STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055045	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riviera Healthcare Center	8203 Telegraph Rd Pico Rivera, CA 90660

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to ensure:1. The garbage was properly disposed of in the designated dumpsters.2. The dumpster lids were maintained in a closed position to prevent exposure to the environment.3. Timely removal or management of accumulated trash when scheduled waste collection did not occur.These deficient practices had the potential to contribute to environmental contamination, pest infestation, odors and unsanitary conditions that could negatively impact the health and safety of residents, staff, and visitors.Findings:During concurrent interview and observation on 3/9/2026 at 9:05 a.m., with the Dietary Supervisor (DS), three dumpsters were observed in the facility's designated trash disposal area. Multiple bags filled with trash were noted placed on the ground outside of the dumpsters rather. The lids of the three dumpsters were observed to be unable to close properly due to the dumpsters being overfilled with trash. The DS stated the trash bags should not have been left on the ground and should have been properly placed inside the dumpsters with the lids fully closed. The DS stated the dumpsters were overfilled and stated that leaving trash outside the dumpsters and failing to maintain the lids in a closed position could have attracted rodents and pests, which could create an unsanitary environment and negatively impact the health and wellbeing of residents.During an interview on 3/11/2026 at 8:30 a.m. with the Maintenance Supervisor (MS), the MS stated that all trash generated by the facility should be placed inside the designated dumpsters and that dumpster lids should remain closed to prevent exposure to the environment. The MS stated that trash should never be left on the ground outside of the dumpsters. The MS stated that when dumpsters become full, staff should notify the maintenance department or administration so arrangements can be made for additional waste removal. The MS stated overfilled dumpsters and trash left outside of the containers could attract rodents, insects, and other pests and create an unsanitary condition on the facility grounds, which could potentially impact the health and safety of residents, staff, and visitors. The MS confirmed that the observed condition did not meet the facility's expectations for proper waste management.During a review of the facility's Policy and Procedures (P&P) titled, Waste Disposal dated 1/2026, the P&P indicated All infectious and regulated waste shall be handled and disposed of in a safe appropriate manner.During a review of the facility's P&P titled Pest Control dated 1/2026, the P&P indicated Garbage and trash are not permitted to accumulate and are removed from the facility daily.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility failed to ensure the urine characteristics were appropriately assessed and the urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) drainage bag was kept off the floor for five out of eight sampled residents (Resident 9, Resident 10, Resident 2, Resident 34, and Resident 3).These deficient practices had the potential to lead to delay in treatment and identification of urinary tract infections (UTI- an infection in the bladder/urinary tract) for Residents 9 and 10, and the development of UTIs due to improper urinary catheter management for Residents 2, 3, 9, and 34.Findings: 1a. During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 9's diagnoses included dementia (a progressive state of decline in mental abilities), hypertension (high blood pressure), and chronic kidney disease (long-term condition where the kidneys are damaged). During a review of Resident 9's Minimum Data Set (MDS- a resident assessment tool), dated 2/2/2026, the MDS indicated Resident 9's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 9 was dependent on staff's assistance with toileting, bathing, and lower body dressing. The MDS indicated Resident 9 had an indwelling urinary catheter (a hollow tube inserted into the bladder to drain or collect urine). During a review of Resident 9's History and Physical (H&P), dated 11/8/2025, the H&P indicated Resident 9 had fluctuating capacity to understand and make decisions. During a review of Resident 9's Physician Orders, dated 11/8/2025, the Physician Order indicated to monitor Resident 9's urine for color, odor, and sediments (solid matter in the urine that could contain cells, bacteria, mucus, or minerals) every shift. During a review of Resident 9's Care Plan titled, Alteration in Urinary Elimination, dated 8/27/2025, the care plan indicated to monitor Resident 9's urine for sediments, cloudiness, odor, blood, and amount of output. During observations on 3/9/2026 at 9:58 a.m., 3/9/2026 at 2:06 p.m., 3/10/2026 at 8:38 a.m., 3/10/2026 at 1:27 p.m., and 3/11/2026 at 8:15 a.m., in Resident 9's room, Resident 9 was observed lying in bed. The indwelling urinary catheter bag hung on the left side of the bed frame. Resident 9's indwelling urinary catheter tubing had an off-white, thick, milky sediment present. During a concurrent observation and interview on 3/11/2026 at 9:09 a.m., with Treatment Nurse (TN) 1, in Resident 9's room, Resident 9 was observed lying in bed. The indwelling urinary catheter bag hung on the left side of the bed frame. Resident 9's indwelling urinary catheter tubing had an off-white, thick, milky sediment present. TN 1 stated Resident 9 had sediment in her urine which was visible in the urinary catheter tubing. During a concurrent interview and record review on 3/11/2026 at 9:15 a.m., with TN 1, Resident 9's Treatment Administration Record (TAR), dated 3/1/2026 through 3/31/2026, was reviewed. The TAR did not indicate the presence of sediment from 3/9/2026 through 3/11/2026. TN 1 stated sediment should have been identified as early as possible because the presence of sediments could indicate a (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	urinary tract infection (UTI- an infection in the bladder/urinary tract). During a concurrent interview and record review, on 3/11/2026 at 10:07 a.m., with the Infection Preventionist Nurse (IPN), photos of Resident 9's indwelling urinary catheter tubing, dated 3/9/2026 at 9:58 a.m., 3/9/2026 at 2:06 p.m., 3/10/2026 at 8:38 a.m., 3/10/2026 at 1:27 p.m., and 3/11/2026 at 8:15 a.m., were reviewed. The photos revealed the presence of sediment in Resident 9's indwelling urinary catheter tubing. The IPN stated the urinary sediment should have been identified by the treatment nurses, licensed nurses, and/or certified nursing assistants (CNAs) because the sediments were present as early as 3/9/2026. The IPN stated the presence of urinary sediment could indicate a UTI and require antibiotic treatment (medication to treat a bacterial infection). 1b. During observations on 3/9/2026 at 2:06 p.m. and 3/10/2026 at 1:27 p.m., in Resident 9's room, Resident 9 was lying in bed. The indwelling urinary catheter bag hung on the left side of the bed frame. Resident 9's bed was in a low-to-the-floor position and the indwelling urinary catheter bag was touching the floor. During an interview on 3/11/2026 at 10:09 a.m., with the IPN, the IPN stated indwelling urinary catheter bags should be hung on the side of the resident's bed and should not touch the floor. The IPN stated the drainage tip on the drainage bag was covered, however, bacteria on the drainage bag could migrate to the tip. The IPN stated if bacteria entered the drainage tip, the bacteria could move through the urinary catheter system and enter Resident 9's bladder and kidneys. The IPN stated Resident 9's urinary catheter bag touching the floor placed Resident 9 at risk for a UTI. During an interview on 3/12/2026 at 9:25 a.m., with the Director of Nursing (DON), the DON stated indwelling urinary catheter bags should never touch the floor. The DON stated the floor was dirty and if the drainage bag drags along the floor, the drainage tip could become contaminated with bacteria. The DON stated having Resident 9's indwelling urinary catheter bag touching the floor placed Resident 9 at risk for a UTI. 2. During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was initially admitted on [DATE] and readmitted on [DATE]. Resident 10's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke- caused by a blocked blood vessel in the brain) affecting the right side, vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, damaging brain tissue), and neuromuscular dysfunction of the bladder (loss of bladder control caused by [NAME] damage). During a review of Resident 10's MDS, dated [DATE], the MDS indicated Resident 10's cognition was severely impaired. The MDS indicated Resident 10 was dependent on staff's assistance with toileting, bathing, and lower body dressing. The MDS indicated Resident 10 had an urinary catheter. During a review of Resident 10's H&P, dated 10/24/2025, the H&P indicated Resident 10 had fluctuating capacity to understand and make decisions. During a review of Resident 10's Physician Orders, dated 10/24/2025, the Physician Orders indicated to monitor Resident 10's urine for color, odor, and sediment every shift. During a review of Resident 10's Care Plan titled, Alteration in Urinary Elimination, dated 2/29/2024, the care plan indicated to monitor Resident 10's urine for sediment, cloudiness, odor, blood, and (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	amount of output. During observations on 3/9/2026 at 10:03 a.m., 3/9/2026 at 2:07 p.m., 3/10/2026 at 8:38 a.m., 3/10/2026 at 1:27 p.m., and 3/11/2026 at 8:15 a.m., in Resident 10's room, Resident 10 was observed lying in bed. The suprapubic catheter (an indwelling hollow tube inserted through a small incision in the lower abdomen into the bladder to drain or collect urine) bag hung on the left side of the bed frame. Resident 10's suprapubic catheter tubing had an off-white, thick, milky sediment present. During a concurrent observation and interview on 3/11/2026 at 9:10 a.m., with TN 1, in Resident 10's room, Resident 10 was observed lying in bed. The suprapubic catheter bag hung on the left side of the bed frame. Resident 10's subrapubic catheter tubing had an off-white, thick, milky sediment present. TN 1 stated Resident 10 had sediment in her urine which was visible in the urinary catheter tubing. During a concurrent interview and record review on 3/11/2026 at 9:15 a.m., with TN 1, Resident 10's TAR, dated 3/1/2026 through 3/31/2026, was reviewed. The TAR did not indicate the presence of urinary sediment from 3/9/2026 through 3/11/2026, TN 1 stated Resident 10's sediment should have been identified as early as possible because the presence of sediment could indicate an UTI. During a concurrent interview and record review, on 3/11/2026 at 10:07 a.m., with the IPN, photos of Resident 10's indwelling tubing, dated 3/9/2026 at 10:03 a.m., 3/9/2026 at 2:07 p.m., 3/10/2026 at 8:38 a.m., 3/10/2026 at 1:27 p.m., and 3/11/2026 at 8:15 a.m., were reviewed. The photos revealed sediment was present in the indwelling urinary catheter tubing. The IPN stated Resident 10's sediment should have been identified by the treatment nurses, licensed nurses, and/or CNAs because the sediment was present as early as 3/9/2026. The IPN stated the presence of urinary sediment could indicate an UTI and require antibiotic treatment. During an interview on 3/12/2026 at 9:22 a.m., with the DON, the DON stated the licensed nurses were responsible for monitoring the urine output, color, consistency, presence of sediment, and other signs of infections for residents with indwelling urinary catheters. The DON stated residents with indwelling urinary catheters were at a higher risk of developing a UTI and early identification of sediment could result in early treatment. The DON stated the delay in identifying sediment in Resident 10's urinary catheter placed her at risk of developing a UTI. During a review of the facility's policy and procedure (P&P) titled, Urinary Tract Infections/Bacteriuria, revised 1/2026, the P&P indicated nurses should observe, document, and report any signs and symptoms of a possible UTI. 3a. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE]. Resident 2's diagnoses included gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), dysphagia (difficulty swallowing), pedestrian on foot collision with a motor vehicle, and fractures (broken bones) of the vertebrae (spine), ribs, left tibia (leg bone), right femur (thigh bone), skull and facial bones. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 2 was dependent on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2's H&P, dated 6/15/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2's Physician Order, dated 2/7/2026, the Physician Order indicated indwelling urinary catheter. During observations made on 3/9/2026 at 9:30 a.m., 12:19 p.m. and 2:49 p.m., Resident 2's indwelling urinary catheter drainage bag was observed resting on the floor. 3b. During a review of Resident 34's admission Record, the admission Record indicated Resident 34 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 34's diagnoses included UTI, chronic kidney disease, Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), and muscle weakness. During a review of Resident 34's MDS, dated [DATE], the MDS indicated Resident 34's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 34 was dependent on staff for toileting, showering, and dressing. During a review of Resident 34's H&P, dated 1/1/2026, the H&P indicated Resident 34 did not have the capacity to understand and make decisions. During observations made on 3/9/2026 at 2:49 p.m. and 3/10/2026 at 12:29 p.m., observed Resident 34's indwelling urinary catheter drainage bag resting on the floor. During a concurrent interview and record review on 3/11/2026 at 9:10 a.m. with Registered Nurse (RN) 1, a photo of Resident 2's and Resident 34's urinary catheter drainage bag, dated 3/9/2026 and timed at 2:49 p.m., was reviewed. The photo revealed Resident 2 and 34's urinary catheter drainage bags resting on the floor. RN 1 stated the nurses were expected to keep the urinary catheter drainage bags off the floor to prevent contamination and reduce the risk of infection. RN 1 stated if Resident 2's and Resident 34's urinary catheter drainage bags were left touching the ground, the residents' drainage bags could become contaminated, which increased the risk of Resident 2 and Resident 34 developing a UTI. 4. