STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055253	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. John of God Retirement	2468 South St Andrews Place Los Angeles, CA 90018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the temperature in the residents' rooms were within range for two of two sampled residents (Resident 63 and Resident 120).This failure had the potential to negatively affect the residents' quality of life.Findings:During a review of Resident 63's admission Record (undated), the admission Record indicated the facility admitted the resident on 2/15/2024, with diagnoses including but not limited to arthropathy (abnormal condition affecting a joint), iron deficiency anemia (condition where the body does not have enough healthy red blood cells), hypotension (abnormally low blood pressure), and dementia (a progressive state of decline in mental abilities).During a review of Resident 63's History and Physical (H&P) Examination, dated 2/23/2025, the H&P indicated the resident does not have the capacity to understand and make decisions.During a review of Resident 63's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 10/2/2024, the MDS indicated the resident's BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score indicated he was moderate cognitive impairment. The MDS indicated Resident 63 can comprehend most conversations and can communicate words or thoughts if given time.During a review of Resident 120's admission Record (undated), the admission Record indicated the facility admitted the resident on 7/03/2023, with diagnoses including but not limited to lumbosacral spinal stenosis (narrowing of the spine in the lower back), diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension (high blood pressure).During a review of Resident 120's H&P, dated 10/17/2025, the H&P indicated the resident does have the capacity to understand and make decisions. During a review of Resident 120's MDS, dated [DATE], the MDS indicated the resident's BIMS score indicated she was cognitively intact. The MDS indicated Resident 120 can understand others and express wants or needs.During a concurrent observation and interview on 12/2/2025 at 11:56 AM with Resident 63 in Resident 63's room, the room's thermostat displayed 67 degrees Fahrenheit (F- a temperature scale). Resident 63 stated the room is always cold. The resident stated he informed the staff, but the issue remains unresolved. During a concurrent observation and interview on 12/2/2025 at 2:13 PM with Resident 120 in Resident 120's room, the room's thermostat displayed 69 F. Resident 120 stated it gets cold in the room despite staff checking the temperature the previous day. During an interview on 12/3/2025 at 2:31 PM with Resident 63, Resident 63 stated his face is always cold and he feels uncomfortable because the room is cold. Resident 63 stated even with blankets, he still feels cold. Resident 63 stated he feels like he is developing a cold.During an interview on 12/3/2025 at 2:35 PM with the Maintenance Manager (MM). MM stated that residents' room temperatures should be maintained between 71-81 F. MM stated the daily temperature checks are performed using a laser thermometer in the rooms, and the readings are documented on temperature logs.During a concurrent observation and interview on 12/03/2025 at 2:42 PM with MM and Maintenance Supervisor (MS) in Resident 63's room, MM checked the room temperature using a laser thermometer. The laser thermometer indicated 66.2 F. MM stated that the room temperature was too cold. MS stated the room temperature should be no lower than 71 F. Maintaining temperatures above 71 F is part of the regulation and necessary for the comfort of the residents.During an observation on 12/3/2025 at 2:49PM with MM in Resident 120's room, MM measured the room temperature with a laser thermometer. The laser thermometer indicated 64.9 F During a concurrent observation and interview on 12/03/2025 at 2:50 PM with Resident 120, in Resident 120's room. Resident 120 was in bed covered by multiple blankets and had an uncomfortable look on her face. Resident 120 stated she was freezing even with multiple blankets. Resident 120 also stated it hurts to breath due to room being cold.During review of the facility's policy and procedure (P&P) titled, Room Temperature, revised 3/2025, indicated the required temperature range in all resident areas are to be maintained between 71 F and 80 F.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record, the facility failed to ensure an accurate Minimum Data Set ([MDS] - a resident assessment tool) assessment was completed accurately for two of 26 sampled residents (Resident 5 and Resident 130) by failing to: 1. Ensure Resident 5 and Resident 130's Gabapentin (medication used to treat seizure and nerve pain) was encoded as anticonvulsant medication. This failure had the potential to negatively affect the plan of care and services for Resident 5 and Resident 130. Findings:A. During a review of Resident 5's admission Record, the admission Record indicated, Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 5's diagnoses included gastrostomy tube ([GT] - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) placement, cerebral infarction (also known as stroke, the death of brain tissue due to a lack of blood flow), and Diabetes Mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 5's History and Physical (H&P), dated 3/13/2025, the H&P indicated, Resident 5 did not have the capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set ([MDS] - a resident assessment tool), dated 9/25/2025, the MDS indicated, Resident 5's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated Resident 5 was dependent (helper does all of the effort) from staff with oral hygiene, toileting hygiene, and upper and lower body dressing. During a review of Resident 5's Order Summary Report (a document containing active orders), dated 12/5/2025, indicated the physician placed a telephone order on 1/10/2025 for Resident 5 to start on Gabapentin (medication used to treat seizure and nerve pain) 100 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) to take one capsule via GT in the evening (5 p.m.) for muscle spasm. During a concurrent interview and record review on 12/3/2025 at 10:45 a.m., with Minimum Data Set Nurse 1 (MDSN 1), Resident 5's MDS assessment, dated 9/25/2025, was reviewed. MDSN 1 stated MDS Section N (Medications) look back period (the specific time frame within which certain resident conditions and events are assessed) was 7 days before the completion date. MDSN 1 stated there should be a checked mark on Resident 5's MDS Section N0415 (High-Risk Drug Classes) K (anti-convulsant) since Gabapentin was classified as anti-convulsant medication. MDSN 1 stated Resident 5's MDS assessment was completed inaccurately. MDSN 1 stated MDS assessment should be completed accurately for the safety of the residents. B. During a review of Resident 130's admission Record, the admission Record indicated, Resident 130 was admitted to the facility on [DATE]. Resident 130's diagnoses included Diabetes Mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing), and hypertension ([HTN] - high blood pressure). During a review of Resident 130's History and Physical (H&P), dated 7/12/2025, the H&P indicated, Resident 130 had the capacity to understand and make decisions. During a review of Resident 130's Minimum Data Set ([MDS] - a resident assessment tool), dated 10/22/2025, the MDS indicated, Resident 130's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS indicated