not to activate the facility's emergency plan. Review of the Facility's Assessment dated 7/8/24, did not show the direct care staff member, direct care representatives, residents, residents' representatives, and residents' family members were actively involved in developing the Facility Assessment; the resources necessary to care for the residents including weekends; and a plan to maximize recruitment and retention of the direct care staff, or include a contingency plan for the	F 838		

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F 838	Continued From page 78 staffing needs. On 6/19/25 at 1343 hours, an interview and concurrent facility document review of the Facility Assessment was conducted with Administrator. The Administrator verified the Facility Assessment was dated 7/8/24, and acknowledged he was not aware of the new update of the Facility Assessment from the CMS. The Administrator verified there were no direct care staff, direct care representatives, residents, resident representatives, and family members actively involved in developing the Facility Assessment. The Administrator further verified there were no resources necessary to care for the residents including weekends, and a plan to maximize recruitment and retention of the direct care staff, or include a contingency plan for the staffing needs. The Administrator verified and acknowledged the Facility Assessment was not updated based on the latest update from the CMS.	F 838		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility	F 842		

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F 842	Continued From page 79 must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F 842	F- 842 Resident Records -identifiable information Corrective Action Initiated for Resident/ On 7/3/25, the inaccurate entry for Resident 94's vital signs dated 6/12/25 was identified and corrected by marking the documentation as an error in the electronic medical record (EMR) with appropriate notation by DON. CNA who made the error in documentation was given 1:1 training by the DSD on 6/18/25. A late entry progress note was added by DON on 7/3/25 clarifying that Resident 94 was hospitalized during that period and that the vital signs were entered in error RT #94 was discharged on 6/17/25. How Potential Other Residents Were Identified and Corrective Action Taken An audit was conducted by medical records/designee on 7/3/25 of residents who were transferred to acute care hospitals between 6/3/25 to 7/3/25 to ensure no other inaccurate entries were made post-discharge. 17 residents were checked with 1 resident noted with blood pressure taken after he was transferred to the hospital. Vital sign was struck out and progress note done on 7/3/25. 1:1 training with the charge nurse who made the error done on 7/3/25. Measures/Systemic Changes Initiated to Prevent Future Recurrence On 6/20/25, nursing staff received re-education by the DSD on proper documentation protocols, including: verifying resident presence before documentation. Correct use of EMR templates and discontinuing charting once a resident is discharged or transferred. Medical Records will audit each discharge record to ensure documentation entries are accurate – findings will be submitted to DON for follow up and resolution	

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F 842	Continued From page 80 §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and closed medical record review, the facility failed to ensure the medical record was accurate, for one of three resident closed records. * The facility documented Resident 94's vital signs were obtained on 6/12/25, however, Resident 94 was not in the facility on 6/12/25, having been transferred to the acute care hospital on 6/10/25. This failure had the potentail to negative impact Resident 94's well-being as the medical record information was inaccurate. Findings: Closed medical record review for Resident 94 was initiated on 6/16/25. Resident 94 was admitted to the facility on 5/22/25, and transferred to Acute Care Hospital 1 on 6/10/25. Review of Resident 94's Nursing Progress Note dated 6/10/25 at 1100 hours, showed Resident 94 was transferred to Acute Care Hospital 1 for lethargy on 6/10/25.	F 842	Monitoring Plans to Ensure Solutions are Achieved and Integrated into QA System. The MRD will provide a summary trend analysis of the findings to the facility's monthly QAPI Committee x 3 months or until such time consistent substantial compliance has been achieved as determined by the committee. Date of compliance: 7/3/25	

