STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055052	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Post-Acute Care	3615 E. Imperial Hiwy Lynwood, CA 90262

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure the Director of Nursing (DON) did not wear Smart Glasses (eyeglasses with a built-in camera to record videos and take photos) while inside the facility.This deficient had the potential for a breach in the residents' personal privacy and confidentiality.Findings:During an observation on 5/18/2026 at 1:58 p.m. in the facility's hallway, the Director of Nursing (DON) was observed wearing Smart Glasses (eyeglasses with a built-in camera to record videos and take photos).During a concurrent interview and record review on 5/19/2026 at 7:55 a.m., with the DON, the DON was observed wearing Smart Glasses. The DON stated the eyeglasses were prescription and he was not recording at that time.During an interview on 5/19/2026 at 12:20 p.m., with the DON, the DON stated he wore his Smart Glasses to the facility because they were prescription eyeglasses. The DON stated the Smart Glasses had video and photo capabilities; however, those were not active because the battery was depleted. The DON stated when he was in the facility, he only used the Smart Glasses strictly for his vision. The DON stated he did not feel wearing the Smart Glasses posed any privacy or confidentiality issues because he did not wear the Smart Glasses for video or photo purposes. The DON stated the residents' privacy and confidentiality was important and the facility was responsible for protecting them.During a concurrent interview and record review on 5/19/2026 at 12:41 p.m., with the Administrator (ADM), the facility's Employee Handbook, dated 5/2025, was reviewed. The Employee Handbook indicated, Phones and other devices with cameras or recording capabilities are strictly prohibited in all work areas that contain proprietary information (confidential information owned by the facility) or confidential documents. The ADM stated all individuals employed by the facility had to abide by the Employee Handbook. The ADM stated the DON should not have worn his Smart Glasses inside the facility due to their photo and recording capabilities. The ADM stated any device with such capabilities should not be used or worn in the presence of facility confidential documents, resident documents, or the residents themselves. The ADM stated the DON wearing the Smart Glasses could be misinterpreted by an individual who would not know how the eyeglasses functioned and would believe they were being recorded without their consent. The ADM stated wearing the Smart Glasses inside the facility could result in distrust between the residents and/or their family members with the facility protecting the residents' privacy and confidentiality.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure the following food safety and food preparation practices was observed:1. Ensure foods were stored and/or prepared under sanitary conditions.2. Ensure proper sanitation and food handling practices were maintained to prevent outbreak or foodborne illness.3. Ensure dishes and utensils were cleaned and stored under sanitary conditions.4. Ensure snacks in the refrigerator were dated and labeled to prevent the potential for foodborne illness. These deficient practices had the potential for bacterial growth in potentially hazardous foods (PHFs- foods that require strict time and temperature control to prevent the growth of harmful bacteria or the formation of toxins) and increased the risk for food borne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) for 110 residents who consumed food prepared and served from the kitchen. Findings: 1. During a concurrent observation and interview on 5/18/2026 at 8:15 a.m., with the Dietary Aid (DA), during the initial kitchen tour, one open bag of wheat bread was observed exposed on the kitchen counter without protective covering or proper storage, the kitchen tray line counter contained accumulated crumbs, food debris, and used utensils and scoops were left resting on the tray line surface between food preparation activities. The DA stated the uncovered bread and leftover food after breakfast increased contamination risks (an accidental introduction of hazardous substances into materials, environments, or products, potentially harming human health). The DA stated used utensils left out could spread germs, cause cross-contamination, and make meals unsafe. During a concurrent interview and record review on 5/19/2026 at 2:25 p.m., with the Regional Dietary Manager (RDM), the facility's Policy and Procedure (P&P) titled, Storage of Food and Supplies, dated 2023, was reviewed. The P&P indicated food will be stored properly, in safe manner and open food are to be tightly closed to prevent exposure to pest. The RDM stated these errors could expose residents to unsafe food and unclean meal service areas increasing risk of illness. During a review of the facility's P&P titled, Storage of Food and Supplies, dated 2023, the P&P indicated dry food that has been opened will be tightly closed, labeled and dated. During a review of the facility's P&P titled, Cleaning and Disinfection of Environmental Surfaces, dated 1/2018, the P&P indicated tabletops and surfaces will be cleaned on a regular basis, when surfaces are visibly soiled. 2. During a concurrent observation and interview on 5/18/2026 at 8:19 a.m., with the DA, during the initial kitchen tour, observed a tray of pasteurized eggs was left unattended on a cart near the kitchen sink. A plastic container of apple sauce was left uncovered inside the refrigerator. The DA stated these mistakes could increase the risk of cross contamination and spread of bacteria and unsafe meal service to residents. During a concurrent interview and record review on 5/19/2026 at 2:29 p.m., with the RDM, the facility's P&P titled, Storage of Food and Supplies, dated 2023, was reviewed. The P&P indicated liquid foods which have been opened will be tightly closed, labeled, and dated. The RDM stated these errors put residents at risk of illness from unsafe food and cross-contamination. During a review of the facility's P&P titled, Storage of Food and Supplies, dated 2023, the P&P indicated food and supplies will be stored properly and in a safe manner. 3. During a concurrent observation and interview on 5/18/2026 at 8:22 a.m., with the DA, during the initial kitchen tour, three soiled plates and two used forks were observed left unattended on the kitchen tray line. The dishwashing area had water on the floor, cluttered dishes, and visible debris. The DA stated dirty dishes and utensils should be cleaned and removed promptly, and the dishwashing area should remain clean to prevent contamination and ensure resident safety during meal service. During a concurrent interview and record review on 5/19/2026 at 2:35 p.m., with the RDM, the facility's P&P titled, Storage of Food and Supplies, dated 2023, was reviewed. The P&P indicated routine cleaning should be developed and followed. The RDM stated these errors could expose residents to unclean meal service areas and risk of illness. During a review of the facility's P&P titled, Cleaning and Disinfection of Environmental Surfaces, dated 1/2018, the P&P indicated (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	surfaces will be cleaned on a regular basis, when spills occur and when these surfaces are visibly soiled. 4. During a concurrent observation and interview on 5/18/2026 at 8:24 a.m., with the DA, during the initial kitchen tour, six peanut butter and jelly sandwiches on white bread and eight ham sandwiches on wheat bread were found unsealed and unlabeled in the refrigerator. The DA stated the weekend staff may have forgotten to properly label and seal the sandwiches before storing them in the refrigerator. The DA stated this mistake may place residents at risk for food contamination, spoilage, and possible illness. During a concurrent interview and record review on 5/19/2026 at 2:38 p.m., with the RDM, the facility's P&P titled, Labeling and Dating of Foods, dated 2023, was reviewed. The P&P indicated, all prepared foods need to be covered, labeled, and dated. The RDM stated these errors may place residents at risk foodborne illness, cross-contamination, poor food quality, and unsafe meal service. During a review of the facility's P&P titled, Labeling and Dating of Foods, dated 2023, the P&P indicated, all food items in the storeroom, refrigerator, and freezer need to be labeled and dated.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the safe medication administration and medication adherence for four of four sampled residents (Residents 95, 101, 114, and 76) when the facility failed to: 1. Clarify an Aspirin (a medication used for cerebrovascular accident [CVA - an interruption in the flow of blood to cells in the brain, mainly caused by hypertension (high blood pressure)] prophylaxis ([PPX] - prevention) order for two (2) of four (4) observed residents during medication administration task (Resident 95 and 101). 2. Reconcile (the process of comparing transactions and activity to supporting documentation) one (1) medication emergency kit ([eKIT] - storage container for emergency use medications) containing controlled medications (also known as Controlled Drug and Controlled Substance [CM, CD, CS]- medications which have a potential for abuse and may also lead to physical or psychological dependence) for May 2026, in one (1) of two (2) inspected medication rooms (Medication Room Station A).3. Timely reorder of Resident 114's oxycodone-acetaminophen (an opioid medication used to treat pain).4. Properly dispose of five pills left on Resident 76's bedside table.These deficient practices had the potential to result in Resident 95 and 101 receiving suboptimal (less than standard) care and experiencing adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have), in addition to increasing the opportunity for CM diversion (the transfer of a controlled medication or other medication from a lawful to an unlawful channel of distribution or use,) and the risk that residents in the facility could have accidental exposure to harmful medications and delayed medication treatment during emergencies possibly leading to physical and psychosocial harm, and hospitalization. These deficient practices resulted in oxycodone-acetaminophen being unavailable to Resident 114 for seven days and the potential to result in unmanaged pain. And these deficient practices had the potential to result in Resident 76's medications ingested by another resident not intended for and harmful medication interactions.Findings:1a. During a review of Resident 95's admission Record, the admission Record indicated Resident 95 was originally admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 95's diagnoses included heart disease. During a review of Resident 95's (Medication Administration Record ([MAR] - a record of mediations administered to residents), for 5/2026, the MAR indicated to administer aspirin 81 mg tablet orally once a day for prophylaxis related to heart disease. During an observation on 5/18/2026 at 8:40 a.m., in Medication Cart D, Licensed Vocational Nurse (LVN) 6 was observed administering aspirin 81 milligram ([mg]- a unit of measure of mass) enteric coated ([EC] – a form of aspirin that is designed to slowly release medication) tablet orally to Resident 95. Resident 95 was observed swallowing the aspirin 81 mg EC tablet with a glass of water. 