Resident 130 required moderate assistance (helper does less than half the effort) from staff with showering, upper and lower body dressing, and personal hygiene. During a review of Resident 130's Order Summary Report (a document containing active orders), dated 12/5/2025, indicated the physician placed a telephone order on 3/25/2024 for Resident 130 to start on Gabapentin (medication used to treat seizure and nerve pain) 300 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) to take one capsule by mouth at bedtime (9 p.m.) for neuropathic (nerve) pain. During a concurrent interview and record review on 12/3/2025 at 10:57 a.m., with Minimum Data Set Nurse 2 (MDSN 2), Resident 130's MDS assessment, dated 10/22/2025, was reviewed. MDSN 2 stated Resident 130's Gabapentin was not encoded as anticonvulsant medication on MDS Section N0415 (High-Risk Drug Classes) K. MDSN 2 stated accuracy of MDS assessment was important for the care planning of the resident, facility reimbursement and to improve quality measures (a specific tool used to quantify and evaluate the quality of care provided to residents in long term care facilities) of the facility. During a review of the facility's policy and procedure (P&P) titled, Accuracy of Assessment, dated 3/2025, the P&P indicated, Any Person completing a portion of the Minimum data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment During a review of Centers

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Develop a comprehensive person-centered care plan for anti-fungal (a drug that kills or stops the growth of harmful fungi causing infections in humans) medication for one of one sampled resident (Resident 143). This deficient practice had the potential not able to monitor the side-effect (undesired effects of a drug) of antifungal medication that could possibly harm Resident 143. Findings: During a review of Resident 143's admission record, the admission Record indicated, Resident 143 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 143's diagnoses included, urinary tract infection ([UTI] - an infection in the bladder/urinary tract), cerebral infarction (also known as stroke, the death of brain tissue due to a lack of blood flow), and Diabetes Mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 143's History and Physical (H&P), dated 1/28/2025, the H&P indicated, Resident 143 did not have the capacity to understand and make decisions. During a review of Resident 143's Minimum Data Set ([MDS] - a resident assessment tool), dated 9/8/2025, the MDS indicated, Resident 143's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated Resident 143 was dependent (helper does all of the effort) from staff with oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 143's medication administration records ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) from November to December, 2025, the MAR indicated, Resident 143 received fluconazole (anti-fungal drug) 100 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) once a day for yeast infection (fungal infection that affects different body parts) on 11/27/2025, 11/28/2025, 11/29/2025, 11/30/2025, 12/1/2025, 12/2/2025, and 12/3/2025). During a concurrent interview and record review on 12/4/2025 at 9:07 a.m., with Minimum Data Set Nurse 2 (MDSN 2), Resident 143's electronic health records, were reviewed. MDSN 2 stated there was no comprehensive person-centered care plan for Resident 143's use of antifungal medication. MDSN 2 stated each member of the interdisciplinary team ([IDT] - team members from different disciplines who come together to discuss resident care) was responsible in creating a comprehensive person-centered care plan. MDSN 2 stated it was important to have a care plan for medication in order to monitor the side-effects or the black box warning (drugs that have special problems, particularly ones that may lead to death or serious injury) of the medication. MDSN 2 stated in general care plan should be developed to improve the standard of care and to provide interventions needed for the care of the residents. During an interview on 12/4/2025 at 10:29 a.m., with the Assistant Director of Nursing (ADON), the ADON stated it was important to develop care plan in order for the facility staff to be aware of each resident's individualized needs.During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Plan, dated 3/2025, the P&P indicated, A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to review and revise one of two sampled residents (Resident 76) when her condition changed. This failure had the potential to result in inappropriate plan of care, outdated treatments, and patient centered goals not being met. Findings: During a review of Resident 76's admission Record, it indicated Resident 76 was admitted to the facility on [DATE] with diagnoses that included but not limited to: Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), anxiety disorder, adult failure to thrive and osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D). During a review of Resident 76's Minimum Data Set (MDS-a comprehensive assessment and screening tool) dated 10/25/2025, the MDS indicated Resident 76 has severely impaired cognitive skills for daily decision making. Resident 76 requires a helper to do all of the effort for oral hygiene, toileting hygiene, shower/bathe, dressing, rolling left and right, sit to lying, chair/bed to chair transfer, and tub/shower transfer. During a review of Resident 76's Care Plan (CP), initiated on 2/12/2024, the CP indicated Resident 76 should have tab alarms in bed and wheelchair to alert staff of attempts to get up unassisted. This CP has a target date of 11/9/2025. During a review of Resident 76's Fall Risk Evaluation, dated 8/13/2025, it indicated Resident 76 cannot get up or stand on her own. Resident 76 is not a high risk for falls. During an observation on 12/2/2025 at 10:28 am in Resident 76's room, Resident 76 sitting upright in a wheelchair sleeping with no chair alarm. During an observation on 12/3/2025 at 8:20 am in Resident 76's room, Resident 76 was sitting upright in bed being fed breakfast. During an observation on 12/3/2025 at 12:50 pm in Resident 76's room, Resident 76 was upright in a wheelchair appearing sleepy, knee splints on, and with no chair alarm. During a concurrent observation and interview on 12/3/2025 at 1:00 pm with Certified Nursing Assistant (CNA) 1, in Resident 76's room, the resident does not have chair or bed alarm in her room. CNA 1 stated the alarms are used for residents on fall precautions to warn staff that the resident is getting up without their help. CNA 1 stated Resident 76 does not need an alarm because she is contracted and unable to get up on her own. During an interview on 12/5/2025 at 10:30 am with Registered Nurse Supervisor (RNS) 1, RNS 1 stated charge nurses and nurses are supposed to update the care plans as necessary. RNS 1 stated the CPs are for more structured goals to better the residents care and make sure they are getting better. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered revised March 2025, the P&P indicated care plans are revised as information or the resident's condition change. The P&P also indicated, the interdisciplinary team must review and update the care plan: -When there has been a significant change in the resident's condition; -When the desired outcome is not met; -When the resident has been readmitted to the facility from a hospital stay; and -At least quarterly, in conjunction with the required quarterly MDS assessment.