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F 842	Continued From page 81 Review of Resident 94's Weights and Vital Signs dated 6/12/25 1455 hours, showed the following vital signs were obtained for Resident 94 on 6/12/25 at 1455 hours: blood pressure 146/83 mmHg, respirations 19 breaths per minute, pulse 70 beats per minute, and oxygen saturation level 96%. On 6/18/25 at 1625 hours, an interview and concurrent closed medical record was conducted with the DON. The DON verified Resident 94 was transferred to Acute Care Hospital 1 on 6/10/25, and had remained at Acute Care Hospital 1 thereafter. The DON verified Resident 94's closed medical record was inaccurate specific to the documentation of Resident 94's vital signs (blood pressure, pulse, respirations, and oxygen saturation) being obtained in the facility on 6/12/25 at 1455 hours (as Resident 94 resided in Acute Care Hospital 1 on this date and time).	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		

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F 880	Continued From page 82 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880	F880 Infection Prevention and Control • How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1:1 training was done by the IP nurse with the charge nurse who failed to ensure hand hygiene was performed in between changing of gloves during med pass observation with a resident who had enteral feeding. The 1:1 training included hand hygiene and universal precautions. C N A did not follow EBP precaution when assisting the resident back to bed. CNA 4 was given a 1:1 training by the DSD on 6/16/25 on policy and procedure for Enhanced Barrier Precautions. Laundry personnel failed to ensure the laundry aide did not store personal items adjacent to the resident clean linens in the laundry sorting area. 1:1 training with the laundry aide provided by IP nurse on 7/3/25 on storage of personal items in clean working stations. The personal item was discarded and the area was sanitized per facility protocol. Maintenance director verified that the water bottle did not touch or contaminate any clothing items and that no re-washing was necessary. In-services will be provided by the IP nurse on hand hygiene, EBP practice, personal items in clean working stations by 7/10/25. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. On 6/18/25, the DSD did a spot check on the CNAs observing EBP practices and no other issue was noted.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 83 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review, and P&P review, the facility failed to implement the infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of diseases and infections. * The facility staff failed to ensure hand hygiene was performed in between changing of gloves during the medication pass administration on Resident 52 with GT feeding. * The facility failed to ensure CNA 4 followed the enhanced barrier precaution for Resident 85 when assisting the resident back to bed. * The facility failed to ensure the Laundry Aide did not store his personal items adjacent to resident clean linens in the laundry sorting area. These failures posed the risk for the transmission of disease-causing microorganisms. Findings: 1. Review of the facility's P&P titled Hand	F 880	On 6/18 IP performed a hand hygiene audit with the nursing staff and no other issue was identified. On 6/20/25, a spot check of the laundry room was done by the IP to check for personal items near the sorting area and no other issue was found. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. I.P. will do random checks on hand hygiene, EBP practices and storing/using personal items in clean working areas 3x/week x 3 months. Report any findings to the DON. • How the facility plans to monitor its performance to make sure that solutions are sustained. IP nurse provide a summary trend analysis of the findings to the facility's monthly QAPI Committee x 3 months or until such time consistent substantial compliance has been achieved as determined by the committee • Include dates when corrective action will be completed. Date of compliance : 7/10/25	

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F 880	Continued From page 84 Hygiene revised 12/19/22, showed the use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves. Medical record review of Resident 52 was initiated on 6/18/25. Resident 52 was admitted on 10/22/24. Review of Resident 52's H&P examination dated 10/23/24 showed Resident 52 had no capacity to understand and make decisions. Review of Resident 52's Order Summary Report dated 6/18/25, showed the following physician's orders: - dated 1/30/25, for enhanced barrier precaution related to G-tube every shift. - dated 6/4/25, for enteral feed order every shift for G-tube feeding. Continuous enteral feeding: formula: Glucerna 1.2 (enteral feeding formula) rate 70 ml/hr x 20 =1400 ml/24 hours, 84 grams protein, 1134 ml free water. Start at 12 PM and stop at 8 AM, may run until full dose is completed. On 6/18/25 at 0842 hours, an observation was conducted with LVN 1 during the medication pass administration for Resident 52 with a G-tube feeding. LVN 1 was observed to not perform hand hygiene in between the changing of the gloves on the following situations: - LVN 1 failed to perform hand hygiene after removing his gloves, proceeded to touch the edge of the bed to check the wiring, then wore his gloves and turned off the G-tube machine of Resident 52 and proceeded to check G-tube placement of Resident 52. - LVN 1 removed his gloves to get spoons from	F 880		