1b. During a review of Resident 101's admission Record dated 5/18/2026, the admission Record indicated Resident 101 was originally admitted to the facility on [DATE]. Resident 101's diagnoses included cerebral infarction (a condition where blood and oxygen supply to the brain is blocked). During a review of Resident 101's MAR for 5/2026, the MAR indicated aspirin 81 mg capsule orally once a day. During an observation on 5/18/2026 at 9 a.m., in Medication Cart D, LVN 6 was observed administering aspirin 81 mg EC tablet orally to Resident 101. Resident 101 was observed swallowing the aspirin 81 mg EC tablet with a glass of water.2. During a concurrent observation and interview on (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/18/2026 at 12:03 p.m., with LVN 7 and the Director of Nursing (DON,) in Medication Room Station A there was one (1) medication eKIT stored in the refrigerator containing CMs. The eKIT was labeled 580. There was no accountability log for the reconciliation of CM inventory at every shift change for 5/2026. LVN 7 stated that all CMs should be reconciled at every shift. LVN 7 stated the facility did not have a reconciliation log at each shift change for the eKIT labeled 580. LVN 7 stated that the eKIT stored in Medication Room Station A refrigerator labeled 580 contained CMs and was not reconciled at every shift in 5/2026. LVN 7 stated it was important to account for all CMs to ensure accountability and prevent CM diversion and accidental exposure of harmful substances to residents. During an interview 5/18/2026 at 12:30 p.m., with LVN 6, LVN 6 stated Resident 95 and 101's physician's orders indicated to administer aspirin 81 mg. LVN 6 stated the orders did not specify which form of aspirin to administer. LVN 6 stated aspirin 81 mg was available as a chewable tablet and EC tablet LVN 6 stated she administered aspirin 81 mg EC to Resident 95 and 101. LVN 6 stated chewable aspirin was released immediately into the body and EC was released slowly over time into the body. LVN 6 stated she needed to clarify the physician's orders for aspirin 81 mg to know which form of aspirin to administer each resident to ensure safe and appropriate absorption. During an interview 5/18/2026 at 1:58 p.m., with the DON, the DON stated the aspirin orders for Residents 95 and 101 did not indicate which form of aspirin to administer. The DON stated that aspirin 81 mg was available as chewable and EC tablets, and that the physician order needed to indicate which form to administer. The DON stated that several LVN's failed to clarify Resident 95 and 101's physician orders for aspirin 81 mg to indicate chewable or EC tablet. The DON stated that medication eKITs containing CMs needed to be counted and reconciled at every shift change to ensure accountability and prevent CM diversion. The DON stated the eKIT labeled 580 stored in the refrigerator in Medication Room A contained CMs and was not reconciled at each shift change in 5/2026. 3. During a review of Resident 114's admission Record (Face Sheet), the Face Sheet indicated Resident 114 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 114's diagnoses included multiple sclerosis (MS- a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord) and chronic pain syndrome (pain that lasts longer than three months which could lead to significant emotional, physical, and functional impairment). During a review of Resident 114's Minimum Data Set (MDS- a resident assessment tool), dated 5/1/2026, the MDS indicated Resident 114's cognitive skills for daily decision making (process of thinking) was intact. The MDS indicated Resident 114 required substantial assistance (helper does more than half the effort) with toileting, bathing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 114 received opioid medication (medication used to treat pain). During a review of Resident 114's History and Physical (H&P), dated 11/28/2025, the H&P indicated Resident 114 had the capacity to understand and make decisions. During a review of Resident 114's Physician Order, dated 4/14/2026, the Physician Order indicated to administer oxycodone-acetaminophen (an opioid medication) 5-325 milligrams (mg, a unit of measurement) by mouth, every four hours as needed for moderate to severe pain (pain rated four through ten on the pain scale) related to chronic pain syndrome. During an interview on 5/18/2026 at 10:32 a.m., with Resident 114, Resident 114 stated she has had left leg pain for the last two days but was told her oxycodone-acetaminophen was not delivered yet. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 114 stated the licensed nurses told her the oxycodone-acetaminophen order was authorized; however, the facility was awaiting the delivery. During an observation on 5/19/2026 at 9:13 a.m., outside of Resident 114's room, Resident 114 was observed speaking to Licensed Vocational Nurse (LVN) 1. Resident 114 complained of 8 out of ten pain. LVN 1 informed Resident 114 that the oxycodone-acetaminophen was not delivered yet, however, he would contact the pharmacy to obtain a dose from the facility's emergency kit (e-kit-secured container with small quantity of medications that can be dispensed when pharmacy services are unavailable). During an interview on 5/20/2026 at 1:05 p.m., with Registered Nurse (RN) 1, RN 1 stated licensed nurses were responsible for reordering Resident 114's oxycodone-acetaminophen from the pharmacy. RN 1 stated medication should always be ordered a few days prior to the last dose to ensure the facility had enough time to obtain authorization from the pain specialist, order the medication from their pharmacy, and receive the medication. During a concurrent interview and record review on 5/20/2026 at 1:08 p.m., with RN 1, Resident 114's Controlled Record, dated 4/29/2026 through 5/11/2026, and Order Authorization, dated 5/12/2026, were reviewed. The Controlled Record indicated Resident 114's last dose of oxycodone-acetaminophen was administered on 5/11/2026 at 8 p.m. The Controlled Record indicated a Time to Reorder bar highlighting to reorder medication when 14 doses remained. The Order Authorization indicated, on 5/12/2026, Pain Specialist 1 authorized the order for Resident 114's oxycodone-acetaminophen. RN 1 stated according to Resident 114's Controlled Record, Resident 114 received oxycodone-acetaminophen approximately twice a day. RN 1 stated the Time to Reorder bar was a tool to assist the licensed nurses to determine whether the medication should be reordered. RN 1 stated the process to reorder Resident 114's oxycodone-acetaminophen should have started when Resident 114 had approximately 14 doses left. RN 1 stated, on 5/12/2026, Resident 114's oxycodone-acetaminophen was reordered after Resident 114 received the last dose from the bubble pack (a packaging system organized with individual doses of a medication). RN 1 stated timely medication ordering was essential to allow enough time for the medication to be delivered to the facility while having some doses on hand. RN 1 stated Resident 114 did not have her oxycodone-acetaminophen available if Resident 114 complained of pain. RN 1 stated the facility had oxycodone-acetaminophen available in the facility's medication e-kit. RN 1 stated removing oxycodone-acetaminophen from the e-kit took time because the pharmacy had to produce a code to remove the oxycodone-acetaminophen, therefore delaying the administration and providing pain management. During an interview on 5/21/2026 at 10:56 a.m., with the DON, the DON stated medications, especially opioid medications, should be reordered timely to ensure the facility had adequate doses on hand. The DON stated the licensed nurses should use their judgement, however, when a week supply remained, the medication should be reordered. The DON stated the time from when the medication was ordered to when it was delivered to the facility could take time. The DON stated Resident 114's oxycodone-acetaminophen should have been reordered sooner, and the licensed nurses should not have waited to order once the oxycodone-acetaminophen doses were depleted. The DON stated the delay in reordering resulted in the facility not having Resident 114's oxycodone-acetaminophen readily available to administer. 4. 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 thrombotic pulmonary (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	emboli (a sudden, life-threatening blockage in a lung artery caused by a blood clot traveling from a deep vein in the leg or pelvis), hypokalemia (low potassium levels in the blood), and hypertension (high blood pressure). During a review of Resident 76'2 H&P, dated 3/2/2026, 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 cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 76 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) to complete daily activities. During concurrent observation and interview on 5/18/2026 at 9:40 a.m., with Resident 76's, inside Resident 76's room, five unidentified pills were observed in a medicine cup on top of Resident 76's bedside table. Resident 76 stated that she did not know if those pills were for her or not. Resident 76's stated that she did not know when those pills were left there. During concurrent observation and interview on 5/18/2026 at 9:44 a.m., with Registered Nurse (RN) 1, inside Resident 76's room, RN 1 observed the five unidentified pills in the medicine cup on top of Resident 76's bedside table. RN 1 stated that he did not know who left those pills there. RN 1 stated that the medication nurse should make sure Residents take the medications and if the Residents do not want to take the medications when the medications are due, the nurse administering the medication should take the pills back and not leave the pills on the bedside table. RN 1 stated that the fills should have been disposed off in the waste medication container located in the medication room. RN 1 stated that leaving pills behind can be a safety concern because it can cause residents to take extra medications when they are not due. During a concurrent observation and interview on 5/18/2026 at 9:46 a.m., with the DON, outside of Resident 76's room, RN 1 gave the medicine cup containing the five unidentified pills to the DON. The DON stated that the nurse administering medications is responsible for ensuring medications are taken by the residents at the time of administration and should not leave medications unattended at the bedside. The DON stated that if a resident refuses or is unable to take the medications when offered, the administering nurse should remove the medications from the room and dispose of them in the designated waste medication container located in the medication room. DON stated that leaving unknown medications unattended in a resident's room is a safety concern because residents could later ingest the medications when they are no longer due, consume an incorrect dosage, or another resident could gain access to the medications. The DON stated that some residents can take their own medications, but those residents need to be evaluated first and a proper process needs to be followed prior to residents being able to administer their own medications. The DON stated the five pills should not have been left on Resident 76's bedside table and should have been properly disposed of immediately. During a review of the facility's Policy and Procedures (P&P) titled Administering Medications, dated 1/2018, the P&P indicated: The individual administering the medication checks 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. During a review of the facility's P&P titled Emergency Pharmacy Service and Emergency Kits (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(E-KITS), dated 1/2018, the P&P indicated accountability for CSs stored in emergency kit is maintained in the incoming and outgoing nurses verify the inventory of CSs at each change of shift or exchange of keys. During a review of the facility's P&P titled Controlled Substances, dated 1/2018, the P&P indicated CSs are reconciled upon receipt, administration, disposition, and at the end of each shift. During a review of the facility's P&P titled, Medication and Treatment Orders, dated 1/2018, the P&P indicated, Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy no less than three days prior to the last dosage being administered to ensure the refills are readily available. During a review of the facility's P&P titled Administering Medications dated 1/2018, the P&P indicated Medications are administered in a safe and timely manner, and as prescribed. During a review of the facility's P&P titled Disposal of Medications and Medication -Related Supplies dated 1/2022, the P&P indicted Destruction methods comply with federal and state laws and regulations for medication destruction. During review of the facility's P&P titled Storage of Medications the P&P indicated The facility stored all drugs and biologicals in a safe, secure and orderly manner. During a review of the facility's P&P titled Licensed Vocational Nurse, dated 10/29/2015, the P&P indicated Responsibilities/Accountabilities: Provision of direct patient care- administers medications and performs treatments per physician orders.