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to:Ensure low air loss mattress settings were accurate for two of 16 sampled residents (Resident 1 and Resident 3). Findings: During a review of Resident 1's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 1's diagnoses included a stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle), dysphagia (difficulty swallowing), type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 9/1/2025, the MDS indicated Resident 1's cognitive (thinking) skills were severely impaired. The MDS also indicated Resident 1 was dependent on staff with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an observation, on 12/02/2025 at 3:48 p.m., Resident 1 was observed laying in bed on a low air loss mattress with weight settings at 350 lbs. During a concurrent observation and interview, on 12/3/2025, at 11:27 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated low air loss mattress settings were based on a resident's weight. LVN 1 stated Resident 1's low air loss mattress was set to 350 pounds. LVN 1 stated Resident 1 weighed 129 lbs. LVN 1 stated the low air loss mattress was on the wrong setting for Resident 1. LVN 1 stated the risk of setting a low air loss mattress on the wrong setting could result in skin breakdown and wounds. During a review of Resident 3's admission Record, it indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to: necrosis (death of most or all of the cells in an organ or tissue or failure of the blood supply) of amputation stump (left lower foot), diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), peripheral vascular disease (a slow progressive narrowing of the blood flow to the arms and legs), and stage 3 pressure ulcer (full-thickness loss of skin. Dead and black tissue may be visible) of the sacral region (above the buttocks and at the base of the spine). During a review of Resident 3's Minimum Data Set (MDS – a comprehensive assessment and screening tool) dated 10/24/2025, the MDS indicated Resident 3 has difficulty communicating some words or finishing thoughts and misses some part/intent of messages. Resident 3 requires a helper for all of the effort to roll left and right, sit to lying, and lying to sitting on side of bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Care Plan (CP), initiated on 10/21/2025, the CP indicated Resident 3 will have a low air loss mattress, and to monitor for proper setting, placement and functioning every shift. During a review of Resident 3's Weights and Vitals Summary, it indicated Resident 3 weighed 150 pounds when last checked on 11/7/2025. During an observation on 12/3/2025 at 12:30 pm in Resident 3's room, Resident 3 was lying on her right side with the low air loss mattress set at 225 pounds. During a concurrent observation and interview on 12/4/2025 at 2:00 pm with Treatment Nurse (TN) 1 by Resident 3's room, TN1 stated the setting at 225 pounds is incorrect for Resident 3. If the low air loss mattress is set at the wrong weight, there is a potential for the pressure injury to worsen. During an interview on 12/5/2025 at 10:30 am with Registered Nurse Supervisor (RNS) 1, RNS 1 stated the low air loss mattress is set based on the weight of the resident. If the weight setting is wrong, pressure ulcers can worsen. During a review of the facility's low air loss owner's manual, the manual indicated to adjust the air mattress to a desired firmness according to the resident's weight. During a review of the facility's policy and procedure (P&P) titled, Prevention of Pressure Injuries, revised March 2025, the P&P indicated, select the appropriate support surface based on resident's weight. Equipment can include a low air loss mattress.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to: 1. Ensure continuous supervision was provided for one of eight sampled residents (Resident 32).This deficient practice had the potential to result in injuries and accidents.Findings:During a review of Resident 32's face sheet (front page of the chart that contains a summary of basic information about the patient), the face sheet indicated Resident 32 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 32's diagnoses included dementia (a progressive state of decline in mental abilities), type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), cardiomyopathy (chronic disease of the heart muscle) and benign prostatic hyperplasia (a common, non-cancerous enlargement of the prostate gland).During a review of Resident 32's Minimum Data Sheet (MDS- a federally mandated resident assessment tool), dated 11/26/2025, the MDS indicated Resident 32's cognitive (thinking) skills was severely impaired. The MDS also indicated Resident 32 was dependent on staff members with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During a review of Resident 32's history and physical (H&P) form, dated 6/16/2025, the H&P indicated Resident 32 did not have the capacity to understand and make decisions.During a review of Resident 32's care plan, titled Resident is on 1:1 sitter, dated 8/24/2025 indicated Resident 32 was to be on continuous monitoring due to poor safety awareness. During an observation, on 12/2/2025 at 10:49 a.m., Resident 32 was observed laying in bed with floor mats on both sides of his bed. An empty seat was noted at the end of Resident 32's bed.During a concurrent observation and interview, on 12/2/2025 at 10:51 a.m., with Certified Nurse Assistant 9 (CNA 9), CNA 9 stated continuous monitoring required a staff member to be with a resident at all times. CNA 9 stated there was no staff member present to monitor Resident 32. CNA 9 state Resident 32 required continuous monitoring. CNA 9 stated the risk of not having 1:1 sitter at a resident's bedside as ordered could result in falls and/or accidents and is a safety hazard.During a review of the facility's policy and procedures (P&P), titled 1:1 Monitoring, revised 3/2025, the P&P indicated, It is the policy of this Skilled Nursing Facility to provide continuous, uninterrupted one-to-one observation for residents assessed to be at risk of harm to self or others, elopement, severe behavioral dysregulation, or significant fall risk.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Ensure one of one sampled resident (Resident 13) was provided with Bladder training (type of training that will help a person manage urinary incontinence).This deficient practice had the potential for decline in bladder function for Resident 13.Findings:During a review of Resident 13's admission Record, the admission Record indicated, Resident 13 was admitted to the facility on [DATE]. Resident 13's diagnoses included osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of both hips, hyperlipidemia (too many fats like cholesterol and triglycerides in your blood), and hypertension ([HTN] - high blood pressure). During a review of Resident 13's History and Physical (H&P), dated 11/5/2025, the H&P indicated, Resident 13 had the capacity to understand and make decisions.During a review of Resident 13's Minimum Data Set ([MDS] - a resident assessment tool), dated 9/16/2025, the MDS indicated, Resident 13's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS indicated Resident 13 required supervision (helper provides verbal cues) from staff with oral hygiene, toileting hygiene, and personal hygiene. The MDS indicated Resident 13 was frequently incontinent (7 or more episodes or urinary incontinence, but at least one episode of continent voiding) of urine. The MDS also indicated that a trial of a toileting program such as scheduled toileting (a technique that involves using a set