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnosis included dementia (a progressive state of decline in mental abilities), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension (HTN- high blood pressure). During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 3 was dependent on staff for ADLs. During a review of Resident 3's H&P, dated 3/3/2026, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3's care plan titled The resident has Foley (indwelling) catheter., initiated revised 2/18/2026, the care plan indicated Resident 3 was to have no signs and symptoms of infection. The interventions indicated to monitor proper alignment of the Foley and Foley catheter (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bag. During observations on 3/10/2026 at 8:48 a.m., and 2:45 p.m., and on 3/11/2026 at 8:52 a.m., at Resident 3's bedside, Resident 3 was observed lying in bed. The Foley catheter drainage bag was observed on the left side of Resident 3's bed, touching the floor. During a concurrent observation and interview on 3/11/2026 at 8:52 a.m., with the DON, at Resident 3's bedside, Resident 3 was observed lying in bed. The Foley catheter drainage bag was directly on the floor on the left side of the bed. The DON stated the catheter drainage bag should be kept off the floor and below the level of the bladder to prevent contamination and backflow of the urine. The DON stated the catheter bag should not have been touching the floor because of infection control. The DON stated that when the bag was on the floor, bacteria from the floor could contaminate the drainage bag and travel into Resident 3's urine. The DON stated the Foley catheter drainage bag should be placed in a clean basin (container) when the resident was in bed. The DON stated failing to ensure Resident 3's catheter drainage bag was kept off the floor exposed the drainage bag to contamination. The DON stated this placed the resident at risk for infection, development of a catheter-associated UTI, and other preventable infection-related complications. During a review of the facility's P&P titled Catheter Care, Urinary, revised 1/2026, the P&P indicated the facility will ensure the catheter tubing and bag were kept off the floor to prevent catheter-associated urinary tract infections.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of 12 sampled residents (Resident 103 and Resident 31) were treated with dignity and respect.This deficient practice had the potential to cause Residents 103 and 31 to feel disregarded, humiliated, emotionally distressed, and also had the potential to compromise the residents' dignity and quality of life. Findings: a. During a review of Resident 103's admission Record, the admission Record indicated Resident 103 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 103's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and anxiety (a feeling of fear, unease and restlessness). During a review of Resident 103's Minimum Data Set ([MDS]- a resident assessment tool), dated 12/3/2025, the MDS indicated Resident 103's cognition (the ability to think and process information) was moderately impaired. The MDS indicated Resident 103 was dependent (helper does all the effort) on staff for 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 103's care plan titled Resident with mittens only during dialysis session., dated 6/13/2025, the care plan indicated Resident 103 would have mittens applied during her dialysis sessions and would be removed during ADLs and mealtimes. During an observation on 3/9/2026 at 12:26 p.m., at Resident 103's bedside, Resident 103 was observed lying in bed. Latex gloves were applied to both hands. During a concurrent observation and interview on 3/10/2026 at 12:27 p.m., with Certified Nursing Assistant (CNA) 4, in Resident 103's room, Resident 103 was observed sitting on a wheelchair with latex gloves to both hands. CNA 4 was providing care to Resident 103. CNA 4 stated the latex gloves were to prevent Resident 103 from scratching her lips and mouth. CNA 4 stated applying latex gloves did not maintain the resident's dignity. CNA 4 stated Resident 103 should be treated with dignity and respect. During an interview on 3/10/2026 at 1:21 p.m., with the Director of Nursing (DON), the DON stated the staff were expected to follow the resident's care plan and provide care in a manner that maintained dignity and respect. The DON stated latex gloves had the potential to cause humiliation and emotional distress. The DON stated the staff failed to ensure the Resident 103 was treated with dignity and respect. During a review of the facility's policy and procedure (P&P) titled Quality of Life - Dignity revised 1/2026, the P&P indicated residents shall be treated with dignity and respect at all times. The P&P indicated each resident shall be cared for in a manner that promotes and enhance quality of life. b. During a review of Resident 31's admission Record, the admission Record indicated Resident 31 was admitted to the facility on [DATE]. Resident 31's diagnoses included diabetes mellitus (DM- a (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disorder characterized by difficulty in blood sugar control), blindness glaucoma (an eye disease that damages the eye and can slowly cause blindness), low vision of the right eye, blindness to the left eye, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on the side of the body, like one arm and one leg not working as well) affecting the left dominant side. During a review of Resident 31's History and Physical (H&P) dated 10/20/2025 indicated Resident 31 did not have the capacity to understand and make decisions. During a review of Resident 31's MDS dated [DATE] indicated Resident 31's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 31 required set-up assistance for oral hygiene, personal hygiene, and upper body dressing. During an observation on 3/10/2026 at 7:51 a.m., in Resident 31's room, Resident 31 was observed seated upright at the edge of the bed. Resident 31 was eating his breakfast using his hands. Oatmeal, eggs, and juice were observed on Resident 31's clothing, lap, and bed linens. There were no staff providing feeding assistance to Resident 31. During a concurrent observation and interview on 3/10/2026 at 7:53 a.m. with CNA 1, in Resident 31's room, Resident 31 was observed seated upright at the edge of the bed. CNA 1 stated she was busy with other residents and did not know if Resident 31 was an assigned feeder for the day. During an interview on 3/10/2026 at 8:03 a.m. with Resident 31, Resident 31 stated he always feeds himself and did not remember staff assisting him during meals. Resident 31 stated, I am legally blind and I feel like I don't matter in this facility. During a concurrent interview and record review on 3/12/2026 at 12:56 p.m. with the Director of Staff Development (DSD), the facility's document titled Assigned Feeders dated 3/10/2026 was reviewed. The Assigned Feeders document indicated CNA 1 was assigned to Resident 31 and another resident for feeding assistance during the day shift (7:00 a.m. to 3:00 p.m.). The DSD stated she overlooked the daily assignment. The DSD stated CNA 1 should only be assigned to assist one resident with feeding per shift. During an interview on 3/12/2026 at 11:35a.m. with the Director of Nursing (DON), the DON stated staff must ensure residents receive meals with dignity. The DON stated staff assigned to feeder residents should promote a sense of belonging so residents feel respected.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain and/or renew informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for psychotropic medication (a drug that changes brain function and results in alterations in perception, mood, consciousness or behavior) for two of six sampled residents (Resident 103 and Resident 41), by failing to:1. Obtain informed consent from Resident 103 and/or their responsible party (RP) for the administration of Olanzapine (a medication used to treat schizophrenia [a mental illness that is characterized by disturbances in thought] and bipolar disorder [sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs]) 2.5 milligram ([mg]- a unit of dose measurement).2. Ensure Resident 41's informed consent for Depakote (a medication used to treat mood disorder and seizure [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) and Seroquel (antipsychotic medication used to treat schizophrenia) was renewed every six months.These deficient practices had the potential to result in Residents 103 and 41 receiving psychotropic medication without consent. Findings: a. During a review of Resident 103's admission Record, the admission Record indicated Resident 103 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 103's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 103's Minimum Data Set (MDS- a resident assessment tool), dated [DATE], the MDS indicated Resident 103's cognitive (the ability to think and process information) skills for daily decision making was moderately impaired. The MDS indicated Resident 103 was dependent (helper does all the effort) on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 103 received antipsychotic medication. During a review of Resident 103's physician order, dated [DATE], the physician order indicated Resident 103 was to receive Olanzapine (antipsychotic medication) 2.5 milligrams ([mg]- metric unit of measurement, used for medication dosage and/or amount) daily for schizophrenia. During a review of Resident 103's Medication Administration Record (MAR) dated [DATE] through [DATE] and [DATE] through [DATE], the MAR indicated Olanzapine 2.5 was administered daily, a total of 39 doses. During a concurrent interview and record review on [DATE] at 1:10 p.m., with the Director of Nursing (DON), Resident 103's medical records were reviewed. The medical records did not indicate written informed consent was obtained for the administration of Olanzapine 2.5 mg prior to initiation. The DON stated informed consent should be obtained and documented prior to initiating and/or making dosage changes to Olanzapine to ensure the resident and/or RP were aware of the medication's intended purpose, potential benefits, possible risks and side effects, and available alternatives. The DON stated residents and their RP had the right to be informed and provided the opportunity to accept or refuse treatment. (continued on next page)

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	055045	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riviera Healthcare Center	8203 Telegraph Rd Pico Rivera, CA 90660

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. During a review of Resident 41's admission Record, the admission Record indicated Resident 41 was admitted to the facility on [DATE]. Resident 41's diagnoses included dementia (a progressive state of decline in mental abilities), metabolic encephalopathy (a change in how the brain works due to an underlying condition), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), hypertension (HTN- high blood pressure), and hyperlipidemia (high cholesterol). During a review of Resident 41's History and Physical (H&P), dated [DATE], the H&P indicated Resident 41 had fluctuating capacity to understand and make decisions. During a review of Resident 41's MDS, dated [DATE] the MDS indicated Resident 41's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 41 required supervision or touching assistance from staff for toileting, showering, and lower body dressing. During a review of Resident 41's physician orders dated [DATE], the physician orders indicated Resident 41 was to receive Depakote Oral Capsule Delayed Release Sprinkle 125 mg. Give 2 capsules by mouth every 12 hours for mood swings. During a review of Resident 41's physician order dated [DATE], the physician order indicated Resident 41 was to receive Seroquel Oral Tablet 50 mg. Give 1 tablet by mouth one time a day for psychosis manifested by angry outburst. During a concurrent interview and record review on [DATE] at 2:27 p.m., with the DON, Resident 41's consent forms were reviewed. The DON stated that the consent forms for Depakote and Seroquel had not been renewed as required. The DON stated that this failure did not meet facility policy or regulatory standards and should have been completed to ensure compliance and protection of resident rights. The DON stated that it was the facility's responsibility to ensure that informed consent for all prescribed medications were obtained, current, and maintained in the resident's medical record. The DON stated consents must be renewed at least every six months, including when medications were continued over time or when prior consents have expired. The DON stated that medications such as Depakote and Seroquel required documented informed consent due to their potential risks and side effects, and that failure to maintain current consent forms may result in residents or resident representatives not being fully informed regarding treatment. During a review of the facility's policy and procedure (P&P) titled Informed Consent, revised 1/2026, the P&P indicated the facility would ensure residents' rights to informed consent for psychotherapeutic drugs. The P&P indicated renewal every 6 months, and provide written notice of dosage changes.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain resident rooms in good repair and ensure a functioning television was provided for two of 12 sampled residents (Resident 64 and Resident 76).These deficient practices had the potential to negatively impact Residents 64 and 76's well-being and contributed to an environment that did not promote comfort and homelike atmosphere. Findings: a. During a review of Resident 64's admission Record, the admission Record indicated Resident 64 was admitted to the facility on [DATE]. Resident 64's diagnoses included hypertension (HTN- high blood pressure), dementia (a progressive state of decline in mental abilities), epilepsy (a chronic brain disorder characterized by recurring, unprovoked movements caused by abnormal electrical activity), dysphagia (difficulty swallowing) and splenomegaly (an enlarged spleen, an organ in the upper left abdomen that filters blood and supports the immune system). During a review of Resident 64's History and Physical (H&P), dated 3/4/2026, the H&P indicated Resident 64 had fluctuating capacity to understand and make decisions. During a review of Resident 64's Minimum Data Set (MDS, a resident assessment tool), dated 12/28/2026 the MDS indicated Resident 64's cognitive skills (ability to think and reason) for daily decision making were severely impaired. The MDS indicated Resident 64 was dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During an observation on 3/9/2026 at 10:18 a.m., in Resident 64's room, observed a vertical indent with chipped paint and exposed underlying material, measuring approximately nine inches in length and four inches in width on the wall directly above and adjacent to the right side of Resident 64's bed. Resident 64's bed rail was touching the damaged area on the wall. During a concurrent observation and interview on 3/10/2025 at 3:46 p.m., in Resident 64's room, with the Director of Nursing (DON), Resident 64's bed and wall were observed. The DON stated that resident care areas should be maintained in good repair and free from damaged surfaces to ensure a clean, sanitary, and safe environment. The DON stated the bed placed against the wall potentially caused the wall damage. The DON stated that the wall damage should have been reported to the maintenance department and repaired immediately. The DON stated that the surfaces with chipped paint or exposed material could not be properly cleaned and disinfected, which may increase the risk of infection and did not meet facility standards for maintenance and infection control. During a concurrent observation and interview on 3/11/2026 at 8:30 a.m., with the Maintenance Supervisor (MS), the MS stated that walls should be promptly repaired when scrapes or holes were present to ensure proper maintenance of the environment. The MS stated resident rooms were expected to always maintain a home-like environment. The MS stated the wall scraping and damage were consistent with the bed being positioned too close to the wall and being moved up and down during care activities, such as cleaning or assisting Resident 64. The MS stated the wall damage would have been prevented if the bed had been positioned at an appropriate distance from the wall. The MS stated nursing staff are responsible for reporting repair needs to the maintenance department when issues related to room integrity are identified. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. During a review of Resident 76's admission Record, the admission Record indicated Resident 76 was admitted to the facility on [DATE]. Resident 76's diagnoses included HTN, dysphagia, and muscle weakness. During a review of Resident 76's H&P dated 2/15/2026, the H&P indicated Resident 76 had the capacity to understand and make decisions. During a review of Resident 76's MDS, dated [DATE], the MDS indicated Resident 76's cognition was intact. The MDS indicated Resident 76 required maximum (helper does more than half the effort) assistance form staff for ADLs. During a concurrent observation and interview on 3/9/2026 at 12:48 p.m., with Resident 76, at Resident 76's bedside, Resident 76 was observed sitting on the bed looking at the television screen. Resident 76's television was nonfunctioning. Resident 76 stated his television had not been working for approximately two weeks. Resident 76 stated he informed an unidentified staff but no action was taken to repair or replace the television. Resident 76 stated he felt pissed off because he was not able to watch television in his room. During a concurrent observation and interview on 3/10/2026 at 1:30 p.m., with the DON, in Resident 76's room, Resident 76's television was nonfunctioning. The DON stated Resident 76's television should be maintained in working condition and issues reported by the residents should be addressed promptly. The DON stated allowing Resident 76's television to remain non-functional did not promote a comfortable and homelike environment. During a review of the facility's policy and procedures (P&P) titled Quality of Life – Homelike Environment. revised 1/2026, the P&P indicated Residents are provided with a safe, clean, comfortable and homelike environment. The facility staff and management shall minimize, to the extent possible, the characteristics of the facility that reflects homelike setting. These characteristics include: clen, sanitary and orderly environment. During a review of the P&P titled, Bed Safety revised 1/2026, the P&P indicated Our facility shall strive to provide a safe sleeping environment for the resident. During a review of the P&P titled, Maintenance Service revised 1/2026, the P&P indicated Maintenance services shall be provided to all areas of the building, grounds and equipment. The maintenance department is responsible for maintaining the buildings, grounds and equipment in a safe and operable manner at all times. Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. Maintaining the building in good repair and free from hazards.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one of six sampled residents (Resident 64) was free from the use of an unauthorized physical restraint when the resident's bed was positioned directly against the wall.This deficient practice had the potential to restrict Resident 64's freedom of movement and function as a physical restraint negatively impacting Resident 64's psychosocial well-being.Findings:During a review of Resident 64's admission Record, the admission Record indicated Resident 64 was admitted to the facility on [DATE]. Resident 64's diagnoses included hypertension (HTN- high blood pressure), dementia (a progressive state of decline in mental abilities), epilepsy (a chronic brain disorder characterized by recurring, unprovoked movements caused by abnormal electrical activity), dysphagia (difficulty swallowing) and splenomegaly (an enlarged spleen, an organ in the upper left abdomen that filters blood and supports the immune system).During a review of Resident 64's History and Physical (H&P), dated 3/4/2026, the H&P indicated Resident 64 had fluctuating capacity to understand and make decisions.During a review of Resident 64's Minimum Data Set ([MDS], a resident assessment tool), dated 12/28/2026 the MDS indicated Resident 64's cognitive skills (ability to think and reason) for daily decision making were severely impaired. The MDS indicated Resident 64 was dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During concurrent observation and interview on 3/10/2025 at 3:46 p.m., in Resident 64's room, with the Director of Nursing (DON), Resident 64's bed was positioned directly against the bedroom wall. The DON stated the damage on the wall correlated with the bed being directly against the wall. The DON stated that placing a resident's bed directly against the wall could be considered a form of physical restraint if it restricted Resident 64's ability to freely move. The DON stated the beds should not be positioned against the wall unless there were a physician's order and proper assessment supporting the need. The DON stated residents have the right to move freely, and positioning the bed against the wall may impede that movement and limit residents' independence. The DON stated that this practice is not in accordance with the facility policy and should not have occurred, as it had the potential to negatively impact the Resident 64's safety, dignity, and psychosocial well-being.During a review of the facility's policy and procedure (P&P) titled Use of Restraints. revised 1/2026, the P&P indicated The facility promotes a restraint-free environment and ensures every resident has the right to be free from any physical or chemical restraints.During a review of the P&P titled, Bed Safety revised 1/2026, the P&P indicated Our facility shall strive to provide a safe sleeping environment for the resident.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a PRN (as needed) order for Ativan (a psychotropic medication- drug that affects mental processes, moods, and behaviors) was not continued beyond 14 days for two of six sampled residents (Residents 103 and 83). This deficient practice placed Residents 103 and 83 at risk for continued use of unnecessary psychotropic medication without timely physician reassessment and had the potential for Resident 103 and 83 to be chemically restrained by the administration of unnecessary psychotropic medication, and/or suffer extrapyramidal symptoms (a group of movement disorders that can occur because of certain medications, particularly antipsychotics) due to prolonged use.Findings:a. During a review of Resident 103's admission Record, the admission Record indicated Resident 103 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 103's diagnosis included schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (a feeling of fear, unease and restlessness). During a review of Resident 103's Minimum Data Set ([MDS]- a resident assessment tool), dated 12/3/2025, the MDS indicated Resident 103's cognition (the ability to think and process information) was moderately impaired. The MDS indicated Resident 103 was dependent (helper does all the effort) on staff for activity 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 103's physician order, dated 3/10/2026, the physician order indicated to administer Ativan (a psychotropic medication- drug that affects mental processes, moods, and behaviors) 1 milligrams ([mg]- metric unit of measurement, used for medication dosage and/or amount), one (1) tablet by mouth every six (6) hours as needed for anxiety. The order indicated to continue the medication for 60 days with stop date of 5/9/2026. During a telephone interview and record review on 3/11/2026 at 1:45 p.m., with the Psychiatrist (PST), Resident 103's physician order, dated 3/10/2026, was reviewed. The physician order indicated to administer Ativan 1 mg, 1 tablet by mouth every 6 hours as needed for anxiety. The order indicated the medication was to continue for 60 days with stop date of 5/9/2026. The PST stated Resident 103's physician order for Ativan exceeded the 14 days PRN requirement. The PST stated the resident should be reevaluated every 14 days and the clinical justification documented if the PRN psychotropic medication was to continue beyond 14 days. b. During a review of Resident 83's admission Record, the admission Record indicated Resident 83 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 83's diagnosis included anxiety, and major depression disorder. During a review of Resident 83's MDS, dated [DATE], the MDS indicated Resident 83's cognition was moderately impaired. The MDS indicated Resident 83 was dependent on staff for ADLs. During a review of Resident 83's physician order, dated 2/9/2026, the physician order indicated to administer Ativan 1 mg one (1) tablet by mouth every six (6) hours as needed for anxiety. The order indicated the medication was to continue for 60 days with stop date of 4/10/2026. During a review of Resident 83's Medication Administration Record (MAR), dated 2/9/2026 through 2/28/2026 and 3/1/2026 through 3/11/2026, the MAR indicated Ativan 1 mg was administered daily. The MAR indicated Resident 83 received Ativan 1 mg a total of 31 doses. During a concurrent interview and record review on 3/11/2026 at 2:55 p.m., with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled Antipsychotic Medication Use, revised 1/2026, were reviewed. The DON stated the P&P indicated the resident's PRN orders for psychotropic medication was to be written by a physician for specific time period. The DON stated the P&P indicated PRN orders for psychotropic medications will not be renewed beyond 14 days. The DON stated Resident 103 and Resident 83's Ativan orders were not in alignment with the facility's P&P. The DON stated the purpose of the 14-day limit was to ensure the continued need for the psychotropic medication was clinically justified to prevent unnecessary use of such medications.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an abuse allegation to the State Agency (California Department of Public Health [CDPH]), the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities), and local law enforcement for two of two sampled residents (Residents 7 and 61), after Resident 7 allegedly touched Resident 61's genitals (external reproductive organ).This deficient practice resulted in a delay of an onsite investigation by CDPH and had the potential to result in abuse to all residents in the facility.Findings:1. During a review of Resident 61's admission Record, the admission Record indicated Resident 61 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 61's diagnoses included type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic kidney disease (kidney damage that occurs over time), hypertension (high blood pressure).During a review of Resident 61's Minimum Data Set (MDS- a resident assessment tool), dated 1/15/2026, the MDS indicated Resident 61's cognition (process of thinking) was intact. The MDS indicated Resident 61 was independent with eating, oral hygiene, and toileting.During a review of Resident 61's History and Physical (H&P), dated 9/16/2025, the H&P indicated Resident 61 had the capacity to understand and make decisions.During an interview on 3/10/2026 at 12:50 p.m., with Resident 61, Resident 61 stated, on 1/29/2026, while he was sleeping, Resident 7 tried to touch his genitals. Resident 61 stated he was very upset and told Licensed Vocational Nurse (LVN) 3. Resident 61 stated after the incident, Resident 7 was sent out of the facility and was placed in a different room upon his return.2. During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 7's diagnoses included dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (a mental health condition characterized by excessive fear or worry that interferes with daily life).During a review of Resident 7's MDS, dated [DATE], the MDS indicated Resident 7's cognition was severely impaired. The MDS indicated Resident 7 required setup or clean-up assistance with oral hygiene, upper body dressing, and personal hygiene.During a review of Resident 7's H&P, dated 2/7/2026, the H&P indicated Resident 7 had fluctuating (changing) capacity to understand and make decisions.During a review of Resident 7's Change in Condition (COC), dated 1/29/2026, the COC indicated, on 1/29/2026, Resident 7 had sexually inappropriate behavior towards Resident 61. The COC indicated an order to send Resident 7 to the general acute care hospital (GACH) for behavior evaluation.During an interview on 3/10/2026 at 12:20 p.m., with LVN 3, LVN 3 stated, on 1/29/2026, Resident 61 informed her that Resident 7 tried to touch his genitals. LVN 3 stated Resident 61 was very upset about the incident. LVN 3 stated after separating Residents 7 and 61 she reported the incident to Registered Nurse (RN) 1 and the Administrator (ADM). LVN 3 stated she reported the incident to the ADM because it is a sensitive situation and could be seen as an allegation of sexual abuse. LVN 3 stated the ADM was the abuse coordinator and all abuse allegations were reported to him.During an interview on 3/12/2026 at 10:18 a.m., with the ADM, the ADM stated he was the abuse coordinator and was responsible for reporting all abuse allegations to CDPH, law enforcement, and Ombudsman. The ADM stated the staff had the ability to report to the three reporting agencies, however, the staff were responsible for notifying him to ensure that not only the allegation was reported but investigated. The ADM stated immediate reporting was necessary to ensure a thorough investigation was carried out by not only him but by CDPH.During a review of the facility's Policy and Procedure (P&P) titled, Abuse Investigation and Reporting, revised 1/2026, the P&P indicated all alleged violations involving abuse, neglect, exploitation, or mistreatment would be reported by the facility's Administrator or designee to the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	state licensing/certification agency, the local/State ombudsman, and law enforcement officials immediately but no later than two hours.