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F 880	Continued From page 85 the medication cart, then when LVN 1 got spoons from the medication cart, LVN 1 proceeded to wear new set of disposable gloves without performing hand hygiene. On 6/18/25 at 1034 hours, an interview was conducted with LVN 2. LVN 2 was informed he missed to perform hand hygiene in between changing of the gloves. LVN 2 verified he should have performed hand hygiene On 6/19/25 at 1604 hours, an interview was conducted with the DON. The DON acknowledged the above findings. 2. On 6/16/25 at 1031 hours, initial tour of the facility, an observation and concurrent interview for Resident 85 was conducted with CNA 4. Resident 85 was observed sitting in his wheelchair inside his room. A posted signage was observed at Resident 85's doorway showing Resident 85 was placed on EBP, and the staff must wear a gown and gloves when providing high contact resident care such as changing incontinent briefs or assisted in transferring. Resident 85 asked CNA 4 for assistance for going back to bed. CNA 4 performed hand hygiene and donned of disposable gloves. CNA 4 assisted Resident 85 back to bed with no PPE gown was observed. On 6/16/25 at 1041 hours, an observation and concurrent interview with CNA 4 was conducted. CNA 4 was asked about Resident 85. CNA 4 verified Resident 85 was on enhanced barrier precaution (EBP), as shown on the resident's doorway posted signage. CNA 4 was asked when she assisted Resident 85 in the room. CNA 4 verified and acknowledged she performed hand hygiene and put on gloves but did not put a gown	F 880		

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F 880	Continued From page 86 per EBP protocol. On 6/16/25 at 1056 hours, an interview for Resident 85 was conducted with LVN 6. LVN 6 verified Resident 85 was on enhanced barrier precaution. LVN 6 verified and stated the staff should wear the PPE first before providing care to the resident such as changing linens, providing hygiene and transferring the resident. Medical record review for Resident 85 was initiated on 6/17/25. Resident 85 was admitted to the facility on 4/30/25. Review of Resident 85's Order Summary Report dated 6/17/25, showed a physician's order dated 4/30/25 to place Resident 85 on an EBP related to urostomy. Review of Resident 85's Plan of Care showed a care plan problem dated 4/30/25, addressing the enhance barrier precaution. The interventions included to apply EBP to prevent the spread of infection for specific care activities. On 6/18/25 at 1318 hours, an interview for Resident 85 was conducted with the IP. The IP was asked about the facility's process about the EBP. The IP stated they placed the residents who had a central lines, urinary catheters, and other devices placed inside the resident's body on EBP. The IP stated the staff would put on PPE when providing a closed contact care such as transferring, changing diapers and if expecting a splash, they must wear a face shield. The IP was informed of the observation when CNA 4 assisted Resident 85 in an EBP room not wearing a PPE gown for transferring the resident back to bed. The IP stated CNA 4 should have been wearing a	F 880		

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F 880	Continued From page 87 PPE gown for providing care to the resident. On 6/19/25 at 1612 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. On 6/19/25 at 1129 hours, an observation of the facility's laundry room and concurrent interview was conducted with the Laundry Aide. The counter designated for clean laundry sorting was observed with clean bed linens folded and stacked on top of the counter. The Laundry Aide's cell phone charger, plastic water bottle, and water flask were observed stored on the clean laundry counter adjacent to the clean resident bed linens. The Laundry Aide verified the findings and stated his personal items should not be stored adjacent to resident clean linens. On 6/19/25 at 1133 hours, an interview was conducted with the IP. The IP stated the staff's personal items should not be stored on the residents clean laundry sorting area adjacent to the clean resident laundry, to prevent contamination of the clean residents' laundry from potentially unclean staff personal items.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 883		