schedule to go to the bathroom), prompted voiding (behavioral strategy for bladder incontinence), or bladder training have not been attempted. During a concurrent interview and record review on 12/4/2025 at 8:04 a.m., with Minimum Data Set Nurse 1 (MDSN 1), Resident 13's Bowel and Bladder Assessment, dated 9/16/2025, was reviewed. The Bowel and Bladder Assessment indicated Resident 13 was not continent of both bowel and bladder function. The Bowel and Bladder Assessment indicated Resident 13 had a total score of 4 (candidate for bowel and bladder training). MDSN 1 stated there was no documented evidence in the clinical records of Resident 13's indicating staff implemented a bladder training. MDSN 1 stated Resident 13 would benefit for a trial of toileting program for bladder training to reduce problem with incontinence. MDSN 1 stated by not offering a toileting program, Resident 12 would be at risk for urine infection and skin breakdown. During an interview on 12/4/2025 at 10:23 a.m., with the Assistant Director of Nursing (ADON), the ADON stated offering toileting program such as bladder training was important for the dignity of the resident being able to use the bathroom on their own without using a diaper. During a review of the facility's policy and procedure (P&P) titled, Toileting Program, dated 3/2025, the P&P indicated, The options for managing urinary incontinence include primarily behavioral programs, toileting plans and medication therapy.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure the oxygen tubing (flexible tube that delivers oxygen-rich air) was not kinked (bent) for one of one sampled resident (Resident 109).This failure had the potential to result in decreased oxygen flow (to move continuously) to Resident 109.Findings:During a review of Resident's 109 admission Record, the admission Record indicated Resident 109 was admitted to the facility on [DATE] with the diagnoses but not limited to chronic respiratory failure with hypoxia (a condition when the body's respiratory system cannot absorb enough oxygen and has low oxygen levels), emphysema (a condition when the air sacs in the lungs become damaged), and cerebral ischemia (when the blood flow to the brain is decreased). During a review of Resident 109's Minimum Data Set (MDS- a comprehensive resident assessment tool), dated 4/29/2025, the MDS indicated Resident 109 is currently receiving oxygen therapy.During a review of Resident 109's physician order, dated 4/23/2025, the physician orders indicated Resident 109 has an order for continuous oxygen at 2 liters per minute (unit of measurement).During a review of Resident 109's care plan (a plan for each resident's physical, functional, and psychosocial needs) titled, At Risk for Impaired Airway Clearance related to Chronic Respiratory Failure with Hypoxia, dated 4/23/2025, the care plan indicated the goal of Resident 109 is to maintain a clear airway (passageway from nose to lungs).During an observation on 12/2/2025 at 12:01 P.M. in the dining room, Resident 109's oxygen tubing was kinked at the humidifier (a small plastic container that adds moisture) port (connector from tubing to humidifier).During an interview on 12/4/2025 at 11:45 A.M. with Certified Nursing Assistant (CNA) 3, CNA 3 stated she would notify the licensed nurses if there was a kink in the oxygen tubing of a resident. CNA 3 stated if there was a kink in the oxygen tubing, this could result in a lower oxygen saturation (a measurement of how much oxygen the blood is carrying as a percentage) for the resident. During an interview on 12/4/2025 at 2:25 P.M. with the Assistant Director of Nursing (ADON), the ADON stated if there was a kink or obstruction (blockage) in the oxygen tubing, the resident would be assessed (checked), and the oxygen tubing would be replaced. ADON stated if there was a problem with oxygen tubing, the CNA would notify the licensed nurses, and the nurse would assess the resident. The ADON stated if there was a kink in the oxygen tubing, this could result in a lower oxygen saturation for the resident. During a review of the facility's policy & procedure (P&P) titled Respiratory Services/Oxygen Administration, dated February 2024, the P&P indicated to check the oxygen tubing to make sure it is free of kinks.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview and record review, the facility failed to assess the pain for one sampled resident (Resident 112), in accordance with the facility policy and procedure for pain management. This failure had the potential to negatively impact Resident 112's quality of life.Findings: During a review of Resident 112's History and Physical (H&P), dated 3/11/2025, the H&P indicated Resident 112 was admitted with the diagnosis, but not limited to dementia (a significant decline in memory , thinking, problem-solving and other cognitive skills that interferes with daily life) and chronic kidney disease (a long term condition where kidneys are damaged and can't filter waste and extra fluid from the body effectively leading to build up that can harm the body).During a review of Resident 112's physician order dated 12/1/2025, it indicated Resident 112 had an order for acetaminophen (a medication to treat mild pain) 325 milligrams, 2 tablets by mouth every 6 hours as needed for mild pain.During a review of Resident 112's Pain Level Summary dated 12/4 /2025, the summary indicated Resident 112 was last assessed for pain at 2:24 A.M. During a concurrent observation and interview on 12/4/2025 at 10:38 A.M., with Resident 112 in the Resident 112's room, the resident's face was frowning. Resident 112 stated he had pain in his right forearm.During an interview on 12/4/2025 at 11:03 A.M. with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 112 told her she had pain which is bothering him. CNA2 stated that she believes that licensed nurses should give the resident some medication for the pain after they would assess the resident. During a concurrent interview and record review on 12/4/2025 at 11:39 A.M. with Registered Nurse (RN) 2, the completed standard assessment was reviewed. RN 2 stated that the last completed standard assessment was dated 10/31/2025 and licensed nurses should perform a pain assessment every shift and daily for the residents and these results should be documented. RN 2 stated that she didn't perform any pain assessment for Resident 112 and further said that there was no documentation of an assessed pain upon review of the resident's chart. During a concurrent observation and interview on 12/4/2025 at 11:50 A.M. with RN 2 in the activity room, RN 2 assessed and interviewed Resident 112. RN 2 stated Resident 112 had a mild pain and she will give Resident 112 acetaminophen per physician's order.During a review of the facility's policy and procedure (P&P) titled, Pain Assessment, dated March 2025, the P&P indicated the facility's steps in recognizing pain includes observing the resident (during rest and movement) for behavioral signs of pain including negative verbalizations and vocalizations such as groaning, crying screaming; facial expressions such as grimacing, frowning , and asking the resident if he/she is experiencing pain.