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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 observation, interview, and record review, the facility failed to develop a comprehensive, person-centered care plan for four of eight sampled residents (Resident 61, Resident 93, Resident 41, and Resident 14) for the following:1. Resident 61 was allegedly touched sexually and inappropriately by another resident.2. Resident 93, who had out-on pass privileges, and a known history of alcohol use and relapse (resumption of drinking alcohol after a period of abstinence, often involving a return to previous levels of heavy consumption) behaviors.3. Resident 41's use of Depakote (an anticonvulsant medication, used to treat seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] and other behavioral conditions) and Seroquel (an antipsychotic medication [a medication that affects the mind, emotions, and behavior]). 4. Resident 14's use of dentures (removable, custom-made appliances to replace missing teeth and gum tissue). These deficient practices had the potential to negatively affect Residents 61, 93, 41, and 14's physical, mental, and psychosocial well-being and had the potential to delay in the delivery of necessary care and services.Cross Reference F684 and F842. Findings:a. During a review of Resident 61's admission Record, the admission Record indicated Resident 61 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 61's diagnoses included type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic kidney disease (kidney damage that occurs over time), and hypertension (high blood pressure).During a review of Resident 61's Minimum Data Set (MDS- a resident assessment tool), dated 1/15/2026, the MDS indicated Resident 61's cognition (process of thinking) was intact. The MDS indicated Resident 61 was independent with eating, oral hygiene, and toileting.During a review of Resident 61's History and Physical (H&P), dated 9/16/2025, the H&P indicated Resident 61 had the capacity to understand and make decisions.During an interview on 3/10/2026 at 12:20 p.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated on 1/29/2026, Resident 61 informed her that his roommate tried to touch his genitals. LVN 3 stated Resident 61 was very upset.During an interview on 3/10/2026 at 12:50 p.m., with Resident 61, Resident 61 stated, on 1/29/2026, his roommate tried to touch his genitals while he was sleeping. During a concurrent interview and record review on 3/12/2026 at 7:54 a.m., with LVN 3, Resident 61's Care Plans, active and resolved from 1/29/2026 through 3/12/2026, were reviewed. The care plans did not indicate a care plan was developed to address Resident 61's allegation of being inappropriately touched by his roommate. LVN 3 stated after the incident between Resident 61 and his roommate, on 1/29/2026, a care plan should have been developed. LVN 3 stated care plans were used to guide the nurses on Resident 61's plan of care. LVN 3 stated developing a care plan was important to ensure necessary interventions were carried out such as providing emotional support and psychosocial monitoring.During an interview on 3/12/2026 at 10:02 a.m., with the Director of Nursing (DON), the DON stated care plans should always be developed after a change in condition, specifically after an abuse allegation was made. The DON stated Resident 61 did not have a care plan to address his allegation against his roommate, who allegedly touched Resident 61 inappropriately. The DON stated without a care plan, the nurses may not monitor Resident 61 for psychosocial distress which could result in undetected trauma. b. During a review of Resident 93's admission Record, the admission Record indicated Resident 93 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 93's diagnoses included alcohol abuse, other stimulant abuse, alcoholic cirrhosis (scarring) of the liver, hepatic encephalopathy (serious brain dysfunction caused by liver failure), end stage renal disease (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(irreversible kidney failure), noncompliance with medical treatment, and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 93's MDS, dated [DATE], the MDS indicated Resident 93's cognitive skills for daily decision making were intact. The MDS indicated Resident 93 required moderate assistance (helper does less than half of the effort) for 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 93's H&P dated 1/21/2026, the H&P indicated Resident 93 had the capacity to understand and make decisions. During a record review of Resident 93's Change of Condition (COC) Note, dated 7/10/2025, the COC note indicated on 7/10/2025, Resident 93 returned from an out-on-pass visit intoxicated, as evidenced by smell, slurred speech, drowsiness, impaired coordination, and two episodes of vomiting. During a record review of Resident 93's Nursing Progress Note, dated 2/23/2026, the note indicated on 2/23/2026, Resident 93 returned from an out on pass visit with agitation and bleeding to the right side of his lip. The note indicated Resident 93 was holding a brown paper bag containing items and he refused inspection per facility protocol. During a concurrent record review and interview on 3/12/2026 at 10:31 a.m. with the Assistant Director of Nursing (ADON), all of Resident 93's care plans were reviewed. The care plans did not indicate interventions including monitoring, assessing for alcohol use, and re-educating Resident 93 on the risks of alcohol consumption were implemented. The ADON stated Resident 93 had a known history of alcohol use while out on pass. The DON stated there were no care plan interventions addressing Resident 93's continued out-on-pass privileges with known history of alcohol use. The ADON stated proper care plan interventions should have included monitoring behaviors, assessing for alcohol use, and re-educating Resident 93 on the risks of alcohol consumption. The ADON stated the lack of care plan interventions placed Resident 93 at risk for continued alcohol use, adverse health outcomes, and potential drug to drug interactions. c. During a review of Resident 41's admission Record, the admission Record indicated Resident 41 was admitted to the facility on [DATE]. Resident 41's diagnoses included dementia (a progressive state of decline in mental abilities), metabolic encephalopathy (a change in how the brain works due to an underlying condition), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), hypertension (HTN- high blood pressure), and hyperlipidemia (high cholesterol). During a review of Resident 41's H&P, dated 8/14/2025, the H&P indicated Resident 41 had fluctuating capacity to understand and make decisions. During a review of Resident 41's MDS, dated [DATE] the MDS indicated Resident 41's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 41 required supervision or touching assistance from the staff for toileting, showering, and lower body dressing. During a review of Resident 41's physician order dated 9/30/2025, the physician order indicated Resident 41 was to receive Depakote Oral Capsule Delayed Release Sprinkle 125 milligrams ([mg]-metric unit of measurement, used for medication dosage and/or amount). Give 2 capsules by mouth (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	every 12 hours for mood swings. During a review of Resident 41's physician order dated 10/29/2025, the physician order indicated Resident 41 was to receive Seroquel Oral Tablet 50 mg. Give 1 tablet by mouth one time a day for psychosis manifested by angry outburst. During an interview on 3/12/2026 at 2:17 p.m., with the DON, the DON stated that it was the facility's expectation and standard of practice that all active medications be incorporated into the resident's comprehensive care plan. The DON stated that care plans were essential to ensure staff awareness of the medication's purpose, required monitoring parameters, and potential adverse effects, and to promote consistent, individualized care and resident safety. The DON stated that the failure to include the administration of Depakote and Seroquel in Resident 41's care plan did not meet facility standards and should have been completed. d. During a review of Resident 14's admission Record, the admission Record indicated Resident 14 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 14's diagnoses included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and hypertension (HTN- high blood pressure). During a review of Resident 14's MDS, dated [DATE], the MDS indicated Resident 14's cognitive skills for daily decision making was intact. The MDS indicated Resident 14 required maximum assistance from staff with ADLs. During a concurrent observation and interview on 3/9/2026 at 1:45 p.m., with Resident 14, at Resident 14's bedside, Resident 14's dentures were observed on the top of the bedside table. Resident 14 stated she used her dentures during meals. During a concurrent interview and record review on 3/11/2026 at 8:23 a.m., with the ADON, Resident 14's medical records were reviewed. The medical records did not indicate a care plan related to Resident 14's use of dentures. The ADON stated a care plan should have been developed to address Resident 14's use of dentures, including interventions to ensure safe use of dentures, monitoring of oral health status, and staff awareness of the resident's needs related to dentures care. During an interview on 3/12/2026 at 9:45 a.m., with the DON, the DON stated residents with dentures should have an individualized care plan to ensure the residents' needs were addressed, communicated, and coordinated with staff for continuity of care and services. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person Centered dated 1/2026, 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. Care plans reflect treatment goals, timetables and objectives in measurable outcomes. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents condition changes.