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 79) was free of unnecessary medications when an order for Divalproex Sodium Divalproex Sodium (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) did not indicate a specific target behavior and did not indicate behavior monitoring.This deficient practice resulted in the lack of behavioral monitoring which had the potential for the inadequate treatment of Resident 79's behavioral symptoms.Findings:During a review of Resident 79's admission Record (Face Sheet), the Face Sheet indicated Resident 79 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 79's diagnoses included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), dementia (a progressive state of decline in mental abilities), anxiety disorder (persistent, excessive fear and worry), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Face Sheet did not indicate a diagnosis of seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness).During a review of Resident 79's Minimum Data Set (MDS- a resident assessment tool), dated 3/13/2026, the MDS indicated Resident 79's cognitive skills for daily decision making (process of thinking) was severely impaired. The MDS indicated Resident 79 Resident required supervision or touching assistance with toileting, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 79 received anticonvulsant medication (used to treat seizures and other behavioral conditions). The MDS did not indicate a diagnosis of seizures.During a review of Resident 79's History and Physical (H&P), dated 12/9/2025, the H&P indicated Resident 79 had fluctuating capacity to understand and make decisions.a. During a concurrent interview and record review on 5/20/2026 at 10:39 a.m., with Registered Nurse (RN) 1, Resident 79's Physician Orders, dated 11/20/2024 through 3/17/2026, were reviewed. The Physician Orders indicated to administer Divalproex Sodium (an anticonvulsant) 125 milligrams (mg, unit of measurement) for seizures from 11/20/2024 through 8/5/2025, and from 12/11/2025 through 3/17/2026. RN 1 stated Resident 79 never had a diagnosis of seizures. RN 1 stated Divalproex Sodium was to treat Resident 79's behavioral symptoms. RN 1 stated if any discrepancies were identified in the order, the licensed nurses were responsible for clarifying orders with the physician. RN 1 stated clarifying the order was necessary to ensure Resident 79 received Divalproex Sodium for its intended use. RN 1 stated Resident 79 receiving Divalproex Sodium for seizures compared to behavioral symptoms would necessitate different monitoring processes and affect Resident 79's plan of care. During an interview on 5/21/2026 at 11:13 a.m., with the Director of Nursing (DON), the DON stated Divalproex Sodium should not have been used to treat seizures because Resident 79 did not have a history of a seizure disorder. The DON stated clarifying the order would have ensured Divalproex Sodium was used for the correct indication. The DON stated administering Divalproex Sodium for seizures affected the monitoring the licensed nurses conducted and allowed for the behavioral symptoms to potentially worsen. b. During a concurrent interview and record review on 5/20/2026 at 10:53 a.m., with RN 1, Resident 79's Physician Orders, dated 3/17/2026, was reviewed. The Physician Order indicated to administer Divalproex Sodium 125 mg by mouth, once a day for mood stabilizer related to anxiety disorder. RN 1 stated Resident 79's Divalproex Sodium did treat a specific target behavior. RN 1 stated Divalproex Sodium was used to stabilize mood; however, the target behavior had to be specific to ensure proper monitoring to help direct Resident 79's plan of care. RN 1 stated specific target behavior was essential to determining the appropriateness of a Gradual Dose Reduction (GDR- process of slowly lowering the dosage of a medication over time to determine if symptoms could be managed at a lower dosage).During an (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 5/21/2026 at 11:13 a.m., with the DON, the DON stated Resident 79's order for Divalproex Sodium should have indicated specific target behaviors the medication was used to treat. The DON stated specific target behaviors was necessary to determine the effectiveness of the medication treatment. The DON stated without a specific target behavior, the facility would not be able to adjust Resident 79's medication treatment accordingly.c. During a concurrent interview and record review on 5/20/2026 at 10:58 a.m., with RN 1, Resident 79's Physician Order Details, dated 3/17/2026, was reviewed. The Physician Order indicated to monitor episodes of mood cycling every shift and record the number of episodes for the use of Divalproex Sodium. The Physician Order indicated, No documentation required. RN 1 stated the licensed nurses were supposed to monitor and document Resident 79's episodes of mood cycling every shift. RN 1 stated the order was inputted incorrectly which led to the lack of documentation of the number of episodes of mood cycling. RN 1 stated usually behavior monitoring appeared on the Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) which prompted the licensed nurses to monitor and document every shift. RN 1 stated mood cycling was not a specific target behavior, however, if there was documentation of the number of episodes, the documentation could assist in determining the effectiveness of Resident 79's Divalproex Sodium treatment.During an interview on 5/21/2026 at 11:13 p.m., with the DON, the DON stated behavioral monitoring should occur every shift to keep count of the amount of episodes Resident 79 experienced. The DON stated Resident 79's order was inputted incorrectly, therefore, did not show on the MAR. The DON stated without behavioral monitoring, the facility was unable to determine the efficacy of the Divalproex Sodium treatment.During a review of the facility's Policy and Procedure (P&P) titled, Behavioral Assessment, Intervention, and Monitoring, dated 1/2018, the P&P indicated medications prescribed for behavioral symptoms must include rationale for use, specific target behaviors, and monitoring for efficacy.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 its medication error rate was less than five (5) percent (%). Three (3) medication errors out of 27 total opportunities contributed to an overall medication error rate of 11.11% affecting one (1) of four (4) residents observed for medication administration (Resident 110). The medication errors were as follows: 1. Resident 110 did not receive famotidine (a supplement used for heartburn) at the scheduled order time. 2. Resident 110 received multivitamins with minerals (a vitamin supplement) not ordered by Resident 110's physician. 3. Resident 110 did not receive aspirin (a medication used for cerebrovascular accident [CVA - an interruption in the flow of blood to cells in the brain, mainly caused by hypertension (high blood pressure)] prophylaxis ([PPX] - prevention), as ordered by Resident 110's physician. These deficient practices had the potential to result in Resident 110 experiencing medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and health complications such as heartburn and CVA resulting in Resident 110's health and well-being to be negatively impacted.Findings: During an observation on 5/18/2026 at 9:30 a.m., in Medication Cart C, Licensed Vocational Nurse (LVN) 5 was observed administering famotidine 20 milligram ([mg]-a unit of measure of mass) tablet and multivitamin with mineral tablet orally to Resident 110. Resident 110 was observed swallowing the famotidine and multivitamin with mineral tablets with glass of water. LVN 5 was not observed administering aspirin 81 mg enteric coated ([EC] - a form of aspirin that is designed to slowly release medication) tablet to Resident 110.During an interview on 5/18/2026 at 11:50 a.m., with LVN 5, LVN 5 stated she administered famotidine 20 mg tablet and multivitamin with mineral tablet but failed to prepare and administer aspirin 81 mg EC tablet during the morning medication administration at 9:30 a.m. to Resident 110. LVN 5 acknowledged Resident 110's physician's orders specified to administer famotidine 20 mg tablet at 7 a.m. and aspirin 81 mg EC at 9 a.m. LVN 5 stated Resident 110's physician did not prescribe multivitamin with minerals. LVN 5 stated per facility policy, there was a 60-minute window before and after the scheduled time for medication administration, and that Resident 110 did not receive famotidine and aspirin during that timeframe. LVN 5 stated she administered multivitamin with minerals without a physicians order. LVN 5 stated she failed to follow the five (5) rights of medication administration and failed to administer medications as prescribed to Resident 110 that day. LVN 5 stated these were considered medication errors, placing Resident 110 at risk of heartburn and CVA. During an interview on 5/18/2026 at 1:58 p.m., with the Director of Nursing (DON,) the DON stated that licensed nurses should follow facility medication administration guidelines to ensure physician orders were followed and the right medications were administered to residents. The DON stated that LVN 5 failed to administer famotidine 20 mg within one (1) hour of the scheduled dose, omitted the administration of aspirin EC 81 mg, and administered multivitamin with minerals without a physician order to Resident 110 that day (5/18/2026) during the morning medication administration. The DON stated per facility policy, medications should be administered within a 60-minute window from the time scheduled by the physician. The DON stated that LVN 5 failed to follow the five (5) rights of medication administration and facility medication administration guidelines, resulting in medication errors and placing Resident 110 at risk of adverse effects such as heartburn and CVA. During a review of Resident 110's admission Record, the admission Record indicated Resident 110 was originally admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 110's diagnoses included cerebral infarction (the death of brain tissue caused by a sudden lack of blood flow,) dysphagia (difficulty swallowing,) and hypertension.During a review of Resident 110's Order Summary Report (a report listing the physician order for the resident,) dated 5/18/2026, the report indicated Resident 110 was not prescribed multivitamin with minerals. The report indicated Resident 10 was prescribed the following: 1. Aspirin EC 81 mg tablet to give orally once a day for CVA PPX, (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	starting 3/6/2026. 2. Famotidine 20 mg tablet to give orally once a day for heartburn, starting 3/29/2026. During a review of Resident 110's ([MAR] - a document of the medications administered to a resident that is part of the resident's permanent medical record], for 5/2026, the MAR indicated Resident 110 was not prescribed multivitamin with minerals. The MAR indicated Resident 110 was prescribed the following: 1. Aspirin EC 81 mg tablet orally once a day for CVA PPX, to be given at 9 a.m. 2. Famotidine 20 mg tablet orally once a day for heartburn, , to be given at 7 a.m. During a review of the facility's Policy and Procedures (P&P) titled Administering Medications, dated January 2018, the P&P indicated that Medications are administered in a safe and timely manner, and as prescribed. The P&P indicated: 1. Medications are administered in accordance with prescriber orders, including any required time frame. 2. Medications are administered within one (1) hour of their prescribed time. 3. The individual administering the medication checks 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.