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interviews and record reviews, the facility failed to provide a competency assessment (a skill or ability, especially one required to perform a particular job or role) for four of four CNA's. This failure had the potential to result in untimely and inaccurate weights and improper range of motion for the residents. Findings:During a record review on 12/4/2025 at 12:28 p.m., the Director of Staff Development (DSD) did not have the competency (the ability to perform a particular skill) checked off as competency demonstrated, for the skill of weighing residents for three CNAs and for the skill of providing range of motion exercises for one RNA. During an interview on 12/4/2025 at 12:52 p.m., in the Administration office, the DSD stated that it is possible the CNAs and RNA will not follow the steps listed in the competency and there is a possibility something unsafe could occur with the residents.During an interview on 12/5/2025 at 12:22 p.m. with the Director of Nursing (DON), the DON stated staff competency is very important because it reflects the care provided to the residents. If competencies are not completed, that would expose staff to making errors in providing care.During a review of Competency Checks-CNA policy and procedure (P&P), dated March 2025, the P&P indicated that, nursing assistants employed (or contracted) by the facility will: a. participate in a facility-specific, competency-based staff development and training program; and b. demonstrate specific competencies and skill sets deemed necessary to care for the needs of residents, as identified through resident assessments and described in the plans of care.c. plan of care.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to: 1. Ensure narcotic (controlled medication) drug records were accurate for Med Cart 3 for Resident 15 and Med Cart 4 for Resident 49. 2. Ensure 2 signatures were obtained on a narcotic destruction form for Resident 146.This deficient practice had the potential to result in medication errors and medication diversions.Findings:a. During a review of Resident 15's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 15 was originally admitted on [DATE] and readmitted on [DATE]. The face sheet also indicated Resident 15's diagnoses' which included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), epilepsy (seizures), anxiety (a feeling of unease, worry, or fear) and chronic obstructive pulmonary disorder (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 15's history and physical (H&P), dated 7/17/2024, the H&P indicated Resident 15 did not have the capacity to understand and make decisions. During a review of Resident 15's Minimum Data Sheet (MDS- a federally mandated resident assessment tool), dated 11/7/2025, the MDS indicated Resident 15's cognitive (thinking) skills were severely impaired. The MDS also indicated Resident 15 required substantial assistance from staff members with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During a concurrent interview and record review, on 12/4/2025 at 10:45 a.m., at Medication Cart 3, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 observed Resident 15's bottle of Morphine Sulfate. LVN 1 stated Resident 15's morphine bottle had 16 mL yet the narcotic medication documentation stated Resident 15 had 13.75 mL in the bottle. LVN 1 stated the morphine bottle had usually came with more ml's than what was ordered. LVN 1 stated the facility documents based on the pharmacy label, not the surplus of what was inside the bottle. LVN 1 stated the risk of not documenting the full amount inside of the bottle could result in medication diversion.During a concurrent observation and interview, on 12/4/2025 at 11:08 a.m., with Registered Nurse 1 (RNS 1), RNS 1 stated Resident 15's morphine bottle had about 16-17 ml. RNS 1 stated the narcotic medication form indicated there was 13.75 ml in Resident 15's bottle. RNS 1 stated the bottle amount and narcotic documentation form did not match. RNS 1 stated the risk of not having correct dosage labeled on the narcotic medication form compared to the actual bottle could result in a possible narcotic diversion. b. During a review of Resident 49's face sheet, the face sheet indicated Resident 49 was originally admitted on [DATE] and readmitted on [DATE]. The face sheet also indicated Resident 49's diagnoses' which included malignant neoplasm of the bladder (bladder cancer), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), cerebral infarction (stroke), and dementia (a progressive state of decline in mental abilities).During a review of Resident 49's MDS, dated [DATE], the MDS indicated Resident 49's cognitive skills were severely impaired. The MDS also indicated Resident 49 was dependent on staff members with ADLs.During a concurrent observation and record review, on 12/4/2025 at 11:16 a.m., on Medication Cart 4, with LVN 5, LVN 5 stated Resident 49's narcotic medication form indicated resident 49 had 15 mL's of morphine available yet the bottle contained 25 ml's. LVN 5 stated the amount in the bottle compared to the documentation on the narcotic medication form did not match. LVN 5 stated the risk for inaccurate narcotic count documentation indicate a staff member could be taking the medication.During a concurrent observation and interview, on 12/4/2025 at 11:32 a.m., with RNS 2, RNS 2 stated Resident 49 had around 24-25mL in his morphine bottle. RNS 2 observed the narcotic documentation form and stated the form indicated 15ml's in the bottle but it was not accurate compared to what was in the bottle. RNS 2 stated the documentation did not reflect the amount in the bottle compared to the documentation log. RNS 2 stated the risk of not reflecting an actual narcotic amount on a documentation form could result in a medication error and possible narcotic diversion. During an interview, on 12/4/2025 at 11:53 a.m., with a Pharmacist Consultant 1, he stated the facility should record the actual amount that is in the bottle rather than go by the mL's from the physician's order once a medication was delivered. The pharmacy consultant stated the risk of not documenting the actual medication volume could result a possible medication diversion.During an interview, on 12/4/25 at 12:24 p.m., with the Director of Nursing (DON), the DON stated if medication amount received from the pharmacy does not match order then staff were required to reconcile correct amount by the actual bottle and the prescription. The DON stated the actual amount in the bottle should be documented on the narcotic medication form and pharmacy should be notified. The

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to:Label multi-use medication bottles (a container that holds a drug for multiple doses) with an open date in four of seven sampled medication storage areas (Medication Storage room [ROOM NUMBER], Medication Cart 2, Medication Cart 3, and Medication Cart 4). Refrigerate an opened Acidophilus (drug that maintains healthy bacteria) bottle in one of four sampled medication carts (Medication Cart 1).These failure had the potential to result in resident harm due to the weakened strength of the medication and the administration of ineffective drug dosages. Findings: a. During observation on [DATE] at 9:48AM in the first floor medication storage room, an opened tuberculin (proteins used to test for a bacterial infection) vial was not labeled with an open date. During an interview on [DATE] at 9:49 AM with Registered Nurse Supervisor 2 (RN 2), RN 2 stated the opened tuberculin vial should have an opened date, but it is missing. RN 2 stated that all opened medication vials must have an open date. RN 2 stated that residents are at risk for harm because medication may be expired. During observation on [DATE] at 10:31AM of medication cart 2, one opened box of Omeprazole (a drug used to treat conditions that cause increased stomach acid) tablets was not labeled with an open date. During an interview on [DATE] at 10:32 AM with Licensed Vocational Nurse (LVN) 4, LVN 4 stated the opened box of Omeprazole was open but was not labeled with an opened date. LVN 4 stated that having undated medications puts resident safety at risk. During observation on [DATE] at 10:44 AM of medication cart 3, two opened boxes of Tamiflu (a drug used to treat the flu) were not labeled with an open date. During an interview on [DATE] at 10:45 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the two boxes of Tamiflu were opened and undated. LVN 1 stated undated medication might not help the residents due to the potential decrease in the effectiveness of the medication. During observation on [DATE] at 11:15 AM of medication cart 4, one opened box of anti-diarrheal medication (a drug used to treat watery feces) was not labeled with an open date. During an interview on [DATE] at 11:16 AM with Licensed Vocational Nurse (LVN) 5, LVN 5 stated the antidiarrheal medication was opened and undated. LVN 5 stated that undated medications risk losing their effectiveness. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, revised 8/2025, indicated the date a multidose container is opened must be recorded on the container. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During an interview on [DATE] at 10:22 AM with Licensed Vocational Nurse (LVN) 3, LVN 3 stated opened Acidophilus label indicated medication should be refrigerated after opening. LVN 3 stated the medication was not placed back in the refrigerator after finishing medication administration. LVN 3 stated leaving unrefrigerated medications that require refrigeration in the medication cart put residents' safety at risk. During a review of the facility's policy and procedure (P&P) titled, Storage of Medications, revised 7/2025, indicated medications requiring refrigeration are stored in a refrigerator located in the medication room or other secured location.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to:Label and discard food items in two of three sampled refrigerators.Ensure test strips used to test sanitation strength were not expired.These failures had the potential to increase the risk of foodborne illness in the residents.Findings: 1.During a concurrent observation and interview on 12/2/2025 at 8:45 A.M. in the kitchen, the following items were found: In Refrigerator 1, a container filled with many individual serving sized salad dressing containers were not labeled and no open and/or use by dates. In Refrigerator 3, a large plastic container of mustard sauce had a best by use date of 10/21/2025; Italian salad dressing container's used by date was not legible, chocolate syrup had an used by date of 11/30/2025. Director of Food Services (DFS) stated all food items should be labeled with names and have an opened and used by date on them. DFS also stated that all expired, un-labeled, and un-dated food items should not be used by their kitchen. If residents were served the expired food, they may get sick. During a review of the facility's policy and procedure (P&P) titled, Food Storage, dated 3/2025, P&P indicated all food stored in the refrigerator or freezer are covered, labeled and dated (use by date). 2.During a concurrent observation and interview on 12/2/2025 at 9:08 A.M. in the kitchen dishwashing area, the Director of Food Services (DFS) tested the dishwasher sanitation strength of a clean food tray after it was sanitized with a chlorine test strip. The test strips container indicated an expiration date of 10/2025. The DFS confirmed the test strip container had expired. During an interview on 12/5/2025 at 11:35 A.M. with the DFS, the DFS stated if the facility used expired chlorine test strips, then the cleanliness of food tray items cannot be verified, and this can result in the residents becoming sick.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Ensure a contingency plan (a pre-defined set of actions to be taken if an original plan fails or an unexpected event occurs) was developed and included in the Facility Assessment (a process for evaluating a facility's resident population and identifying the resources needed to provide care and services). This deficient practice had the potential for the facility to ineffectively respond during unexpected circumstances and negatively impact resident care.Findings:During a concurrent interview and record review on 12/3/2025 at 3:25 p.m., with the Administrator (ADM), the Facility assessment dated [DATE], was reviewed. The ADM stated he was responsible in updating the Facility Assessment. The ADM stated the Facility Assessment was incomplete. The ADM stated the Facility Assessment did not include the contingency plan including staffing needs during emergency that would affect resident's care. The ADM stated the Facility Assessment did not indicate the facility's plan of action for staffing shortage during emergency. The ADM stated contingency plan should be included in the Facility Assessment so the facility would be able to provide proper care and to operate without delay for the safety of the residents. During a review of the facility's Policy and Procedure (P&P) titled, Facility Assessment, dated 3/2025, the P&P indicated A Facility Assessment is conducted annually to determine and update the capacity to meet the needs of and competently care for residents during day-to-day operations (including nights and weekends) and emergencies. The P&P also indicated the Facility Assessment is used to inform contingency planning for situations that do not require activation of the emergency plan but do have the potential to affect resident care that includes the availability of direct nursing staffing. During a review of Centers for Medicare and Medicaid Services (CMS), reference QSO-24-13-NH, dated 6/18/2024, titled Revised Guidance for Long-Term Care Facility Assessment Requirements, indicated the new requirements specify that the facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations including nights and weekends and emergencies.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the weekly nursing assessment for one of three sampled residents (Resident 56) was accurate.This failure resulted in inaccurate medical documentation with the potential to cause delayed or incorrect treatments, missed diagnoses or even medication errors for Resident 56. Finding:During a review of Resident 56's admission Record, the admission Record indicated Resident 56 was admitted to the facility on [DATE]. Resident 56 had the following diagnosis but not limited to chronic respiratory failure (a condition person's lungs can't get enough oxygen into their body or can't remove enough carbon dioxide from it - and this problem lasts for a long time.), obesity (a condition that having too much body fat.), dementia (a condition that affects the brain and makes it hard for someone to remember things, think clearly, or make decisions.), diabetes (a condition where the body has trouble controlling the amount of sugar (called glucose) in the blood.).During a review of Resident 56's Minimum Data Set (MDS, a resident assessment tool) dated 7/7/2025, the MDS indicated Resident 56 is bowel incontinent (a condition that a person cannot control when they poop.).During a review of Resident 56's daily bowel movement (BM) log from 11/5/2025 to 12/4/2025, the log indicated Resident 56 had a BM every day.During a review of Resident 56's weekly nursing assessment, dated 11/6/2025, the assessment indicated Resident 56's last BM was 10/22/2025.During a review of Resident 56's weekly nursing assessment, dated 11/12/2025, the assessment indicated Resident 56's last BM was at 10/22/2025.During a review of Resident 56's weekly nursing assessment, dated 11/26/2025, the assessment indicated Resident 56's last BM was at 11/19/2025. During an interview on 12/4/2025 at 10:20 A.M. with Assistant Director of Nursing (ADON), ADON stated Resident 56's weekly nursing assessments had discrepancies regarding how often Resident 56's had BM, and they should be updated to reflect correct information of the assessment of the resident. ADON also stated it was important for their nurses to do assessments correctly including accurate documentation. During a review of the facility's policy and procedures titled, Charting and Documentation, dated 3/2025, indicated Documentation in medical record will be complete and accurate.