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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 interview and record review, the facility failed to revise two of three sampled residents' (Resident 6 and Resident 104) care plans after testing positive for influenza A (a contagious viral infection that affects the respiratory system).This deficient practice had the potential to negatively affect Residents 6 and 104's physical well-being and had the potential to delay the delivery of necessary care and services.Findings:a. During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 6's diagnoses included encephalopathy (damage or brain disease that alters the brain's function), dementia (a progressive state of decline in mental abilities), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool), dated 1/5/2026, the MDS indicated Resident 6's cognition (process of thinking) was intact. The MDS indicated Resident 6 was dependent on staff's assistance with eating, oral hygiene, toileting, bathing, dressing, and personal hygiene.During a review of Resident 6's History and Physical (H&P), dated 1/2/2026, the H&P indicated Resident 6 did not have the capacity to understand and make decisions.During a review of Resident 6's Change in Condition (COC), dated 3/5/2026, the COC indicated Resident 6 had a nonproductive cough (cough that does not produce mucus) and audible phlegm (mucus). The COC indicated order to test for influenza (a contagious viral infection that affects the respiratory system).During a review of Resident 6's Lab Results Report, dated 3/6/2026, the Lab Results Report indicated Resident 6 was positive for influenza A.During a review of Resident 6's COC, dated 3/7/2026, the COC indicated Resident 6 tested positive for influenza A. The COC indicated order to initiate isolation precaution (procedure to separate sick people from healthy and to prevent the spread of germs) per facility protocol and to start Tamiflu (medication to treat influenza) 75 milligrams (mg, a unit of measurement), twice a day for five days.During a concurrent interview and record review, on 3/11/2026 at 10:17 a.m., with the Infection Preventionist Nurse (IPN), Resident 6's Care Plan titled, Nonproductive Cough and Audible Phlegm, dated 3/5/2026, was reviewed. The Care Plans interventions indicated to test for influenza, encourage deep breathing and coughing exercise, and monitor vital signs. The IPN stated Resident 6's Care Plan was not revised when Resident 6 tested positive for influenza A. b. During a review of Resident 104's admission Record, the admission Record indicated Resident 104 was admitted to the facility on [DATE] with diagnoses that included epilepsy (chronic brain disorder characterized by recurring seizures [sudden burst of uncontrolled electrical activity in the brain that disrupts normal function]), end stage renal disease (irreversible kidney failure), and hypertension (high blood pressure).During a review of Resident 104's MDS, dat3ed 2/18/2026, the MDS indicated Resident 104's cognition was intact. The MDS indicated Resident 104 required moderate assistance (helper does less than half the effort) with oral hygiene, upper body dressing, and personal hygiene.During a review of Resident 104's H&P, dated 2/16/2026, the H&P indicated Resident 104 had the capacity to understand and make decisions.During a review of Resident 104's COC, dated 3/4/2026, the COC indicated Resident 104 complained of cough, sore throat, and body aches and had two episodes of emesis (vomit). The COC indicated order to test for influenza.During a review of Resident 104's Lab Results Report, dated 3/7/2026, the Lab Results Report indicated Resident 104 tested positive for influenza A.During a review of Resident 104's COC, dated 3/7/2026, the COC indicated Resident 104 tested positive for influenza A. The COC indicated order to initiate droplet isolation precautions (infection control measures used to prevent the spread of pathogens transmitted through close respiratory contact) and start Tamiflu 75mg twice a day for five days. During a concurrent interview and record review, on 3/11/2026 at 10:17 a.m., with the IPN, Resident 104's Care Plan titled, Flu-like Symptoms and Two Episodes of Emesis, dated 3/4/2026, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was reviewed. The Care Plan's interventions indicated to monitor vital signs and assess for worsening symptoms. The IPN stated Resident 6's Care Plan was not revised when Resident 6 tested positive for influenza A.During an interview on 3/11/2026 at 10:19 a.m., with the IPN, the IPN stated Residents 6 and 104's Care Plans were not revised with their positive influenza A diagnosis and additional interventions. The IPN stated revising the care plan was necessary to know how to treat and monitor Residents 6 and 104. The IPN stated Residents 6 and 104 were on Tamiflu to treat influenza A and there should have been interventions to monitor for adverse reactions. The IPN stated without the necessary revisions, Residents 6 and 104 were at risk of treatment and other interventions not being carried out.During an interview on 3/12/2026 at 9:36 a.m., with the Director of Nursing (DON), the DON stated after Residents 6 and 104 tested positive for influenza A, their care plans should have been revised. The DON stated interventions should have included the treatment of Tamiflu and additional monitoring. The DON stated without a revised care plan, Residents 6 and 104 were at risk of not receiving the appropriate care.During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 1/2026, the P&P indicated, Assessments of residents are ongoing and care plans are revised as information about the residents' conditions change.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct 72-hour monitoring for two of two sampled residents (Resident 61 and Resident 7), after an allegation of sexual abuse.This deficient practice had the potential to result in a decline in Resident 61's psychosocial well being and potential for Resident 7's sexually inappropriate behavior being undetected.Cross Reference F609 and F842.Findings:1. During a review of Resident 61's admission Record, the admission Record indicated Resident 61 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 61's diagnoses included type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic kidney disease (kidney damage that occurs over time), hypertension (high blood pressure).During a review of Resident 61's Minimum Data Set (MDS- a resident assessment tool), dated 1/15/2026, the MDS indicated Resident 61's cognition (process of thinking) was intact. The MDS indicated Resident 61 was independent with eating, oral hygiene, and toileting.During a review of Resident 61's History and Physical (H&P), dated 9/16/2025, the H&P indicated Resident 61 had the capacity to understand and make decisions.During an interview on 3/10/2026 at 12:50 p.m., with Resident 61, Resident 61 stated, on 1/29/2026, while he was sleeping, Resident 7 tried to touch his genitals. Resident 61 stated he was very upset and told Licensed Vocational Nurse (LVN) 3. Resident 61 stated after the incident, Resident 7 was sent out of the facility and was placed in a different room upon his return.During a concurrent interview and record review on 3/10/2026 at 12:32 p.m., with Licensed Vocational Nurse (LVN) 3, Resident 61's Progress Notes, dated 1/29/2026 through 2/3/2026, were reviewed. The Progress Notes did not indicate Resident 61 was monitored for psychosocial distress following the allegation of sexual abuse from Resident 7 on 1/29/2026. LVN 3 stated Resident 61 should have been monitored for at least 72-hours. LVN 3 stated monitoring Resident 61's psychosocial well-being was important to provide additional resources if Resident 61 felt emotional or psychosocial distress. During an interview on 3/11/2026 at 11:24 a.m., with the Social Services Director (SSD), the SSD stated she was not aware of the details of the incident between Residents 61 and 7 and did not know Resident 61 was the alleged victim. The SSDD stated 72-hour monitoring for Resident 61's psychosocial well-being should have been conducted from the nursing and social services department. The SSD stated throughout the monitoring, psychosocial support would have been given to Resident 61. The SSD stated without the appropriate psychosocial monitoring, Resident 61 could experience trauma from the incident which could be unnoticed and services would not be provided.During a review of the facility's policy and procedure (P&P) titled, Abuse and Neglect, revised 1/2026, the P&P indicated, The staff and physician will monitor individuals who have been abused at least until their medical condition, mood, and function have stabilized, and periodically thereafter.2. During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 7's diagnoses included dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (a mental health condition characterized by excessive fear or worry that interferes with daily life).During a review of Resident 7's MDS, dated [DATE], the MDS indicated Resident 7's cognition was severely impaired. The MDS indicated Resident 7 required setup or clean-up assistance with oral hygiene, upper body dressing, and personal hygiene.During a review of Resident 7's H&P, dated 2/7/2026, the H&P indicated Resident 7 had fluctuating capacity to understand and make decisions.During a review of Resident 7's Change in Condition (COC), dated 1/29/2026, the COC indicated, on 1/29/2026, Resident 7 was transferred to the general acute care hospital (GACH) for behavior evaluation. During a concurrent interview and record review on 3/10/2026 at 12:33 p.m., with LVN 3, Resident 7's Progress Notes, dated 2/6/2026 through 2/9/2026, were reviewed. The Progress Notes indicated, on 2/6/2026, Resident 7 was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	readmitted to the facility with a medical diagnosis of bizarre behavior. The Progress Notes indicated Resident 7 was monitored for 72 hours upon readmission to the facility but did not indicate monitoring for sexually inappropriate behavior. LVN 3 stated Resident 7 was sent to the GACH for evaluation for sexually inappropriate behavior towards another resident. LVN 3 stated Resident 7 was not monitored for sexually inappropriate behaviors when he was readmitted to the facility. LVN 3 stated monitoring Resident 7 for sexually inappropriate behavior during his readmission was important to identify recurrent episodes and intervene immediately. During an interview on 3/12/2026 at 9:48 a.m., with the Director of Nursing (DON), the DON stated when Resident 7 was readmitted to the facility, the licensed nurses were responsible for monitoring Resident 7 for inappropriate sexual behavior. The DON stated this monitoring was necessary to determine whether Resident 7's treatment at the GACH was effective or if additional referrals were needed. The DON stated Resident 7 was at risk of undetected inappropriate sexual behavior and delay in treatment.During a review of the facility's P&P titled, Abuse and Neglect, revised 1/2026, the P&P indicated, The facility management and staff will institute measures to address the needs of residents/patients and minimize the possibility of abuse and neglect.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure intravenous (IV, administered directly into the blood stream) tubing (the tubing that allows medication to flow into the resident's blood stream) was labeled with the date and time for one of three sampled residents (Resident 87).This deficient practice had the potential to result in a bloodstream infection for Resident 87.Findings:During a review of Resident 87's admission Record, the admission Record indicated Resident 87 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 87's diagnoses included muscle weakness, dementia (a progressive state of decline in mental abilities), and hypertension (high blood pressure).During a review of Resident 87's Minimum Data Set ([MDS], a resident assessment tool), dated 1/28/2026, the MDS indicated Resident 87's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 87 required set-up assistance for oral hygiene, toileting, and upper body dressing.During a review of Resident 87's Physician Orders, dated 3/8/2026, the orders indicated to administer ceftriaxone (an antibiotic) one gram IV daily. Change the IV tubing every 24 hours.During an observation on 3/9/2026 at 10:10 a.m., in Resident 87's room, Resident 87 was observed in bed. Ceftriaxone was infusing. The IV tubing was unlabeled.During a concurrent interview and record review on 3/11/2026 at 12:03 p.m. with Registered Nurse (RN) 1, a photograph of Resident 87's IV tubing, dated 3/9/2026 and timed at 10:10 a.m., was reviewed. The photo revealed Resident 87's IV tubing was unlabeled. RN 1 stated that it was important for the licensed RN to label the IV tubing with the date and time to verify when the IV tubing was last changed. RN 1 stated that if Resident 87's IV tubing was not labeled, there was a potential risk for blood stream infection.During a review of the facility's policy and procedure (P&P) titled, Administration Set/Tubing Changes, revised 1/2026, the P&P indicated the facility was to ensure all tubing was labeled with the start and change date and time. The P&P indicated any tubing that was observed not to have a label must be changed and then labeled accordingly.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to post an oxygen in use sign outside the room of one of three sampled residents (Resident 105). This deficient practice increased the risk for injury related to fire hazards.Findings:During a review of Resident 105's admission Record, the admission Record indicated Resident 105 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 105's diagnoses included pleural effusion (buildup of fluid between the thin layers of tissue lining the lungs and the chest cavity) and pneumonia (an infection/inflammation in the lungs). During a review of Resident 105's Minimum Data Set (MDS- a resident assessment tool), dated 2/3/2026, the MDS indicated Resident 105's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 105 was dependent with toileting, bathing, and lower body dressing. The MDS indicated Resident 105 required oxygen therapy (a medical gas used to help with breathing).During a review of Resident 105's History and Physical (H&P), dated 11/6/2025, the H&P indicated Resident 105 had the capacity to understand and make decisions.During a review of Resident 105's Physician Orders, dated 2/25/2026, the Physician Orders indicated to administer oxygen at 2 liters (L, a unit of volume measurement) per minute via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen), as needed for shortness of breath. During an observation on 3/9/2026 at 10:27 a.m. and 3/9/2026 at 2:09 p.m., in Resident 105's room, Resident 105 was observed lying in bed receiving 2L of oxygen via nasal cannula. Resident 105 did not have an oxygen in use sign posted outside of the doorway.During an interview on 3/11/2026 at 11:41 a.