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to: 1. Ensure food items were not stored in the medication refrigerator for one (1) of two (2) inspected medication rooms (Medication Room Station C).2. Label the following in accordance with facility's policy and procedures (P&P) and manufacturer's requirements in one (1) of three (3) inspected medication carts (Medication Cart C).a. one (1) open insulin (medication used to regulate blood sugar levels) Lispro (rapid-acting insulin) pen stored at room temperature for Resident 56,b. one (1) open insulin Lantus (long-acting insulin) pen stored at room temperature for Resident 71,c. one (1) open insulin Humulin N (intermediate-acting insulin) pen stored at room temperature for Resident 123,d. one (1) open budesonide (a medication used to treat and prevent shortness of breath) inhalation solution foil pouch (package made of foil protecting the inhalation solution from light and degradation) stored at room temperature for Resident 7.3. Label the following in accordance with facility's P&P and manufacturer's requirements in one (1) of three (3) inspected medication carts (Medication Cart D.)a. One (1) opened insulin (medication used to regulate blood sugar levels) Humalog (rapid-acting insulin) pen stored at room temperature for Resident 22,b. One (1) opened insulin Humalog pen stored at room temperature for Resident 37,c. One (1) opened insulin glargine (long-acting insulin) pen stored at room temperature for Resident 57,d. One (1) unopened insulin Lantus vial stored at room temperature for Resident 95. 4. Label one (1) budesonide inhalation solution foil pouch for Resident 8 at room temperature in accordance with facility P&P and manufacturer's requirements in one (1) of three (3) inspected medication carts (Medication Cart B.)5. Ensure Resident 24's Bengay cream (over the counter topical pain reliever used to soothe muscle aches and joint pain) was not stored at resident's bedside.These deficient practices increased the risk that Resident 7, 8, 22, 24, 37, 56, 57, 71, 95 and 123 could receive medication that had become ineffective or toxic due to inadequate storage and labeling, inadequate monitoring, and experience medication adverse consequences (unwanted, uncomfortable, or dangerous effects that a medication may have) and the cross contamination (the physical transfer of harmful bacteria, viruses, or allergens from one surface or food item to another) between food and medications for residents in the facility, resulting in the negative impact to their health and well-being possibly leading to health complications, hospitalization, or death. Findings: 1. During a concurrent observation and interview on 5/18/2026 at 12:53 p.m., in Medication Room Station C, in the presence of Licensed Vocational Nurse (LVN) 4, the medication refrigerator contained several medications for the residents in Station C together with one (1) open and partially used carton of Med Pass 2.0 (fortified nutritional shakes) and one (1) closed/unused carton of Med Pass 2.0. LVN 4 stated the medication refrigerator should only be used to store medications and not to store food items together with medications. LVN 4 acknowledged one (1) carton of Med Pass 2.0 was open, and one (1) carton was closed, and both were stored in the refrigerator with resident medications. LVN 4 stated Med Pass 2.0 was a nutritional drink and that there was a risk of cross contamination when storing food items with medications. 2. During a concurrent observation and interview on 5/18/2026 at 1 p.m., in Medication Cart C , and in the presence of LVN 4, the following medication was found either stored in a manner contrary to their respective manufacturer's requirements, not labeled with an open date as required by their respective manufacturer's specifications, or stored and labeled contrary to facility policies: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. One (1) opened and used insulin Lispro pen for Resident 56 was observed stored at room temperature without a date indicating when storage or use at room temperature began. According to the manufacturer's product labeling, open Lispro insulin pens should be stored at room temperature below 86 degrees Fahrenheit and used or discarded within 28 days of opening pen. b. One (1) opened and used insulin Lantus pen for Resident 71 was found stored at room temperature without a date indicating when storage or use at room temperature began. According to the manufacturer's product labeling, open Lantus insulin pens should be stored at room temperature below 86 degrees Fahrenheit and used or discarded within 28 days of opening pen. c. One (1) opened and used insulin Humulin N pen for Resident 123 was found stored at room temperature without a date indicating when storage or use at room temperature began. According to the manufacturer's product labeling, open Humulin N insulin pens should be stored at room temperature below 86 degrees Fahrenheit and used or discarded within 14 days of opening pen. d. One (1) opened budesonide inhalation solution foil (aluminum) pouch (envelope) for Resident 7, was found stored at room temperature and not labeled with a date indicating when the foil pouch was opened. Four (4) inhalation solutions were observed stored in the open foil pouch. According to the manufacturer's product storage and labeling, opened foil pouch of budesonide inhalation solutions should always be stored in the foil pouch at room temperature between 68 and 77 degrees Fahrenheit and used or discarded within two (2) weeks of opening the foil pouch. During a concurrent interview with LVN 4, LVN 4 stated insulin Lispro pen for Resident 56, Lantus pen for Resident 71 and Humulin N pen for Resident 123 was open, used, stored at room temperature, and not labeled with a date when use at room temperature began. LVN 4 stated insulin pen was considered a multi-dose (having more than one [1] dose) medication. LVN 4 stated according to manufacturer directions the Lispro and Lantus pens needed to be discarded after 28 days of use, and Humulin N pen discarded after 14 days of use. LVN 4 stated after that timeframe the insulins lost potency (the strength of medication) and were considered expired. LVN 4 stated that LVN 4 was unaware when the insulin pens for Residents 56, 71 and 123 were opened or stored at room temperature therefore unknown when they would expire. LVN 4 stated administering expired insulin in error will not be effective in keeping the blood sugar stable and can harm Resident 56, 71 and 123 by causing high blood sugar levels, leading to shock and coma (a state of deep unconsciousness caused by injury or illness), hospitalization or even death. LVN 4 stated the Lispro, Lantus, and Humulin N pens needed to be removed from Medication Cart C and replaced with new ones from pharmacy to ensure expired insulin was not administered in error to Resident 56, 71 and 123. LVN 4 stated the budesonide inhalation solution foil pouch for Resident 7 in the Medication Cart C was opened and not labeled with a date indicating when the foil pouch was opened, and four (4) inhalations remained stored in the foil pouch. LVN 4 stated per facility policy multi-dose (containing more than one dose) products such as inhalation solutions should be labeled with the date when first opened to know when they expire, and according to manufacturer guidelines the inhalation solutions once opened from the foil pouch needed to discard within two (2) weeks. LVN 4 stated it was unknown when the four (4) budesonide inhalation solutions would expire and if used beyond the two (2) weeks were considered expired and lost potency (effectiveness), potentially leading to the administration of ineffective medication to Resident 7 causing harm by not treating the asthma (a condition that makes breathing (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	by causing high blood sugar levels, leading to shock and coma, hospitalization or even death. LVN 6 stated the Humalog and glargine pens and Lantus vial needed to be removed from Medication Cart D and replaced with new ones from pharmacy to ensure expired insulin was not administered in error to Resident 22, 37, 57 and 95. 4. During a concurrent observation and interview, on 5/18/2025 at 1:42 p.m., in Medication Cart B, with Registered Nurse (RN) 1, the following medication were observed either stored in a manner contrary to their respective manufacturer's requirements, not labeled with an open date as required by their respective manufacturer's specifications, or stored and labeled contrary to facility policies: a. One (1) opened budesonide inhalation solution foil pouch for Resident 8, was found stored at room temperature and not labeled with a date indicating when the foil pouch was opened. One (1) inhalation solution was observed stored in the open foil pouch. According to the manufacturer's product storage and labeling, opened foil pouch of budesonide inhalation solutions should always be stored in the foil pouch at room temperature between 68 and 77 degrees Fahrenheit and used or discarded within two (2) weeks of opening the foil pouch. During a concurrent interview, RN 1 stated the budesonide inhalation solution foil pouch for Resident 8 in the Medication Cart B was opened and not labeled with a date indicating when the foil pouch was opened, and one (1) inhalation remained stored in the foil pouch. RN 1 stated per facility policy multi-dose products such as inhalation solutions should be labeled with the date when first opened to know when they expire, and according to manufacturer guidelines the inhalation solutions once opened from the foil pouch needed to discard within two (2) weeks. RN 1 stated it was unknown when the one (1) remaining budesonide inhalation solution would expire and if used beyond the two (2) weeks were considered expired and lost potency, potentially leading to the administration of ineffective medication to Resident 8 causing harm by not treating the asthma leading to difficulty in breathing, requiring immediate treatment and potential hospitalization. RN 1 stated the one (1) remaining budesonide inhalation solution for Resident 8 should be discarded from Medication Cart B. During an interview on 5/18/2026 at 1:58 p.m., with the Director of Nursing (DON,) the DON stated food items should not be stored together with medications. The DON stated the medication refrigerator was intended to be used for medication storage only, and storing food with medications together in the same refrigerator was not according to facility policy and procedures and increased the risk of cross contamination. The DON stated that breathing inhalation solutions stored in foil pouches should be labeled with a date when opened and removed from the pouch to know when the beyond use date was (a date identifying an expiration date after opening a multi-dose product,) otherwise unable to determine the expiration date. The DON stated several LVN's failed to label the budesonide inhalation foil pouches when opened for Resident 7 and 8. The DON stated budesonide inhalation solutions expire within two (2) weeks of opening the pouch. The DON stated that expired inhalation treatments have lost effectiveness and when administered in error will not treat the asthma further causing respiratory (related to breathing) distress and stoppage of breathing for Resident 7 and 8 requiring immediate treatment. The DON stated the insulin pens and vials should be labeled with a date indicating when use or storage at room temperature began. The DON stated several LVN's failed to label the insulin pens and vials when opened or stored at room temperature in Medication Cart C and D. The DON stated without knowing when the insulin pens and vials were opened or stored at room temperature, it was unknown when they would expire, increasing the risk of administration of expired insulin to Resident 22, 37, 56, 57, 71, 95 and 123. The DON stated expired insulins have lost potency and effectiveness and when administered in error were not effective in controlling blood (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sugar levels leading to hyperglycemia (high blood sugar level) and adverse effects for Resident 22, 37, 56, 57, 71, 95 and 123 potentially resulting in hospitalization. During an interview with the DON on 5/21/2026 at 12:15 p.m., the DON stated all medications should be stored in a locked cart or room to limit accessibility to residents. The DON stated only licensed nurses should administer medications to residents. During a review of the facility's policy and procedure (P&P) titled Administering Medications, dated 1/2018, the P&P indicated: When opening multi-dose container, the date opened is recorded on the container. During a review of the facility's P&P titled Storage of Medications, dated 1/2018, the P&P