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care setting) services meet professional standards for one of four sampled residents (Resident 15) by failing to: 1. Ensure a hospice calendar with the scheduled visits for the hospice team was available. This deficient practice had the potential to result in a delay or lack of coordination in delivery of hospice care and services to Resident 15. Findings:During a review of Resident 15's admission Record, the admission Record indicated, Resident 15 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 15's diagnoses included chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing), cerebral infarction (also known as stroke, the death of brain tissue due to a lack of blood flow), and dysphagia (difficulty of swallowing).During a review of Resident 15's History and Physical (H&P), dated 12/5/2025, the H&P indicated, Resident 15 did not have the capacity to understand and make decisions. During a review of Resident 15's Minimum Data Set ([MDS] - a resident assessment tool), dated 11/7/2025, the MDS indicated, Resident 15's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated Resident 15 required substantial assistance (helper does more than half the effort) from staff with eating, oral hygiene, toileting hygiene, and upper and lower body dressing. The MDS indicated Resident 15 was on hospice care. During a concurrent interview and record review on 12/3/2025 at 11:20 a.m., with Licensed Vocational Nurse 1 (LVN 1), Resident 15's hospice record biner, was reviewed. LVN 1 stated there was no hospice calendar with the scheduled visits for hospice team available for the month of December 2025. LVN 1 stated the hospice calendar was a coordinated schedule for hospice services. LVN 1 stated it was important to have a hospice calendar to keep track of the care that is being provided by the hospice team and for the coordination of hospice services between the facility and hospice staff. During an interview on 12/3/2025 at 11:34 a.m., with the Assistant Director of Nursing (ADON), the ADON stated the hospice calendar serve as a collaboration among the facility's interdisciplinary ([IDT] - team members from different disciplines who come together to discuss resident care) and hospice team for the continuity of care of the residents. During a review of the facility's policy and procedure (P&P) titled, Hospice, dated 3/2025, the P&P indicated, Communicating with the hospice provider to ensure that the needs of the resident are addressed and met 24 hours per day. The P&P indicated collaborating with hospice representatives and coordinating facility staff participation in the hospice care planning process for residents receiving these services.

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F 0868 Level of Harm - Potential for minimal harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to: 1. Ensure the Infection Preventionist (a person designated by the facility to be responsible for the infection prevention and control program) Nurse (IPN) attend, participate and give findings on a regular basis to Quality Assessment and Assurance ([QAA] develop and implement appropriate plans of action to correct identified quality deficiencies) committee. This deficient practice had the potential to negatively impact resident safety and unable to monitor infection control practices and outcome of the facility. Findings:During a concurrent interview and record review on 12/5/2025 at 12:04 p.m., with the Administrator (ADM), the QAA committee and Quality Assurance and Performance Improvement ([QAPI] - a data driven proactive approach to improvement used to ensure services are meeting quality standards) Action Plan, dated 7/28/2025 and 10/23/2025, were reviewed. The ADM stated the IPN did not attend, participate, and were not part of the QAA and QAPI meeting on 7/28/2025 and 10/23/2025. The ADM stated it is a requirement for the IPN to attend QAPI meeting quarterly (every 3 months) so she could discuss infection control issues identified in the facility and share insights about any updated state and federal regulations pertaining to proper infection control measures. During a review of the facility's policy and procedure (P&P), titled Quality Assurance Performance Improvement Plan, dated 3/2025, the P&P indicated, The following individuals serve on the committee: A) Administrator or a designee who is in a leadership role, B) Director of Nursing Services, C) Medical Director, D) Infection Preventionist, and E) Representative of other departments. The P&P also indicated the committee meets at least quarterly or more often as necessary.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to:1. Perform hand hygiene (cleansing hands with soap or an alcohol-based rub) before assisting two of two sampled residents (Resident 68 and 144).2. Ensure one of one sampled residents (Resident 1) gastronomy tube ending was capped off to prevent contamination.This failure had the potential to expose Resident 68 and Resident 1 to potentially infectious organisms. Findings: a. During a review of Resident 68's admission Record (AR), dated 7/18/2023, the AR indicated that Resident 68 has a diagnosis of interstitial pulmonary disease (swelling and scarring in the lung tissue), cirrhosis of the liver (severe scarring of the liver tissue), and moderate protein-calorie malnutrition (a severe nutritional deficiency from a lack of protein). During a review of Resident 68's Minimum Data Set (MDS), dated [DATE], the MDS indicated that Resident 68's has limited vision, used a wheelchair, and required substantial/maximal assistance with personal hygiene, toileting, and lower body dressing. During a review of Resident 68's History & Physical (H&P), dated 4/6/2025, the H&P indicated that Resident 68 does not have the capacity to understand and make decisions. During a review of Resident 68's Order Summary Report (OSR), dated 12/5/2025, the OSR indicated that high touch areas (regularly touched by many different people) are to be cleaned hourly or as often as required with approved disinfectant per manufacturer's instruction in resident care environment, on every shift, dated 9/4/2024. b. During a review of Resident 144's admission Record (AR), dated 11/25/2025, the AR indicated that Resident 144 has a diagnosis of traumatic subdural hemorrhage (bleeding between the brain's outer covering and the surface of the brain), nontraumatic subarachnoid hemorrhage (bleeding in the space around the brain), and a right-side rib fracture (broken bone). During a review of Resident 144's History and Physical (H&P), dated 11/25/2025, the H&P indicated that Resident 144 does not have the capacity to understand and make decisions. During a review of Resident 144's Order Summary Report (OSR), dated 12/5/2025, the OSR indicated Resident 144 may be placed on Enhanced Barrier Precautions (wearing gloves and a gown when caring for patients) secondary to post craniotomy (surgery to remove a section of the skull to perform surgery) and staff are to promptly report any signs of infection to the medical doctor. During an observation on 12/3/2025 at 8:35 p.m., at the door of room [ROOM NUMBER], CNA 1 entered room [ROOM NUMBER], touching Resident 68 to place an updated identification band, and exited room [ROOM NUMBER] without performing hand hygiene. During an interview on 12/3/2025 at 8:37 a.m., with CNA 1, outside room [ROOM NUMBER], CNA stated if hand hygiene is not performed, residents can get infected from germs transferred to them and be hospitalized from the infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/3/2025 at 8:58 a.m., with RNS 1, in the hallway near the conference/board room, RNS 1 stated that if hand hygiene is not performed infectious organisms can spread to the residents and they can become ill and need hospitalization. During an interview on 12/5/2025 at 12:22 p.m., with Director of Nursing (DON), in the DON's office, the DON stated staff are expected to perform hand hygiene before engaging with any resident to prevent the outbreak of an infection which may lead to an adverse outcome for the residents. During a review of the facility's policy and procedure titled, Hand Hygiene, dated 3/2025, indicated, hand hygiene is indicated immediately before touching a resident and after touching a resident with soap and water or an alcohol-based hand rub. c. During a review of Resident 1's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 1's diagnoses included a stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle), dysphagia (difficulty swallowing), type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 9/1/2025, the MDS indicated Resident 1's cognitive (thinking) skills were severely impaired. The MDS also indicated Resident 1 was dependent on staff with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's history and physical (H&P) form, undated, the H&P indicated Resident 1 did not have the capacity to understand make decisions. During an observation, on 12/02/2025 at 3:51 p.m., Resident 1's g-tube was hanging on a feeding tube pole. Resident 1's gastronomy tube was observed without a cap at the end of g-tube, exposed to open air. During a concurrent observation, on 12/03/2025 at 11:22 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated when not in use, all gastronomy tubing must be capped to prevent bacterial growth. LVN 1 observed Resident 1's feeding tube and stated there was no cap on end of feeding tube. LVN 1 stated the risk of not capping a feeding tube could result in illness in residents, contamination of gastronomy tube. During a review of the facility's policy and procedures (P&P), titled Policies and Practices- Infection Control, revised 3/2025, the P&P indicated This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 81) call light was within reach.This failure had the potential to result in Resident inability to access the call light for assistance or emergency.Findings:During a review of Resident 81's admission Record (AR), dated 3/7/2022, indicated Resident 81 has hemiplegia (partial paralysis), hemiparesis (weakness or inability to move on one side of the body), and aphasia (difficulty understanding and speaking).During a review of Resident 81's History & Physical (H&P), dated 8/13/2024, indicated Resident 81 has left sided weakness and does not have the capacity to understand and make decisions.During a review of Resident 81's Minimum Data Set (MDS), dated [DATE], the MDS indicated that Resident 81 has short- and long-term memory problems and severely impaired cognitive skills for daily decision making and is dependent on staff for toileting, personal hygiene, and getting dressed.During an observation and interview on 12/2/2025 at 9:36 a.m., in room [ROOM NUMBER], Resident 81 was fully dressed, sitting in a wheelchair, watching TV, with a bedside table positioned in front of Resident 81. Resident 81 stated they could not reach the call bell device under a pillow on the bed.During an interview on 12/3/2025 at 8:08 a.m., in the hallway of room [ROOM NUMBER], with CNA 4, CNA 4 stated Resident 81 would not be able to reach the call bell if it is placed under the pillow of Resident 81's bed because Resident 81 only uses their left hand, so the call bell needs to be within reach of Resident 81. CNA 4 stated Resident 81 could hurt themself reaching for the call bell or couldn't call for help.During an interview on 12/3/2025 at 8:19 a.m., with RNS 1, in the hallway of room [ROOM NUMBER], RNS 1 stated in this situation, Resident 81 could not reach the call bell and Resident 81 would not be able to verbally request help. RNS 1 stated this would be unsafe and Resident 81 could hurt themselves and no one would know that Resident 81 needed help.During an interview on 12/5/2025 at 12:22 p.m. with the Director of Nursing (DON), DON stated that the call bell is a means of communication between staff and residents and is very important in an emergency. We need to respond immediately if they need help. If the call bell is not within reach that can be a form of abuse if intentionally not left within reach and residents' rights can be hampered.During a review of the facility's policy and procedure titled, Call Light Response, dated 3/2024, indicated, ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review the facility failed to ensure a pack of cigarettes was not left unattended on the bench in the facility's patio (the designated smoking area).This failure had the potential to pose a risk of fire or a serious incident to residents due to unattended cigarettes.Findings:During an observation on 12/03/2025 at 12:38 PM in the designated smoking area behind the chapel, a pack of cigarettes was left unattended on a wooden bench, inside a crocheted pouch.During an interview on 12/03/2025 at 12:43 PM with the Director of Nursing (DON), DON stated the staff store cigarettes in a locked area and provide residents with designated smoking times. DON stated the facility does not permit residents to have cigarettes or lighters in their possession for safety reasons. DON stated there is a designated smoking area that is supervised to ensure it remains free of hazards. During a concurrent observation and interview on 12/03/2025 12:49 PM with DON in the designated smoking area, a pack of cigarettes was left unattended on a wooden bench. The DON stated there is a risk to residents because the cigarettes are easily accessible, allowing residents to take and smoke them. There is a risk of burns and although supervision is usually provided, staff must have forgotten about the cigarettes.During an interview on 12/03/2025 at 1:12 PM, with the DON and Activity Assistant (AA), the AA stated that the designated area is checked daily and was unsure how the cigarettes were left unattended. The AA stated cigarettes are supposed to be locked in the activities room drawer. The DON stated it was unacceptable for cigarettes to be left unattended.During a review of the facility's policy and procedure (P&P) titled, Environmental Safety, revised 3/2025, indicated the facility must maintain a safe and hazard-free environment for residents, staff, visitors, and the community. The facility must prevent accidents, injuries, and hazards by ensuring proper handling, storage, and disposal of hazardous materials and maintaining a safe physical environment.