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Resident 105 was on supplemental oxygen to prevent shortness of breath. LVN 3 stated while Resident 105 was on oxygen therapy, an oxygen in use sign had to be posted outside her door. LVN 3 stated the purpose of the sign was to ensure no one lights an open flame inside the room that could ignite and cause a bigger fire. During an interview on 3/12/2026 at 9:26 a.m., with the Director of Nursing (DON), the DON stated having an oxygen in use sign outside of Resident 105's room was necessary to remind those entering Resident 105's room not to bring any open flames. The DON stated any small flame or spark could cause a fire due to the supplemental oxygen entering the room from Resident 105's nasal cannula.During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration, revised 1/2026, the P&P indicated to place an Oxygen in Use sign on the outside of the room entrance door.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a dialysis (treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) emergency kit (e-kit, a kit used for the management of emergency bleeding on venous access [catheter or device is inserted into a vein to deliver medications or fluids] was kept at the bedside for one of three sampled residents (Resident 142).This deficient practice placed Resident 142 at risk for uncontrolled bleeding and serious harm.Findings:During a review of Resident 142's admission Record, the admission Record indicated Resident 142 was initially admitted to the facility on [DATE]. Resident 142's diagnoses included dependence on dialysis, end stage renal disease (irreversible kidney failure), and muscle weakness.During a review of Resident 142's Minimum Data Set ([MDS], a resident assessment tool), dated, 2/15/2026, the MDS indicated Resident 142's cognitive skills (ability to think and reason) for daily decision making was intact. The MDS indicated Resident 142 required substantial assistance (helper does more than half the effort) for toileting, showering, and lower body dressing.During a review of Resident 142's History and Physical (H&P), dated 2/14/2026, the H&P indicated Resident 142 had the capacity to understand and make decisions.During a review of Resident 142's care plan, titled, Emergency Bleeding, initiated 2/12/2026, the care plan indicated to ensure an e-kit was placed at the bedside for management of emergency bleeding to the venous access site. The care plan indicated to include gauze dressing, wrap bandage, and tape.During an observation on 3/9/2026 at 9:57 a.m., in Resident 142's room, there was no dialysis e-kit observed at the bedside.During an interview on 3/10/2026 at 3:00 p.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated it was important to have the e-kit at the bedside to ensure bleeding was managed in the event of an emergency. LVN 4 stated that if there was no dialysis e-kit at the bedside, there was a potential Resident 142 could suffer from extreme blood loss.During a review of the facility's Policy and Procedure (P&P) titled, End- Stage Renal Disease, Care of a Resident with, revised 1/2026, the P&P indicated the facility was to provide education and training to ensure the dialysis e-kit was available at the nurses' station or at bedside.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide feeding assistance during breakfast for one of seven sampled residents (Resident 31).This deficient practice had the potential to negatively affect the residents' quality of life, and feeling of self-worth.Findings:During a review of Resident 31's admission Record, the admission Record indicated Resident 31 was admitted to the facility on [DATE]. Resident 31's diagnoses included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control), blindness glaucoma (an eye disease that damages the eye and can slowly cause blindness), low vision to the right eye, blindness to the left eye, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on the side of the body, like one arm and one leg not working as well) affecting the left dominant side.During a review of Resident 31's History and Physical (H&P), dated 10/20/2025, the H&P indicated Resident 31 did not have the capacity to understand and make decisions.During a review of Resident 31's Minimum Data Set (MDS- a resident assessment tool), dated 1/16/2026, the MDS indicated Resident 31's cognitive skills (ability to think and reason) for daily decision making were moderately impaired (having some trouble doing things). The MDS indicated Resident 31 required set-up assistance for oral, personal hygiene (keeping your body clean and healthy, like brushing teeth and bathing), and upper body dressing. During an observation on 3/10/2026 at 7:51 a.m., in Resident 31's room, Resident 31 was observed alone, seated upright at the edge of the bed. A breakfast tray was observed. Resident 31 was eating with his hands. Oatmeal, eggs, and juice were observed on Resident 31's clothing, lap, and bed linens. During an interview on 3/10/2026 at 9:20 a.m., with CNA 1, CNA 1 stated, morning shift was understaffed (when there are not enough workers) they can only pass breakfast trays and cannot help feeder (a person who needed help eating) residents as scheduled.During an interview on 3/11/2026 at 12:30 p.m., with the Director of Staff Development (DSD), the DSD stated, adequate (enough workers to do the job) staffing and assignments are important to ensure residents receive timely feeding assistance, prevent neglect (not taking care of someone) and delays (taking longer) in care.During an interview on 3/12/2026 at 11:48 a.m., with the Director of Nursing (DON), the DON stated adequate staffing ensured residents' needs were met, care provided as planned, and residents were not left unattended.During a review of the facility's policy and procedure (P&P), titled Scheduling Nursing Assignment, revised 1/2026, the P&P indicated the facility ensures competent nursing staff are scheduled and assigned to meet resident needs.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe medication administration practices were observed when the following occurred for three of five sampled residents (Resident 1, Resident 66, and Resident 132):1. Failed to ensure Ferrous Sulfate (used to treat or prevent anemia [a lower-than-normal number of red blood cells]) Oral Solution 220 milligrams per five milliters (mg/ml, a unit of measurement) 7.4 ml was administered to Resident 1 one to two hours before or after tube feeding (method of delivering liquid nutrients, fluids, and medications directly into the stomach via a flexible tube) in accordance with physician's order for Resident 1.2. Failed to ensure Zinc Sulfate (a medication essential for wound healing) Oral Tablet 220 mg via g -tube was administered to Resident 1 in accordance with physician's order for Resident 1.3. Failed to ensure Metoprolol Tartrate (a medication used to treat high blood pressure) Oral Tablet 25 mg was administered to Resident 132 with a meal in accordance with physician's order for Resident 132.4. Failed to ensure an accurate narcotic (prescription medication that, because of its potential to cause addiction, misuse, or physical/mental dependence, is tightly regulated) count on the Medication Count Sheet for Resident 66.These deficient practices to administer medications in accordance with the physician's orders and standards of practice placed Resident 1 and Resident 132 at risk for reduced therapeutic effectiveness due to impaired absorption and altered medication delivery. The deficient practice of not ensuring an accurate narcotic count placed Resident 66 at risk for unaccounted controlled substances (prescription medication that, because of its potential to cause addiction, misuse, or physical/mental dependence, is tightly regulated) and potential diversion (when a medication is taken for use by someone other than whom it is prescribed or for an indication other than what is prescribed).Findings:1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE]. Resident 1's diagnoses included gastrostomy (g-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), iron deficiency anemia (not enough iron in the blood) due to blood loss, and cachexia (severe weight and muscle loss).During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 2/16/2026, the MDS indicated Resident 1's cognitive skills (ability to think and reason) for daily decision making were severely impaired. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) for oral hygiene, dressing and toileting.During a review of Resident 1's Physician Order, dated 2/10/2026, the order indicated to administer Ferrous Sulfate Oral Solution 220 milligrams per five milliters (mg/ml, a unit of measurement) 7.4 ml via g-tube daily, one to two hours before or after tube feeding.During a medication administration observation on 3/10/2026 at 8:20 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 prepared Ferrous Sulfate Oral Solution (220 mg/ 5ml) 7.4 ml in a medicine cup. At 8:43 a.m., LVN 3 proceeded to enter Resident 1's room and paused Resident 1's g-tube feeding. LVN 3 verified g-tube placement and administered Resident 1's dose of Ferrous Sulfate Oral Solution (220 mg/ 5ml) 7.4 ml at 8:45 a.m. The g-tube feeding was resumed at 8:55 a.m.During a concurrent interview and record review on 3/10/2026 at 9:00 a.m. with LVN 3, Resident 1's Physician Order, dated 2/10/2026, and Medication Administration Record (MAR), dated 3/2026, were reviewed. The Physician Order and MAR indicated to administer Ferrous Sulfate Oral Solution (220 mg/5ml) 7.4 ml via g-tube daily, one to two hours before or after tube feeding. LVN 3 stated she did not administer the medication as ordered because the feeding was paused shortly before and resumed shortly after administration of the ferrous sulfate (iron). LVN 3 stated the feeding should have been held one to two hours prior to administration to allow for proper absorption of the medication. LVN 3 stated this placed Resident 1 at risk for gastric side effects and reduced therapeutic effectiveness due to impaired iron absorption.2. During a review of Resident 1's (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MAR, dated 3/10/2026, the MAR indicated to administer Zinc Sulfate Oral Tablet 220 mg via g-tube one time a day.During a medication administration observation on 3/10/2026 at 8:20 a.m. with LVN 3, LVN 3 prepared Zinc Sulfate Oral Capsule 220 mg. LVN 3 opened the capsule, poured the contents into a medication cup, and administered the medication via g-tube to Resident 1.During a concurrent interview and record review on 3/10/2026 at 9:00 a.m. with LVN 3, Resident 1's Medication Administration Record (MAR), dated 3/2026, was reviewed. The MAR indicated to administer Zinc Sulfate Oral Tablet 220 mg via g-tube. LVN 3 stated the medication administered was a capsule formulation, which was not in accordance with the physician's order. LVN 3 stated the pharmacy supplied capsules rather than tablets. LVN 3 stated this placed Resident 1 at risk for altered medication absorption.3. During a review of Resident 132's admission Record, the admission Record indicated Resident 132 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 132's diagnoses included cerebral infarction (stroke, loss of blood flow to a part of the brain), heart failure (a heart disorder which causes the heart to not pump the blood efficiently), and hypertension (high blood pressure).During a review of Resident 132's MDS, dated [DATE], the MDS indicated Resident 132's cognitive skills for daily decision making were intact. The MDS indicated Resident 132 required setup assistance for oral hygiene, dressing and toileting.During a review of Resident 132's Physician Order, dated 12/26/2025, the order indicated to administer Metoprolol Tartrate Oral Tablet 25 mg one tablet two times a day with meals.During a medication administration observation on 3/10/2026 at 10:07 a.m. with LVN 1, LVN 1 prepared and administered Metoprolol Tartrate Oral Tablet 25mg to Resident 132. There was no meal tray observed. LVN 1 stated at approximately 7:30 a.m., Resident 132 ate her breakfast meal tray.During a concurrent interview and record review on 3/10/2026 at 10:11 a.m. with LVN 1, Resident 132's Physician Order, dated 12/26/2025, and MAR, dated 3/2026, were reviewed. The Physician Order and MAR indicated to administer Metoprolol Tartrate Oral Tablet 25 mg with meals. LVN 1 stated she did not administer the medication to Resident 132 as ordered, which placed Resident 132 at risk for unwanted gastric (stomach) side effects from the medication.4. During a review of Resident 66's admission Record, the admission Record indicated Resident 66 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 66's diagnoses included cerebral infarction, dysphagia, and diabetes (poor blood sugar control).During a review of Resident 66's MDS, dated [DATE], the MDS indicated Resident 66's cognitive skills for daily decision making were moderately intact. The MDS indicated Resident 66 required maximal assistance for showering, dressing and toileting.During a concurrent observation, interview, and record review on 3/11/2026 at 10:40 a.m. with the Assistant Director of Nursing (ADON), Resident 66's Hydrocodone- Acetaminophen (pain medication)10-325 mg bubble pack (packaging for medications) was observed, and Resident 66's Medication Count Sheet , dated 3/2026, was reviewed. Resident 66's Hydrocodone- Acetaminophen 10-325 mg bubble pack had 19 tablets remaining. The Medication Count Sheet indicated there were 20 tablets remaining. The ADON stated the Medication Count Sheet was inaccurate and stated it was important to ensure controlled medications (prescription medication that, because of its potential to cause addiction, misuse, or physical/mental dependence, is tightly regulated) were accurately accounted for to prevent discrepancies and potential diversion (when a medication is taken for use by someone other than whom it is prescribed or for an indication other than what is prescribed).During an interview on 3/11/2026 at 10:50 a.m. with LVN 5, LVN 5 the normal process for controlled medication administration was to prepare the medication and document on the Medication Count Sheet. LVN 5 stated he administered Resident 66's dose of Hydrocodone- Acetaminophen 10-325 mg but forgot to document it in the Medication Count Sheet, resulting in an inaccurate count. LVN 5 stated that this placed Resident 66 at risk for unaccounted controlled substances.During a review of the facility's Policy and Procedure (P&P) titled, Administering Medications, revised 1/2026, the P&P indicated the following:1. Medications should be administered in a safe and timely manner, as prescribed.2. The individual administering the medication must check the label THREE (3) times to verify the right (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.3. The medications must be administered in accordance with the orders, including any required time frame.During a review of the facility's Policy and Procedure (P&P) titled, Controlled Substances, revised 1/2026, the P&P indicated the resident controlled substance record must contain the name of the resident, name and strength of the medication, number on hand, time of administration, method of administration and signature of nurse administering medication.