indicated: Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications. Medications are stored separately from food and are labeled accordingly. During a review of the facility's P&P titled Food Receiving and Storage, dated 1/2026, the P&P indicated: Medications, blood or blood products may not be stored in the same refrigerator with food. During a review of manufacturer guideline, titled Highlights of Prescribing Information for Lantus, dated 6/2022, the manufactuer guideline indicated to Store unused Lantus in the refrigerator between 36 degrees to 46 degrees degrees Fahrenheit (degrees F). Unopened vials can be used until the expiration date on the carton and vial label if they have been stored in the refrigerator. Unopened vials should be thrown away after 28 days if they are stored at room temperature. Only use your pen for up to 28 days after its first use. Throw away the Lantus pen you are using after 28 days, even if it still has insulin left in it. During a review of manufacturer guideline, titled Highlights of Prescribing Information for glargine, dated 7/2021, the manufacturer guideline indicated to Store glargine between 36 degrees to 46 degrees F until first use. Once you take your pen out of cool storage for use you can use it for up to 28 days. During this time it can be safely kept at room temperature up to 86 degrees F. Do not use it after this time. During a review of manufacturer's guideline, titled Highlights of Prescribing Information for Lispro, dated 12/2020, the manufacturer guideline indicated To store used pens at room temperature below 86 degrees F and to use the pen for up to 28 days after its first use. Throw away the pen you are using after 28 days, even if it still has insulin left in it. During a review of manufacturer's guideline, titled Highlights of Prescribing Information for Humulin N, dated 12/2025, the manufacturer guideline indicated to Store the pen you are currently using at room temperature (up to 86 degrees F). Throw away the Humulin N pen you are using after 14 days, even if it still has insulin left in it. During a review of manufacturer's guideline, titled Highlights of Prescribing Information for Humalog, dated 1/2026, the manufacturer guideline indicated When stored at room temperature Humalog can only be used for a total of (continued on next page)

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	055052	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Post-Acute Care	3615 E. Imperial Hiwy Lynwood, CA 90262

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 days. During a review of manufacturer's guideline Highlights of Prescribing Information for budesonide inhalation dated 1/2026, the guideline indicated Budesonide inhalation suspension should be stored upright at controlled room temperature 68 to 77 degrees Fahrenheit and protected from light. When an envelope has been opened, the shelf life of the unused ampules is 2 weeks when protected. 5. During a review of Resident 24's admission Record, the admission Record indicated Resident 24 was admitted to the facility on [DATE] and readmitted on [DATE]. During a review of Resident 24's History and Physical (H&P), dated 3/13/2026, the H&P indicated Resident 24 did not have medical decision making capacity. During a review of Resident 24's Minimum Data Set (MDS- a resident assessment tool), dated 4/2/2026, indicated Resident 24 had moderate cognitive (ability to think and understand) impairment. The MDS indicated Resident 24 required setup assistance with eating, partial assistance from staff with toileting and personal hygiene and substantial assistance with bathing. During a concurrent observation and interview on 5/18/2026 at 9:45 a.m. with Resident 24, an unopened box of Bengay cream was observed on Resident 24's dresser. Resident 24 stated he had asked his son to bring the Bengay cream for him over the weekend, to help with his leg pain. During a concurrent observation and interview on 5/18/2026 at 10:03 a.m. with LVN 4 in Resident 24's room, an unopened box of Bengay cream was observed on Resident 24's dresser. LVN 4 stated residents should not have medications, including topical creams (medication formulated to be applied directly to the skin) at bedside because there is a risk of accessibility to other residents and topical use needs to be monitored and documented. LVN 4 stated all medications and topicals brought in by residents or their family members require a physician order and pharmacy approval to ensure the medication is not contraindicated. During an interview with the DON on 5/21/2026 at 12:15 p.m., the DON stated all medications should be stored in a locked cart or room to limit accessibility to residents. The DON stated only licensed nurses should administer medications to residents. During a review of the facility's P&P, titled, Storage of Medications dated 1/2018, the P&P indicated, Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify and determine the responsible party (RP- an individual appointed to make decisions for an individual without decision-making capabilities) for one of two sampled residents (Resident 63).This deficient practice resulted in Resident 63 not having a RP who could make medical decisions on his behalf.Cross Reference F552, F580, and F842.Findings:During a review of Resident 63's admission Record (Face Sheet), the Face Sheet indicated Resident 63 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 63'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 and aphasia (a disorder that makes it difficult to speak) following cerebral infarction. The Face Sheet indicated Resident 63 was self-responsible. The Face Sheet listed three family members as Resident 63's emergency contacts and two other family members without a contact type.During a review of Resident 63's Minimum Data Set (MDS- a resident assessment tool), dated 3/5/2026, the MDS indicated Resident 63's cognitive skills (process of thinking) for daily decision making was severely impaired. The MDS indicated Resident 63 was dependent on staff's assistance with oral hygiene, toileting, bathing, upper/lower body dressing, putting on/taking off footwear, and personal hygiene.During a review of Resident 63's History and Physical (H&P), dated 8/29/2025, the H&P indicated Resident 63 did not have the capacity to understand and make decisions.During an interview on 5/20/2026 at 8:27 a.m., with the Social Services Director (SSD), the SSD stated Resident 63 was aphasic (impaired speech) and communication regarding his health was supposed to be with Emergency Contact (EC) 1. The SSD stated Resident 63 did not have decision-making capabilities and was unable to understand his plan of care nor make medical decisions.During a concurrent interview and record review on 5/20/2026 at 9:04 a.m., with the SSD, Resident 63's Care Conference Meeting, dated 3/5/2026, was reviewed. The Care Conference Meeting indicated Resident 63's family, including EC 1, was called, however, the phone call did not go through. The SSD stated the care conferences were conducted quarterly and EC 1 was listed as Resident 63's first emergency contact. The SSD stated she could not recall how long EC 1's phone number was not valid, however, she tried to call EC 1 for the last two care conference meetings and could not get ahold of him. The SSD stated she attempted to call the other three family members listed as Resident 63's emergency contacts, however, none of the calls went through. The SSD stated she did not try to call the additional two family members listed because the Face Sheet did not indicate a contact type. The SSD stated she was told EC 1 was not very involved in Resident 63's care. The SSD stated she should have realized Resident 63 had no responsible party (RP- an individual appointed to make decisions for an individual without decision-making capabilities) because EC 1's phone number was not valid. The SSD stated having an assigned RP, with a reliable way to communicate with, was important to ensure Resident 63 had a decision maker for his medical care.During an interview on 5/21/2026 at 10:29 a.m., with the Director of Nursing (DON), the DON stated having a designated RP for residents without decision-making capabilities was important. The DON stated having an established RP to make critical decisions if an emergency or change in condition occurred was important. The DON stated a RP was essential for communication and to consider the resident's care when the resident could not advocate for themselves. During a review of the facility's policy and procedure (P&P) titled, Resident Representative, dated 1/2018, the P&P indicated if a resident was determined to be incompetent, the rights of the resident would be exercised by the resident representative on the resident's behalf.

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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 informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for two of two sampled residents (Residents 63 and 79) prior to the administration of the following:1. Resident 63's influenza (viral infection that attacks the respiratory system) and Coronavirus Disease 2019 (COVID-19- a highly contagious respiratory illness) vaccinations (medications used to prevent diseases usually given by injection or by mouth).2. Resident 79's Divalproex Sodium (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). These deficient practices resulted in Resident 63, who did not have the capacity to consent, making uninformed decisions about his care and unable to understand the use, side effects, and risks of the vaccines. This deficient practice also resulted in the removal of Responsible Party (RP) 1's right to make decisions regarding Resident 79's care and treatments received in the facility.Cross Reference F551.Findings:1. During a review of Resident 63's admission Record (Face Sheet), the Face Sheet indicated Resident 63 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 63'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 and aphasia (a disorder that makes it difficult to speak) following cerebral infarction. The Face Sheet indicated Resident 63 was self-responsible. The Face Sheet listed three family members as Resident 63's emergency contacts and two other family members without a contact type.During a review of Resident 63's Minimum Data Set (MDS- a resident assessment tool), dated 3/5/2026, the MDS indicated Resident 63's cognitive skills (process of thinking) for daily decision making was severely impaired. The MDS indicated Resident 63 was dependent on staff's assistance with oral hygiene, toileting, bathing, upper/lower body dressing, putting on/taking off footwear, and personal hygiene.During a review of Resident 63's History and Physical (H&P), dated 8/29/2025, the H&P indicated Resident 63 did not have the capacity to understand and make decisions. During an interview on 5/20/2026 at 12:14 p.m., with the Infection Preventionist Nurse (IPN), the IPN stated prior to administering the influenza (viral infection that attacks the respiratory system) and Coronavirus Disease 2019 (COVID-19- a highly contagious respiratory illness) vaccines (medications used to prevent diseases usually given by injection or by mouth), informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) must be obtained from the resident or their responsible party (RP- an individual appointed to make decisions for an individual without decision-making capabilities). The IPN stated obtaining informed consent was necessary to ensure the resident did not receive any vaccines against their, or their RP's, will. During a concurrent interview and record review on 5/20/2026 at 12:21 p.m., with the IPN, Resident 63's Vaccine Consent form for influenza, dated 8/29/2025, and Immunization Report, dated 9/15/2025, were reviewed. The Vaccine Consent form for influenza indicated Resident 63 provided verbal consent to receive the influenza vaccine. The Immunization Report indicated Resident 63 received the influenza vaccine on 9/15/2025. The IPN stated Resident 63 did not have decision-making capabilities and should not have consented to receive the influenza vaccine.During a concurrent interview and record review on 5/20/2026 at 12:24 p.m., with the IPN, Resident 63's Vaccine Consent form for COVID-19, dated 11/11/2025, and Immunization Report, dated 11/14/2025, were reviewed. The