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F 883	Continued From page 88 immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal	F 883	F883 Influenza and Pneumoccoccal Immunizations. Failed to follow up subsequent vaccine. • How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Offered pneumococcal vaccine to resident/responsible party on 6/19/25. The responsible party declined the vaccine on 6/19/25. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. An audit of the pneumococcal vaccinations for all residents was done on 6/24/25 by the IP nurse. No other residents were found. IP was inserviced 6/24/25 by DON about resident pnuemonia vacinations being offered annually. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. DSD will audit the pneumococcal vaccine log once a week x 3 months. Significant findings will be reported to the DON. • How the facility plans to monitor its performance to make sure that solutions are sustained. IP nurse provide a summary of the findings to the facility's monthly QAPI Committee x 3 months or until such time consistent substantial compliance has been achieved as determined by the committee Date of compliance: 6/24/25	

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F 883	Continued From page 89 immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and facility P&P review, the facility failed to offer PCV15 or PCV 20 vaccination to one of five final sampled residents (Resident 23) reviewed for immunizations. * Resident 23 received the PPSV23 vaccine on 12/5/13, however, the facility failed to offer Resident 23 PCV15 or PCV 20 vaccination, in accordance with the facility's P&P and CDC's recommendations. This failure increased the resident's risk for being inadequately vaccinated for the pneumococcal disease and its associated complications. Findings: Review of the CDC's guidelines for pneumococcal vaccination showed adults aged 65 years and older, who had only received PPSV23 vaccination (regardless of risk conditions) are to receive one dose of PCV15 or PCV20 at least one year after the most recent PPSV23 vaccination. Review of the facility's P&P titled Pneumococcal Vaccine Series dated 12/19/22, showed it is the facility's policy to offer residents immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations. The type of pneumococcal vaccine (PCV15, PCV20, or PPSV23) offered will	F 883		

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F 883	Continued From page 90 depend upon the recipient's age and susceptibility to pneumonia, in accordance with current CDC guidelines and recommendations. A pneumococcal vaccination is recommended for all adults 65 years and older and based on the following recommendations: For adults 65 years or older who have only received PPSV23: Give one dose PCV15 or PCV 20. The PCV 15 or PCV 20 dose should be administered at least one year after the most recent PPSV23 vaccination. Medical record review for Resident 23 was initiated on 6/16/25. Resident 23 was admitted to the facility on 6/10/23. Review of Resident 23 admission record dated 6/19/25, showed Resident 23 was 93 years of age. Review of Resident 23's Pneumococcal Vaccine Consent Form dated 6/11/23, showed Resident 23's responsible party declined to give consent for the pneumococcal vaccine, as Resident 23 had received a pneumococcal vaccine (PPSV23) in 2013. Review of Resident 23's California Immunization Registry (CAIR) dated 6/19/25, showed Resident 23 received the PPSV23 vaccine on 12/5/13. The CAIR immunization record failed to show Resident 23 had received the PCV 15 or PCV 20 vaccine. Review of Resident 23's facility Immunization Report dated 6/18/25, failed to show Resident 23 had received the PCV 15 or PCV 20 vaccine. On 6/19/25 at 1445 hours, an interview and concurrent medical record review was conducted with the IP. The IP reviewed Resident 23's medial record and verified Resident 23's medical	F 883		

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F 883	Continued From page 91 record and CAIR immunization record failed to show Resident 23 had received the PCV 15 or PCV 20 vaccine in accordance with the facility's P&P and CDC recommendations (for Resident 23's age group and immunization history). The IP stated he would follow up with Resident 23's responsible party to determine if Resident 23's responsible party would consent for Resident 23 receiving the PCV 15 or PCV 20 vaccine.	F 883		