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the medication error rate was less than five percent (%). Three medication errors out of a total of thirty-six opportunities contributed to an overall medication error rate of 8.33 %, for two of five sampled residents (Resident 1 and Resident 132) observed for medication administration (med pass). The medication errors noted were as follows:1. Failed to ensure Ferrous Sulfate (used to treat or prevent anemia [a lower-than-normal number of red blood cells]) Oral Solution 220 milligrams per five milliters (mg/ml, a unit of measurement) 7.4 ml was administered to Resident 1 one to two hours before or after tube feeding (method of delivering liquid nutrients, fluids, and medications directly into the stomach via a flexible tube) in accordance with physician's order.2. Failed to ensure Zinc Sulfate (a medication essential for wound healing) Oral Tablet 220 mg via gastrostomy tube (a tube that is surgically inserted to allow feedings to be administered directly to the stomach common for people with swallowing problems) was administered to Resident 1 in accordance with physician's order.3. Failed to ensure Metoprolol Tartrate (a medication used to treat high blood pressure) Oral Tablet 25 mg was administered to Resident 132 with a meal in accordance with physician's order.These deficient practices to administer medications in accordance with the physician's orders and standards of practice placed Resident 1 at risk for reduced therapeutic effectiveness due to impaired absorption and altered medication delivery. This also placed Resident 132 at risk for gastrointestinal (stomach) intolerance.Findings:1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE]. Resident 1's diagnoses included gastrostomy (g-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), iron deficiency anemia (not enough iron in the blood) due to blood loss, and cachexia (severe weight and muscle loss).During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 2/16/2026, the MDS indicated Resident 1's cognitive skills (ability to think and reason) for daily decision making were severely impaired. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) for oral hygiene, dressing and toileting.During a review of Resident 1's Physician Order, dated 2/10/2026, the order indicated to administer Ferrous Sulfate Oral Solution 220 milligrams per five milliters (mg/ml, a unit of measurement) 7.4 ml via g-tube daily, one to two hours before or after tube feeding.During a medication administration observation on 3/10/2026 at 8:20 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 prepared Ferrous Sulfate Oral Solution (220 mg/ 5ml) 7.4 ml in a medicine cup. At 8:43 a.m., LVN 3 proceeded to enter Resident 1's room and paused Resident 1's g-tube feeding. LVN 3 verified g-tube placement and administered Resident 1's dose of Ferrous Sulfate Oral Solution (220 mg/ 5ml) 7.4 ml at 8:45 a.m. The g-tube feeding was resumed at 8:55 a.m.During a concurrent interview and record review on 3/10/2026 at 9:00 a.m. with LVN 3, Resident 1's Physician Order, dated 2/10/2026, and Medication Administration Record (MAR), dated 3/2026, were reviewed. The Physician Order and MAR indicated to administer Ferrous Sulfate Oral Solution (220 mg/5ml) 7.4 ml via g-tube daily and to administer one to two hours before or after tube feeding. LVN 3 stated she did not administer the medication as ordered because the feeding was paused shortly before and resumed shortly after administration of the ferrous sulfate (iron). LVN 3 stated the feeding should have been held one to two hours prior to administration to allow for proper absorption of the medication. LVN 3 stated this placed Resident 1 at risk for gastric side effects and reduced therapeutic effectiveness due to impaired iron absorption.2. During a review of Resident 1's MAR, dated 3/10/2026, the MAR indicated to administer Zinc Sulfate Oral Tablet 220 mg via g-tube one time a day.During a medication administration observation on 3/10/2026 at 8:20 a.m. with LVN 3, LVN 3 prepared Zinc Sulfate Oral Capsule 220 mg. LVN 3 opened the capsule, poured the contents into a medication cup, and administered the medication via g-tube to Resident 1.During a concurrent (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview and record review on 3/10/2026 at 9:00 a.m. with LVN 3, Resident 1's Medication Administration Record (MAR), dated 3/2026, was reviewed. The MAR indicated to administer Zinc Sulfate Oral Tablet 220 mg via g-tube. LVN 3 stated the medication administered was a capsule formulation, which was not in accordance with the physician's order. LVN 3 stated the pharmacy supplied capsules rather than tablets. LVN 3 stated this placed Resident 1 at risk for altered medication absorption.3. During a review of Resident 132's admission Record, the admission Record indicated Resident 132 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 132's diagnoses included cerebral infarction (stroke, loss of blood flow to a part of the brain), heart failure (a heart disorder which causes the heart to not pump the blood efficiently), and hypertension (high blood pressure).During a review of Resident 132's MDS, dated [DATE], the MDS indicated Resident 132's cognitive skills for daily decision making were intact. The MDS indicated Resident 132 required setup assistance for oral hygiene, dressing and toileting.During a review of Resident 132's Physician Order, dated 12/26/2025, the order indicated to administer Metoprolol Tartrate Oral Tablet 25 mg one tablet two times a day with meals.During a medication administration observation on 3/10/2026 at 10:07 a.m. with LVN 1, LVN 1 prepared and administered Metoprolol Tartrate Oral Tablet 25mg to Resident 132. There was no meal tray observed. LVN 1 stated at approximately 7:30 a.m., Resident 132 ate her breakfast meal tray.During a concurrent interview and record review on 3/10/2026 at 10:11 a.m. with LVN 1, Resident 132's Physician Order, dated 12/26/2025, and MAR, dated 3/2026, were reviewed. The Physician Order and MAR indicated to administer Metoprolol Tartrate Oral Tablet 25 mg with meals. LVN 1 stated she did not administer the medication to Resident 132 as ordered, which placed Resident 132 at risk for unwanted gastric (stomach) side effects from the medication.During a review of the facility's Policy and Procedure (P&P) titled, Administering Medications, revised 1/2026, the P&P indicated the following:1. Medications should be administered in a safe and timely manner, as prescribed.2. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.3. The medications must be administered in accordance with the orders, including any required time frame.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure food was palatable (tastes good and enjoyable to eat) and consistent with resident preferences for one of seven sampled residents (Resident 124).The deficient practice resulted in the residents not eating their food and had the potential to result in nutritional requirements not being met.Findings:During a review of Resident 124's admission Record, the admission Record indicated Resident 124 was admitted to the facility on [DATE]. Resident 124's diagnoses included chronic respiratory failure with hypoxia (the body or brain is not getting enough oxygen), diabetes mellitus (DM- disorder characterized by difficulty in blood sugar control and poor wound healing), and muscle weakness (loss of muscle strength).During a review of Resident 124's History and Physical (H&P), dated 11/10/2025, the H&P indicated Resident 124 had the capacity to understand and make decisions.During a review of Resident 124's Minimum Data Set (MDS- a resident assessment tool), dated 2/12/2026, the MDS indicated Resident 124 was cognitively intact (the ability to think and process information). The MDS indicated Resident 124 required setup and clean -up assistance (helper sets up and cleans up; resident completes activity) from staff with activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily).During a concurrent observation and interview on 3/10/2026 at 12:59 p.m., with Resident 124, in Resident 124's room, Resident 124 was observed seated upright in bed with a lunch tray placed on the overbed table. The lunch tray contained meatballs. Resident 124 stated that the menu rarely changed and she repeatedly received meatballs despite expressing dislike (things a person does not like or enjoy) to kitchen staff. Resident 124 stated requests for alternate meals were often ignored. Resident 124 stated that this ongoing issue was frequently mentioned to staff, however no changes were done.During a concurrent interview and record review on 3/10/2026 at 3:02 p.m., with the Dietary Supervisor (DS), Resident 124's lunch meal ticket (a document that lists the resident's name, diet order, food preferences, allergy, likes and dislikes), dated 3/10/2026 was reviewed. The lunch meal ticket, indicated Resident 124 dislikes meatballs. The DS stated, the lunch meal ticket may not have been checked as meatballs was served to Resident 124, which could make the resident feel their food preferences were not followed.During an interview on 3/13/2026 at 1:20 p.m., with the Director of Nursing (DON), the DON stated that staff must check meal tickets and ensure residents' food preferences are followed.During a review of the facility's policy and procedure (P&P) titled Meal Service, dated 1/2026, the P&P indicated, nursing and food personnel will serve the trays immediately after checking the tray to be sure nothing is missing from the tray and food preferences are correct.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 two of four sampled residents' (Residents 147 and 61) medical records were complete and accurate when:1. Resident 147's hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care facility) record binder and medical record binder contained conflicting Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) forms.This deficient practice had the potential for licensed staff to rely on inaccurate or conflicting information and follow the incorrect POLST during a life-threatening emergency.2. Licensed Vocational Nurse (LVN) 3 did not document Resident 61's Change in Condition (COC) after his roommate tried to touch him inappropriately.These deficient practices resulted in the lack of care plan development and intervention implementation to monitor Resident 61 for psychosocial distress and trauma. Cross Reference F656 and F684.Findings: 1. During a review of Resident 147's admission Record, the admission Record indicated Resident 147 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 147's diagnoses included palliative care (specialized medical care focused on improving quality of life for people with serious illnesses and their families, addressing physical, emotional, and practical needs), chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing) and dysphagia (trouble with swallowing). During a review of Resident 147's Minimum Data Set ([MDS], a resident assessment tool), dated [DATE], the MDS indicated Resident 147's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 147 was dependent on staff for toileting, showering, and lower body dressing. During a review of Resident 147's History and Physical (H&P), dated [DATE], the H&P indicated Resident 147 did not have the capacity to understand and make decisions. During a review of Resident 147's Nursing Progress Note, dated [DATE], the note indicated Resident 147 was readmitted to the facility with a new diagnosis of an acute stroke (loss of blood flow to a part of the brain) affecting the right side. During a concurrent interview and record review on [DATE] at 9:22 a.m. with Registered Nurse (RN) 1, Resident 147's Physician Orders for Life-Sustaining Treatment (POLST – a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) Forms, dated [DATE] and [DATE], were reviewed. The POLST, dated [DATE], located in Resident 147's medical record binder, indicated Resident 147 elected full life-sustaining measures with long term artificial nutrition. The POLST, dated [DATE], located in Resident 147's hospice medical record binder, indicated Resident 147's surrogate decision maker elected do not resuscitate (DNR- a medical order written by a doctor to instruct health care providers NOT to do cardiopulmonary resuscitation [CPR, an emergency, life-saving procedure] if breathing stops or the heart stops beating), comfort-focused treatment, and no artificial means of nutrition. There was no documentation to indicate the POLST dated [DATE] had been voided, superseded, or removed from Resident 147's active medical record. RN 1 stated the presence of both POLST documents with conflicting treatment preferences had the potential for licensed staff to (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	follow the incorrect POLST in the event of a life-threatening emergency for Resident 147. During a review of the facility's Policy and Procedure (P&P) titled, Charting and Documentation, revised 1/2026, the P&P indicated the facility was to ensure documentation in the medical record would be complete and accurate. 