Vaccine Consent form for COVID-19 indicated Resident 63 provided verbal consent to receive the COVID-19 vaccine. The Immunization Report indicated Resident 63 received the COVID-19 vaccine on 11/14/2025. The IPN stated Resident 63 did not have decision-making capabilities and should not have consented to (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	receive the COVID-19 vaccine.During an interview on 5/21/2026 at 10:45 a.m., with the Director of Nursing (DON), the DON stated informed consent should always be obtained from an individual with decision-making capabilities, whether it was the resident or their RP. The DON stated prior to obtaining informed consent, time should be given to explain the risks and benefits and to allow the resident or their RP to make the informed decision. The DON stated Resident 63 was unable to understand and make decisions, therefore could not make an informed decision regarding the administration of the influenza and COVID-19 vaccines. During a review of the facility's Policy and Procedure (P&P) titled, Influenza Vaccine, dated 8/2018, the P&P indicated, Prior to the vaccination, the resident or resident's legal representative or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine.2. During a review of Resident 79's admission Record (Face Sheet), the Face Sheet indicated Resident 79 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 79's diagnoses included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), dementia (a progressive state of decline in mental abilities), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 79's MDS, dated [DATE], the MDS indicated Resident 79's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 79 Resident required supervision or touching assistance with toileting, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 79 received 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)During a review of Resident 79's H&P, dated 12/9/2025, the H&P indicated Resident 79 had fluctuating capacity to understand and make decisions.During a review of Resident 79's Physician Order, dated 8/5/2025, the Physician Order indicated to administer Resident 79 Divalproex Sodium (an anticonvulsant medication) 125 milligrams (mg, a unit of measurement) by mouth, three times a day for sudden outbursts of anger related to restlessness and agitation (state of severe restlessness, mental distress, or physical excitability).During an interview on 5/20/2026 at 10:47 a.m., with Registered Nurse (RN) 1, RN 1 stated Divalproex Sodium was primarily used as an anticonvulsant medication, however, could also be used to manage behavioral symptoms. RN 1 stated Resident 79's Divalproex Sodium was used to treat Resident 79's behavioral symptoms, therefore, an informed consent had to be obtained and verified.During a concurrent interview and record review on 5/20/2026 at 10:47 a.m., with RN 1, Resident 79's Psyche Consent, dated 8/18/2025, and Resident 79's Medication Administration Record (MAR), dated 8/1/2025 through 8/31/2025, were reviewed. The Psyche Consent indicated, on 8/18/2025, Responsible Party (RP) 1 consented for Resident 79 to receive Divalproex Sodium 125mg for angry outbursts. The MAR indicated Resident 79 received Divalproex Sodium 125mg on 8/3/2025 at 6 p.m. RN 1 stated Resident 79 received Divalproex Sodium prior to the facility verifying informed consent was obtained from RP 1. During an interview on 5/21/2026 at 11:09 a.m., with the DON, the DON stated informed consent had to be obtained and verified for medications used to treat behavioral symptoms. The DON stated Divalproex Sodium was used to treat Resident 79's angry outbursts and required informed consent from RP 1. The DON stated obtaining and verifying informed consent ensured RP 1 was aware of the risks, benefits, and potential side effects of Divalproex Sodium and was able to make an informed decision. The DON stated by administering Divalproex Sodium to Resident 79 prior to obtaining informed consent, RP 1 was unable to make an informed decision regarding Resident 79's care. During a review of the facility's P&P titled, Consents, Informed, dated 1/2018, the P&P indicated, Each new order for a psychotropic drug, physical restraint, or medical device is obtained, the Licensed Nurse verifies with the resident and/or legal representative that informed consent has been obtained.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to notify the physician and/or responsible party (RP- an individual appointed to make decisions for an individual without decision-making capabilities) for two of two sampled residents' (Residents 79 and 63), after Resident 79 sustained self-inflicted scratches to his face, and after Resident 63's change of condition on 3/4/2026 and 5/4/2026.This deficient practice had the potential to result in a delay in Resident 79's care and resulted in a lack of advocacy for Resident 79 and 63's care.Cross Reference F551 and F842.Findings:1. During a review of Resident 79's admission Record (Face Sheet), the Face Sheet indicated Resident 79 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 79's diagnoses included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), dementia (a progressive state of decline in mental abilities), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 79's Minimum Data Set (MDS- a resident assessment tool), dated 3/13/2026, the MDS indicated Resident 79's cognitive skills for daily decision making (process of thinking) was severely impaired. The MDS indicated Resident 79 Resident required supervision or touching assistance with toileting, lower body dressing, putting on/taking off footwear, and personal hygiene. During a review of Resident 79's History and Physical (H&P), dated 12/9/2025, the H&P indicated Resident 79 had fluctuating capacity to understand and make decisions.During a concurrent observation and interview on 5/18/2026 at 9:54 a.m., with Resident 79, in Resident 79's room, Resident 79 was observed lying in bed. Resident 79 had multiple thin, red lines on his face. Resident 79 nodded when asked if he scratched himself on his face. During a phone interview on 5/18/2026 at 2:48 p.m., with Responsible Party (RP) 1, RP 1 stated Resident 79 had a long history of scratching himself on various parts of his body and his face. RP 1 stated she was not notified of this recent incident. RP 1 stated she wanted to be notified of any change so she could keep track of Resident 79's status and well-being.During an interview on 5/20/2026 at 2:36 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 79 was known to scratch himself on his body and face. LVN 1 stated he was unsure how long ago Resident 79 scratched his face because the scratches were scabbed over and in the healing process. LVN 1 stated Resident 79's scratches on his face were considered a change of condition and should have been reported to his physician and RP 1.During a concurrent interview and record review on 5/20/2026 at 2:37 p.m., with LVN 1, Resident 79's Situation, Background, Assessment, Recommendation (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents) form, dated 5/1/2026 through 5/20/2026, were reviewed. The SBAR forms did not indicate a change of condition regarding Resident 79's scratches on his face. LVN 1 stated an SBAR form was completed to describe the change of condition, the assessment, the physician's recommendations, and the physician's and RP's notification. LVN 1 stated Resident 79's physician and RP 1 were not notified of Resident 79's scratches on his face. LVN 1 stated by not notifying Resident 79's physician, there were no orders to monitor and treat the scratches. LVN 1 stated by not notifying RP 1, RP 1 was unable to advocate for Resident 79's care.During an interview on 5/21/2026 at 11:04 a.m., with the Director of Nursing (DON), the DON stated Resident 79's physician and RP 1 should have been notified of his scratches on his face. The DON stated Resident 79 has a recurring behavior of scratching himself, however, each incident should be reported. The DON stated due to the lack of notification, Resident 79's physician was unable to make recommendations and RP 1 was unaware of Resident 79's status.2. During a review of Resident 63's admission Record (Face Sheet), the Face Sheet indicated Resident 63 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 63's diagnoses included hemiplegia (total (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 and aphasia (a disorder that makes it difficult to speak) following cerebral infarction. During a review of Resident 63's MDS, dated [DATE], the MDS indicated Resident 63's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 63 was dependent on staff's assistance with oral hygiene, toileting, bathing, upper/lower body dressing, putting on/taking off footwear, and personal hygiene.During a review of Resident 63's H&P, dated 8/29/2025, the H&P indicated Resident 63 did not have the capacity to understand and make decisions.During an interview on 5/20/2026 at 8:27 a.m., with the Social Services Director (SSD), the SSD stated Resident 63 was aphasic (impaired speech) and communication regarding his health and any changes of condition were supposed to be with Emergency Contact (EC) 1. The SSD stated Resident 63 did not have decision-making capabilities and was unable to understand his plan of care nor make medical decisions.During an interview on 5/20/2026 at 10:32 a.m., with Registered Nurse (RN) 1, RN 1 stated any changes of condition, the resident or their RP were notified. RN 1 stated the resident's H&P, completed by their physician, indicated the resident's decision-making capabilities. RN 1 stated if the resident did not have decision-making capabilities, an RP would be assigned and indicated on the Face Sheet. RN 1 stated when a resident experienced a change of condition, the licensed nurses would refer to the Face Sheet to check if the resident was self-responsible or had an RP in charge of their care. RN 1 stated Resident 63 was able to make some needs known, however, was unable to make decisions.During a concurrent interview and record review on 5/20/2026 at 10:35 a.m., with RN 1, Resident 63's Face Sheet was reviewed. The Face Sheet indicated Resident 63 was self-responsible. The Face Sheet listed three family members as Resident 63's emergency contacts and two other family members without a contact type. RN 1 stated Resident 63's Face Sheet was incorrect and could cause confusion if the licensed nurse was not familiar with Resident 63's mentation. RN 1 stated the Face Sheet was their primary tool to determine the individual to notify of any changes. During a concurrent interview and record review on 5/20/2026 at 10:38 a.m., with RN 1, Resident 63's SBAR form, dated 3/4/2026, was reviewed. The SBAR form indicated Resident 63 had an episode of a low oxygen saturation (percentage of how effectively red blood cells are delivering oxygen to the body, normal range from 95 percent [%) to 100%) at 88 %. The SBAR form indicated Resident 63 was self-responsible. RN 1 stated Resident 63 did not have decision-making capabilities and was unable to advocate for his own care. RN 1 stated EC 1 or other family members should have been contacted.During a concurrent interview and record review on 5/20/2026 at 10:40 a.m., Resident 63's SBAR form, dated 5/4/2026, was reviewed. The SBAR form indicated Resident 63 had a tear in his 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). The SBAR form indicated Resident 63 was self-responsible. RN 1 stated Resident 63 did not have decision-making capabilities and was unable to advocate for his own care. RN 1 stated EC 1 or other family members should have been contacted.During an interview on 5/21/2026 at 10:41 a.m., with the DON, the DON stated Resident 63 was not self-responsible because Resident 63 could not understand and make medical decisions. The DON stated after Resident 63's recent changes of condition, EC 1 or his other family members should have been contacted to allow them to make any necessary medical decisions for Resident 63. During a review of the facility's Policy and Procedure (P&P) titled, Change in a Resident's Condition or Status, dated 1/2026, the P&P indicated the facility would promptly notify the resident, their attending physician, and their RP of changes in the resident's condition.

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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 and interview, the facility failed to ensure resident care equipment was stored appropriately and resident room surfaces were maintained in a clean repaired condition one of one residents (Resident 6). This deficient practice had the potential to expose Resident 6 to contamination and infection risks and failed to ensure all residents resided in a clean and homelike environment.Findings: During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was admitted to the facility on [DATE]. Resident 6's diagnoses included chronic obstructive pulmonary disease (COPD- a progressive lung disease that restricts airflow causing significant breathing difficulties), dysphagia (difficulty swallowing), acute respiratory failure with hypoxia (sudden and life-threatening inability of the respiratory system to supply adequate oxygen in the blood), asthma (a chronic respiratory disease that causes the airways to swell, and narrow making it difficult to breathe), pulmonary embolism (life-threatening blockage in a lung artery caused by a blood clot traveling from the legs or pelvis), hemiplegia (complete or near complete paralysis of one side) and hemiparesis (partial muscular weakness) due to stroke (loss of blood flow to a part of the brain), and dementia (a progressive state of decline in mental abilities). During a review of Resident 6's History and Physical (H&P) dated 10/1/2025, the H&P indicated Resident 6 did not have the capacity to understand and make decisions. During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 5/5/2026, the MDS indicated Resident 6 cognitive skills for daily decision making (the ability to think and process information) was severely impaired. The MDS indicated Resident 6 was dependent on staff (helper does all the effort) to complete activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During an observation on 5/18/2026 at 10:56 a.m., inside Resident 6's room, a nebulizer machine (a medical device that turns liquid medication into a fine mist for inhalation directly into the lungs) with the attached cannula (a thin flexible tube used to administer medication or oxygen) was observed on the floor next to Resident 6's bed. During the observation approximately 16 scuffs (surface abrasions or scrape marks) were observed on the wall next to Resident 6's bed. A coax cable (a heavily shielded cable used to transmit radio frequency signals) located next to Resident 6's bed was observed to have dry brown matter on it. During an interview on 5/20/2026 at 10:55 a.m., with Certified Nursing Assistant (CNA) 6, CNA 6 stated that when assisting residents with toileting or personal care, if bodily fluids or other substances come into contact with walls, cables, or other surfaces in the residents room, the CNA were expected to clean the area immediately and then notify the housekeeping department. CNA 6 stated that housekeeping staff properly disinfected the affected area, especially if contaminated with feces or other bodily fluids, to help prevent the spread of infection and maintain a clean and sanitary environment for residents. CNA 6 stated that if staff observed anything broken, damaged, or in need of repair within a resident's room, staff were expected to notify the maintenance department promptly so repairs could be completed in a timely manner. CNA 6 stated that the nebulizer machine should not be on the floor as this was a medical device and should be on the bedside table. CNA 6 stated that reporting environmental concerns was important to ensure residents resided in a safe, clean, sanitary, and homelike environment. During a concurrent observation and interview on 5/20/2026 at 11:51 p.m., with the Maintenance Director/Housekeeping Director (MDHS), the MDHS stated that the scuffs observed on the wall should not have been present because they did not reflect a homelike environment for Resident 6. The MDHS stated that staff entering the room should have reported the wall damage so repairs could have been completed in a timely manner. The MDHS stated that the dry brown matter observed on the coax cable was unacceptable and should have been cleaned immediately upon identification. The MDHS stated that if bodily fluids were observed by nursing, then nursing staff would clean it first and then notify (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Post-Acute Care	3615 E. Imperial Hiwy Lynwood, CA 90262

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	housekeeping so that area could be properly disinfected. The MDHS stated that maintaining clean walls, equipment, and cables in good repair was the responsibility of the maintenance and housekeeping department to ensure the environment remained sanitary, orderly, and safe for residents. The MDHS stated it was important for staff to promptly identify, report, clean, and repair environmental concerns to help prevent infection risks, maintain resident dignity, and provide residents with a clean and comfortable living environment. During an interview on 5/20/2026 at 3:18 p.m., with the Infection Preventionist Nurse (IPN), the IPN stated that it was important for the facility to provide and maintain a clean, safe, and homelike environment for every resident. The IPN stated that nebulizer machines should not be placed on the floor because the equipment could become contaminated from dirt, dust, and other pathogens present on the floor surface, which could increase the risk of infection and compromise the cleanliness of the respiratory treatment equipment. The IPN stated that all room surfaces and resident care equipment should be maintained in a clean and sanitary condition to reduce the potential spread of infections within the facility. The IPN stated that staff were responsible for ensuring residents' rooms remained clean, organized, safe, and free from environmental concerns that could place residents at risk for infection or diminish a homelike environment. During a review of the facility's policy and procedures (P&P) titled Cleaning and Disinfecting of Environment Surfaces dated 1/2018, the P&P indicated The following categories are used to distinguish the level of sterilization/disinfection necessary for items used in resident care and those in the resident's environment. Spills of blood and other potentially infectious materials will promptly be cleaned and decontaminated. During a review of the facility's P&P titled Homelike Environment dated 1/2026 the P&P indicated Residents are provided with a safe, clean, comfortable and homelike environment .

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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 injury of unknown origin 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 one of one sampled residents (Resident 79) when Resident 79 was found to have a purple-blue discoloration under his left eye.This deficient practice resulted in a delay of an onsite investigation and had the potential to result in further injury to Resident 79.Findings:During a review of Resident 79's admission Record (Face Sheet), the Face Sheet indicated Resident 79 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 79's diagnoses included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), dementia (a progressive state of decline in mental abilities), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 79's Minimum Data Set (MDS- a resident assessment tool), dated 3/13/2026, the MDS indicated Resident 79's cognitive skills for daily decision making (process of thinking) was severely impaired. The MDS indicated Resident 79 Resident required supervision or touching assistance with toileting, lower body dressing, putting on/taking off footwear, and personal hygiene. During a review of Resident 79's History and Physical (H&P), dated 12/9/2025, the H&P indicated Resident 79 had fluctuating capacity to understand and make decisions.During a review of Resident 79's Situation, Background, Assessment, Recommendation (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents) Form, dated 4/22/2026, the SBAR Form indicated, on 4/22/2026, Resident 79 was observed with a discoloration at the left lower eyelid. During a review of Resident 79's Progress Note, dated 4/22/2026 at 7 a.m., the Progress Note indicated Resident 79 was observed with discoloration at the left lower eyelid. The Progress Note indicated Resident 79 was unable to describe how the discoloration occurred.During a review of Resident 79's Post-Event Note, dated 4/22/2026, the Post-Event Note indicated, on 4/22/2026 at 6 a.m., Resident 79 was noted with discoloration to the left lower eyelid. The Post-Event Note indicated Resident 79 was a poor historian and unable to provide details regarding the cause or onset of the discoloration. The Post-Event Note indicated the DON interviewed the staff members who cared for Resident 79 and all the staff members denied knowledge of any incident, trauma, fall, contact injury, or event that could have contributed to the discoloration. The Post-Event Note indicated, At this time, the cause of the bruising/discoloration remains undetermined.During a review of Resident 79's Skin Observation Tool, dated 4/22/2026, the Skin Observation Tool indicated Resident 79 was observed with discoloration on the left lower eye and Resident 79 was unable to answer how the discoloration occurred.During an interview on 5/21/2026 at 7:32 a.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated on 4/22/2026, Certified Nursing Assistant (CNA) 1 notified him, near the end of his shift around 7 a.m., that Resident 79 had discoloration underneath his left eye. LVN 2 stated, The discoloration looked like a bruise and it was purple in color. LVN 2 stated Resident 79 was unable to say what happened. LVN 2 stated after CNA 1 informed him of Resident 79's left lower eye discoloration, he informed the Assistant Director of Nursing (ADON). LVN 2 stated he did not inform the Administrator (ADM), who was the facility's abuse coordinator. LVN 2 stated discoloration could be considered an injury and the circumstances regarding the discoloration were unknown. LVN 2 stated Resident 79's discoloration was an injury of unknown origin. During a concurrent interview and record review on 5/21/2026 at 7:44 a.m., with LVN 2, Resident 79's Photo of the left eye, dated 4/22/2026 and timed at 8:54 a.m., was reviewed. The Photo revealed a purple discoloration present underneath Resident 79's eye, extending from the inner corner to the middle of the eye lid. LVN 2 stated the photo on the facility's phone was of Resident 79's left lower eye discoloration. During a (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	phone interview on 5/21/2026 at 10:10 a.m., with CNA 1, CNA 1 stated, on 4/22/2026 at approximately 2 a.m., she entered Resident 79's room to change his adult brief. CNA 1 stated she noticed Resident 79 had a dark discoloration under Resident 79's left eye which looked like a black eye. CNA 1 stated she asked Resident 79 to explain what happened, however Resident 79 was unable to communicate what happened. CNA 1 stated she did not recall who she notified or what time. CNA 1 stated anytime a resident sustained an injury with an unknown origin, she was responsible for informing the licensed nurse on duty and the ADM. CNA 1 stated she did not inform the ADM because she notified the licensed nurse and knew the Director of Nursing (DON) was informed because she received a text message later that morning inquiring about Resident 79's left eye discoloration.During an interview on 5/21/2026 at 11:30 a.m., with the DON, the DON stated, on 4/22/2026, he conducted an investigation to determine the cause of Resident 79's left lower eye discoloration. The DON stated he was unable to come to a definitive cause of Resident 79's left lower eye discoloration. The DON stated Resident 79's left lower eye discoloration could have been caused by Resident 79 rubbing his eye, a fall, medication side effects, or someone or something hitting Resident 79. The DON stated Resident 79's left lower eye discoloration was considered an injury of unknown origin because they were unaware of the cause. The DON stated abuse allegations were reported 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 however he did not determine Resident 79's discoloration to be caused by abuse or harm. The DON stated an injury of unknown origin could have been a result of abuse, therefore should have been reported. The DON stated reporting to the three agencies was necessary to ensure resident advocacy by the Ombudsman, an investigation by CDPH, and resident safety by the local law enforcement. During an interview on 5/21/2026 at 11:47 a.m., with the ADM, the ADM stated he was aware of Resident 79's left lower eye discoloration. The ADM stated he and the DON conducted an investigation and were unable to determine the cause of the discoloration. The ADM stated abuse was not determined, therefore he did not report the injury of unknown origin to the three agencies. The ADM stated Resident 79's left lower eye discoloration should have been considered as suspicious because the eye was not an area accidentally bumped. The ADM stated because the facility was unable to determine the cause of Resident 79's left lower eye discoloration; he should have reported to the three agencies to ensure abuse did not occur. The ADM stated due to the lack of reporting, Resident 79 was at risk for potential further abuse.During a review of the facility's Policy and Procedure (P&P) titled, Abuse Investigation and Reporting, dated 2/2018, the P&P indicated, an alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but no later than two hours if the alleged violation involves abuse or has resulted in serious bodily injury; or Twenty-four hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury. The P&P indicated all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies:1. The State licensing/certification agency responsible for survey/licensing the facility;2. the local/State Ombudsman;3. The Resident's Representative (Sponsor) of Record;4 Adult Protective Services (where state law provides jurisdiction in long-term care);5. Law enforcement officials;6. The resident's Attending Physician.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR-a federal assessment requirement to help ensure individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care and referred to special services as needed) Level 2 evaluation was completed for one of one sampled residents (Resident 12). This deficient practice had the potential to result in inappropriate placement and unidentified specialized services for Resident 12.Findings: During a review of Resident 12's admission Record, the admission Record indicated Resident 12 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 12's diagnoses included dysphagia (difficulty swallowing), schizophrenia (a mental illness that is characterized by disturbances in thought) and hypertension (HTN- high blood pressure). During a review of Resident 12's Minimum Data Set (MDS), dated [DATE], the MDS indicated Resident 12's cognitive skills for daily decision making was severely impaired cognition (ability to think and understand). The MDS indicated Resident 12 was dependent on staff for toileting, bathing, and personal hygiene. The MDS indicated Resident 12 had a diagnosis of schizophrenia. During a review of Resident 12's PASARR level 1 screening dated 10/17/2025, the PASARR indicated the need for Level 2 PASARR evaluation. During a concurrent interview and record review on 5/20/2026 at 2:45 p.m. with Minimum Data Set Consultant (MDSC), Resident 12's Notice of Attempted Evaluation dated 10/21/2025 and medical records were reviewed. Resident 12's medical records indicated a PASARR Level 2 evaluation had not been completed. Resident 12's Notice of Attempted Evaluation indicated Resident 12 required a Level 2 PASARR evaluation, but it was not completed because facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level 1 screening. The MDSC stated facility staff should have responded to calls in attempts to complete the assessment. The MDSC stated facility staff should have completed another PASARR Level 1 screening for Resident 12 to prompt another PASARR level 2 evaluation. The MDSC stated PASARR evaluations were important to ensure serious mental illnesses were appropriately screened, resident placement was accurate and referrals were made to appropriate programs and services. During an interview with the Director of Nursing (DON) on 5/21/2026 at 12:15 p.m., the DON stated PASARR evaluations were important to ensure the facility was correctly identifying the level of care each resident required, and providing the appropriate services. During a review of the facility's Policy and Procedure (P&P), titled, admission Criteria dated 1/2019, the P&P indicated, If the level 1 (PASARR) screen indicates that the individual may meet the criteria for a mental disorders (MD), intellectual disabilities (ID) or related disorders (RD), he or she is referred to the state PASARR representative for the Level 2 (evaluation and determination) screening process. The P&P indicated, Upon completion of the Level 2 evaluation, the state PASARR representative determines if the individual has physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate.