2. During a review of Resident 61's admission Record, the admission Record indicated Resident 61 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 61's diagnoses included type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic kidney disease (kidney damage that occurs over time), and hypertension (high blood pressure).During a review of Resident 61's MDS, dated [DATE], the MDS indicated Resident 61's cognition (process of thinking) was intact. The MDS indicated Resident 61 was independent with eating, oral hygiene, and toileting. During a review of Resident 61's H&P, dated [DATE], the H&P indicated Resident 61 had the capacity to understand and make decisions.During an interview on [DATE] at 12:20 p.m., with LVN 3, LVN 3 stated, on [DATE], she was the nurse assigned to Resident 61. LVN 3 stated Resident 61 informed her that his roommate tried to touch his genitals (external reproductive organ). LVN 3 stated Resident 61 was very upset. LVN 3 stated after the incident, a change in condition (COC) should have been documented in Resident 61's electronic health record (eHR).During a concurrent interview and record review on [DATE] at 12:31 p.m., with LVN 3, Resident 61's eHR, dated [DATE], was reviewed. Resident 61 did not have a documented COC on [DATE]. LVN 3 stated she recalled calling the physician, however, she did not document. LVN 3 stated documenting the COC was important to show proof of Resident 61's assessment, physician notification, and any pertinent orders. LVN 3 stated COC documentation was also important to communicate to the oncoming nurses of the incident that occurred and to initiate 72-hour monitoring for potential psychosocial distress. During an interview on [DATE] at 9:58 a.m., with the Director of Nursing (DON), the DON stated the COC should always be documented in the resident's eHR to ensure the licensed nurses were aware of details of the COC and to monitor for worsening behavior, adverse effects, or distress of any kind. The DON stated Resident 61's COC was not documented which resulted in the lack of a care plan and implementation of interventions such as monitoring for psychosocial distress and trauma. During a review of the facility's P&P titled, Charting and Documentation, revised 1/2026, the P&P indicated changes in the resident's condition were to be documented in the resident's medical record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 follow infection control measures for two of 11 sampled residents (Residents 33 and 5) when:1. Certified Nursing Assistant (CNA) 5 failed to implement droplet isolation precautions (infection control measures used to prevent the spread of pathogens transmitted through close respiratory contact) and failed to perform hand hygiene (hand washing with soap or using alcohol-based hand rubs) upon exiting Resident 33's room.2. Licensed Vocational Nurse (LVN) 3 disconnected a gastrostomy tube (g-tube- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) connector from Resident 5 and stored the connector inside a plastic bag while the g-tube feeding formula (specialized, nutrient-dense liquid diets delivered via g-tube) was left running.These deficient practices had the potential to place all residents at risk for infection and illness. Findings:1. During a review of Resident 33's admission Record, the admission Record indicated Resident 33 was initially admitted on [DATE] and readmitted on [DATE]. Resident 33's diagnoses included type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (high blood pressure) and chronic kidney disease (long-term damage to the kidneys).During a review of Resident 33's Minimum Data Set (MDS- a resident assessment tool), dated 2/26/2026, the MDS indicated Resident 33's cognition (process of thinking) was intact. The MDS indicated Resident 33 required maximal assistance (helper does more than half the effort) with toileting, bathing, and lower body dressing.During a review of Resident 33's History and Physical (H&P), dated 2/24/2026, the H&P indicated Resident 33 had fluctuating (changing) capacity to understand and make decisions.During a review of Resident 33's Change in Condition (COC), dated 3/9/2026, the COC indicated, on 3/9/2026, Resident 33 complained of fatigue and body aches. The COC indicated Resident 33's physician's order to initiate infection precautions per the facility's protocol and to test for influenza (a contagious viral infection that affects the respiratory system).During a review of Resident 33's Physician Orders, dated 3/10/2026, the Physician Orders indicated to place Resident 33 on droplet isolation precautions (infection control measures used to prevent the spread of pathogens transmitted through close respiratory contact) until 3/16/2026. During a review of Resident 133's Care Plan titled, Risk for Infection Upper Respiratory Infection, dated 3/9/2026, the Care Plan indicated to initiate droplet isolation precautions.During an observation on 3/10/2026 at 9:25 a.m., outside of Resident 33's room, observed a droplet precaution sign posted next to the door. Certified Nursing Assistant (CNA) 5 donned (put on) an isolation gown, gloves, and a face shield and entered Resident 33's room. CNA 5 attended to Resident 33's needs in the room and stepped outside of Resident 33's room. CNA 5 removed his gloves and face shield and threw them into a trashcan. CNA 5 reentered Resident 33's room and removed his gown and threw the gown away in the designated bin. CNA 5 exited Resident 33's room, holding Resident 33's water pitcher, and began walking down the hallway. CNA 5 did not perform hand hygiene (hand washing with soap or using alcohol-based hand rubs) after exiting Resident 33's room. During a concurrent observation and interview on 3/10/2026 at 9:29 a.m., with CNA 5, in the facility's hallway, CNA 5 was observed walking towards the facility's kitchen. CNA 5 was stopped before entering the kitchen. CNA 5 stated he did not doff (take off) his personal protective equipment (PPE- specialized gear worn to act as a barrier against germs and harmful substances) correctly after attending to Resident 33. CNA 5 stated when doffing PPE, he was supposed to remove his gloves, face shield, and gown inside Resident 33's room. CNA 5 stated after exiting Resident 33's room he was supposed to perform hand hygiene, which he forgot to do. CNA 5 stated correct PPE doffing and hand hygiene was necessary to prevent contamination of anything outside Resident 33's room. During an interview on 3/11/2026 at 10:11 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a.m., with the Infection Preventionist Nurse (IPN), the IPN stated Resident 33 was on droplet isolation precautions due to his pending influenza results. The IPN stated the proper doffing process was to remove the gloves, gown, and face shield inside Resident 33's room. The IPN stated there were trash bins designated for the items inside the room. The IPN stated doffing and disposing of the items outside of the room was an incorrect practice because anything contaminated should be kept inside the room until they could be properly disposed. The IPN stated after doffing the PPE, hand hygiene should be done. The IPN stated although gloves were worn, the hands could be contaminated with the influenza virus and hand hygiene should be done to ensure the virus does not spread to other objects and/or individuals. The IPN stated CNA 5 did not follow the droplet isolation precautions, therefore increased the risk of spreading influenza to other residents and staff. During a review of the facility's Policy and Procedure (P&P) titled, Handwashing/Hand Hygiene, revised 1/2026, the P&P indicated hand hygiene was done before and after direct contact with residents and before and after entering isolation precautions settings. 2. During a review of Resident 5's admission Record, the admission Record indicated the facility admitted the resident on 4/22/2025 with diagnoses included but not limited to, type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), gastrostomy, protein-calorie malnutrition (a severe nutritional deficiency caused by a lack of sufficient calories and protein intake, leading to muscle wasting, weight loss and impaired body function), stage 4 pressure ulcers a severe, full-thickness wound with extensive tissue loss, exposing muscle, tendon, ligament, or bone) of the elbow and sacrum (tailbone). During a review of Resident 5's MDS, dated [DATE] the MDS indicated Resident 5's cognitive skills (ability to think and reason) for daily decision making were severely impaired. The MDS indicated Resident 5 required dependent assistance (helper does all the effort) for 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 5's H&P, dated 10/10/25, the H&P indicated Resident 5 did not have the capacity to understand and make decisions. During initial tour observation on 3/9/2026, at 10:17 a.m., in Resident 5's room, the GTube was disconnected from the resident and the GTube feeding was stored inside the syringe bag, while the feeding pump was running. The feeding formula was collected inside the GTube feeding syringe bag. During a concurrent observation and interview on 3/9/2026, at 12:30 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated The GT feeding tube should not be stored in the GT syringe bag because it would be violating infection control. LVN 3 stated she should not have placed the GT feeding tube in the GT feeding syringe bag and should replace the whole tubing system if the cap was missing. During an interview on 3/10/2026, at 2:12 p.m. with the IPN, the IPN stated when the GT feeding tube was disconnected, the tube should be stored and capped off. The IPN stated The GT feeding tube should never be stored in the GT syringe bag because the syringe is held by hand multiple times a day and will be violating infection control. During an interview on 3/10/2026, at 2:20 p.m. with Registered Nurse (RN) 1, RN 1 stated If the GT feeding is disconnected from patient care, the end of the GT feeding tube should be capped and should never be stored in the GT feeding syringe bag because it would be violating infection control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's LVN Job Description, undated, the LVN Job Description indicated, the facility Adheres to state and federal regulations and company policies and procedures. Infection Control, Universal Precautions, OSHA and safety standards in the performance of tasks and the use of equipment and supplies. During a review of the facility's P&P titled, Enteral Tube Feeding via Continuous Pump, revised January 2026, under general guidelines number 1., the P&P indicated Use aseptic technique when preparing or administering enteral feedings.

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of 50 resident rooms accommodated no more than four residents in each room. This deficient practice had the potential to lead to inadequate space to properly care for residents and store residents' belongings and equipment.Findings: During a review of the facility's Census, dated 3/9/2026, the Census indicated a five resident occupied room (room [ROOM NUMBER]) and a four resident occupied room (room [ROOM NUMBER]). During a review of the facility's Room Variance Waiver letter, dated 3/9/2026, submitted by the Administrator (ADM), the letter indicated rooms [ROOM NUMBERS] had five beds each. The letter indicated the rooms were utilized for higher acuity residents requiring more care. room [ROOM NUMBER] was located one foot away from the fire exit door when measured from the doorway to the exit. The letter indicated room [ROOM NUMBER] was located five feet away from a fire exit door when measured from the doorway to the exit. The letter indicated the waiver was in accordance with the special needs of the residents and does not adversely affect the health and safety of the residents or impede the ability of any resident from attaining his or her highest practicable well-being. During a concurrent facility tour observation and interview on 3/12/2026 at 10:00 a.m., with the ADM, observed five residents occupied room [ROOM NUMBER], and four residents occupied room [ROOM NUMBER]. The residents were able to move in and out of the rooms, and there was space for the residents' beds and side tables. and residents' care equipment. The ADM stated there was a risk of decreased space for the residents, staff, and equipment, and a risk that the residents would feel uncomfortable. The ADM stated the room waiver was submitted for rooms [ROOM NUMBERS] because they were occupied by more than four residents.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide at least 80 square feet ([sq. ft.])- a unit of measurement) per resident in 31 of 50 residents' rooms (Rooms 1, 2, 3, 4, 5, 19, 20, 22, 23, 24, 25, 26, 27, 28, 29, 30, 34, 35, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, and 49).This deficient practice could potentially result in residents not being provided with privacy and could potentially affect the residents' health and safety.Findings:During a review of the facility's Census, dated 3/9/2026, the Census indicated four rooms (Rooms 1, 2, 3, and 4) had the capacity for two residents in each room. The Census indicated 27 rooms (Rooms 5, 19, 20, 22, 23, 24, 25, 26, 27, 28, 29, 30, 34, 35, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, and 49) had the capacity for three residents in each room. During a review of the facility's Room Variance Waiver letter, dated 3/9/2026, the letter indicated 31 rooms did not meet the 80 sq. ft. requirement by federal regulations. The letter indicated the waiver was in accordance with the special needs of the residents and does not adversely affect the health and safety of the residents or impede the ability of any resident from attaining his or her highest practicable well-being.The following rooms provided for less than 80 sq. ft. per resident:room [ROOM NUMBER], capacity 2, measured 157.98 sq. ft.room [ROOM NUMBER], capacity 2, measured 142.30 sq. ft. room [ROOM NUMBER], capacity 2, measured 156.65 sq. ft. room [ROOM NUMBER], capacity 2, measured 153.91 sq. ft. room [ROOM NUMBER], capacity 3, measured 223.26 sq. ft. room [ROOM NUMBER], capacity 3, measured 203.95 sq. ft. room [ROOM NUMBER], capacity 3, measured 221.40 sq. ft. room [ROOM NUMBER], capacity 3, measured 216.45 sq. ft. room [ROOM NUMBER], capacity 3, measured 216.45 sq. ft. room [ROOM NUMBER], capacity 3, measured 216.45 sq. ft. room [ROOM NUMBER], capacity 3, measured 259.48 sq. ft. room [ROOM NUMBER], capacity 3, measured 197.96 sq. ft. room [ROOM NUMBER], capacity 3, measured 217.56 sq. ft. room [ROOM NUMBER], capacity 3, measured 217.56 sq. ft. room [ROOM NUMBER], capacity 3, measured 217.56 sq. ft. room [ROOM NUMBER], capacity 3, measured 219.52 sq. ft. room [ROOM NUMBER], capacity 3, measured 214.50 sq. ft. room [ROOM NUMBER], capacity 3, measured 215.60 sq. ft. room [ROOM NUMBER], capacity 3, measured 216.45 sq. ft. room [ROOM NUMBER], capacity 3, measured 216.45 sq. ft.room [ROOM NUMBER], capacity 3, measured 218.40 sq. ft. room [ROOM NUMBER], capacity 3, measured 216.45 sq. ft. room [ROOM NUMBER], capacity 3, measured 217.56 sq. ft. room [ROOM NUMBER], capacity 3, measured 216.45 sq. ft. room [ROOM NUMBER], capacity 3, measured 214.50 sq. ft. room [ROOM NUMBER], capacity 3, measured 217.56 sq. ft. room [ROOM NUMBER], capacity 3, measured 217.56 sq. ft. room [ROOM NUMBER], capacity 3, measured 216.45 sq. ft. room [ROOM NUMBER], capacity 3, measured 215.60 sq. ft. room [ROOM NUMBER], capacity 3, measured 217.56 sq. ft. room [ROOM NUMBER], capacity 3, measured 235.88 sq. ft.During a concurrent facility tour observation and interview on 3/12/2026 at 10:00 a.m., with the Administrator (ADM), there was space noted for residents in 31 rooms (Rooms 1, 2, 3, 4, 5, 19, 20, 22, 23, 24, 25, 26, 27, 28, 29, 30, 34, 35, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, and 49) to be able to move in and out of the rooms, and there was space for the residents' beds, side tables, and residents' care equipment. The ADM stated there was a risk of decreased space for the residents, staff, and equipment, and a risk that the residents would feel uncomfortable. The ADM stated the room waiver was submitted for 31 rooms because these rooms measured less than 80 sq. ft. per resident capacity of the rooms.