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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 care plan addressing behaviors of scratching and the use of supplemental oxygen (medical treatment that delivers extra oxygen to the lungs) for two of two sampled residents (Residents 79 and 29).These deficient practices had the potential to negatively affect Residents 79 and 29's physical and psychosocial well-being and had the potential to delay the delivery of necessary care and services. Findings: 1. During a review of Resident 79's admission Record (Face Sheet), the Face Sheet indicated Resident 79 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 79's diagnoses included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), dementia (a progressive state of decline in mental abilities), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 79's Minimum Data Set (MDS- a resident assessment tool), dated 3/13/2026, the MDS indicated Resident 79's cognitive skills for daily decision making (process of thinking) was severely impaired. The MDS indicated Resident 79 Resident required supervision or touching assistance with toileting, lower body dressing, putting on/taking off footwear, and personal hygiene. During a review of Resident 79's History and Physical (H&P), dated 12/9/2025, the H&P indicated Resident 79 had fluctuating capacity to understand and make decisions. During a concurrent observation and interview on 5/18/2026 at 9:54 a.m., with Resident 79, in Resident 79's room, Resident 79 was observed lying in bed with multiple thin, red lines on his face. Resident 79 nodded yes when asked if he scratched himself on his face. During a phone interview on 5/18/2026 at 2:48 p.m., with Resident 79's Responsible Party (RP 1), RP 1 stated Resident 79 had a long history of scratching himself on various parts of his body and his face. During an interview on 5/20/2026 at 2:36 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 79 was known to scratch himself on his body and face. LVN 1 stated he was unsure how long ago Resident 79 scratched his face because the scratches were scabbed over and in the healing process. During a concurrent interview and record review on 5/20/2026 at 2:39 p.m., Resident 79's Care Plans, dated 5/1/2026 through 5/20/2026, were reviewed. The Care Plans did not indicate a care plan was developed to address Resident 79's behavior of scratching himself. LVN 1 stated a long-term care plan should have been developed to address Resident 79's behavior of scratching himself. LVN 1 stated the behavior was recurring and the care plan would ensure the facility's staff identified the behavior and addressed the cause of the behavior. LVN 1 stated the care plan would ensure Resident 79 was carefully monitored for his physical and psychosocial well-being. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/2026 at 11:06 a.m., with the Director of Nursing (DON), the DON stated care plans were a summary of each resident's plan of care to ensure each resident's identified issues, conditions, and behaviors were addressed appropriately. The DON stated Resident 79's behavior of scratching himself should have been care planned to ensure interventions were developed and implemented to prevent and treat the behavior. 2. During a review of Resident 29's admission Record, the admission Record indicated Resident 29 was admitted to the facility on [DATE]. Resident 29's diagnoses included chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), chronic kidney disease (CKD- kidney damage effecting it's ability to filter blood), and hypertension (HTN-high blood pressure). During a review of Resident 29's H&P dated 4/8/2026, the H&P indicated Resident 29 did not have the capacity to understand or make decisions. During a review of Resident 29's MDS, dated [DATE], the MDS indicated Resident 29 had severe cognitive impairment. The MDS indicated Resident 29 was dependent on staff for eating, toileting and bathing. The MDS indicated Resident 29 was receiving oxygen therapy. During a review of Resident 29's physician's order dated 4/8/2026, the physician's order indicated, Administer continuous oxygen at two liters per minute (LPM-measurement of flow rate used during oxygen therapy) via nasal cannula (thin flexible tube used to deliver oxygen), may titrate oxygen flow to two-four LPM to keep oxygen saturation (O2 sat- measurement of percentage of oxygen in your blood) equal or more than 92 percent (%). Monitor O2 sat with oxygen use every shift. During a concurrent interview and record review on 5/20/2026 at 11:15 a.m. with Registered Nurse (RN) 1, Resident 29's medical record was reviewed. The medical record did not indicate a care plan was developed addressing Resident 29's use of continuous oxygen. RN 1 stated Resident 29 was on 2LMP of continuous oxygen via nasal cannula. RN 1 stated resident care plans should be comprehensive and specific to ensure all resident care needs were addressed. RN 1 stated interventions for oxygen use would include specific respiratory assessments and safety precautions. RN 1 stated failure to ensure an oxygen care plan was created placed Resident 29 at risk of inadequate respiratory assessments and safety monitoring for oxygen use. During an interview on 5/21/2026 at 12:15 p.m. with the Director of Nursing (DON), the DON stated care plans should be comprehensive and specific to resident needs. The DON stated residents on continuous oxygen should have a care plan that addresses oxygen use and interventions that address respiratory assessments and monitoring. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 1/2018, 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. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration dated January 2018, the P&P indicated, The purpose of this procedure is to provide guidelines for safe oxygen administration. The P&P indicated to review the resident's care plan to assess for any special needs of the resident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident's fingernails were maintained in a trimmed and clean manner one of one sampled residents (Resident 7), who was dependent on staff for care. This deficient practice had the potential to result in a negative impact on Resident 7's quality of life and self-esteem, and had the potential for the development of infection.Findings:During a review of Resident 7's admission Record (Face Sheet), the Face Sheet indicated Resident 7 was initially admitted to the facility on [DATE] and was re-admitted on [DATE]. Resident 7's diagnoses included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), dysphagia (difficulty swallowing), and muscle weakness.During a review of Resident 7's Minimum Data Set (MDS - a resident assessment tool), dated 5/8/2026, the MDS indicated Resident 7's cognitive skills for daily decision making (ability to think) was moderately impaired. The MDS indicated Resident 7 required was dependent (helper does all the effort) on staff for activities of daily living (ADLs- routine tasks/activities such as eating, bathing, dressing and toileting a person performs daily to care for themselves).During an observation on 5/18/2026 at 9:55 a.m., at Resident 7's bedside, Resident 7's fingernails were observed. Resident 7's fingernails were long and untrimmed with black debris underneath the nail bed.During a concurrent observation and interview on 5/19/2026 at 3:26 p.m., at Resident 7's bedside, with Licensed Vocational Nurse (LVN) 3, Resident 7's fingernails were observed. Resident 7's fingernails were long and untrimmed. LVN 3 stated Resident 7's fingernails were sharp, long and required trimming. LVN 3 stated nail care was one of the responsibilities of the certified nursing assistant (CNA) which included trimming and cleaning the resident's fingernails when they become long and dirty. LVN 3 stated residents' nails should be checked daily to ensure the nails remained clean and neat. LVN 3 stated residents sometimes scratched their skin, and if they scratched hard enough, they could break the skin and create an open wound. LVN 3 stated if a resident had dirty fingernails and scratched themselves, this increased the risk of infection.During an interview with the Infection Preventionist Nurse (IPN) on 5/20/2026 at 9:51 a.m., the IPN stated nail care should be assessed daily. The IPN stated residents who required assistance with cleaning or trimming their nails should be assisted by the CNA's or licensed nurses. The IPN stated fingernails were a source of bacteria, and that dirty or untrimmed nails could contribute to the spread of infection, especially among residents who may not be able to maintain their own hygiene. The IPN stated routine nail care was an essential part of both personal hygiene and infection control.During an interview on 5/21/2026 at 9:51 a.m., with the Director of Nursing (DON), the DON stated fingernail care was a part of the resident's ADL routine. The DON stated if a resident had long and dirty fingernails, CNAs were expected to clean and trim them. The DON stated dirty fingernails was not acceptable, as they increased the risk of infection.During a review of the facility's policy and procedure (P&P) titled Activities of Daily Living (ADL's), dated 1/2018, the P&P indicated residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain grooming and personal hygiene.

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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 ensure wound care orders were transcribed and dressing changes were performed from 5/15/2026 to 5/17/2026 for one of one sampled residents (Resident 5).This deficient practice had the potential to place Resident 5 at risk for delayed care and delayed wound healing.Findings:During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 5's diagnoses included chronic kidney disease (CKD- kidney damage effecting its ability to filter blood) diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling).During a review of Resident 5's Minimum Data Set (MDS-a resident assessment tool) dated 3/19/2026, the MDS indicated Resident 5's cognitive skills for daily decision making (ability to think and understand) was intact. The MDS indicated Resident 5 required substantial staff assistance for toileting, bathing and setup assistance for eating and personal hygiene. The MDS indicated Resident 5 had an unhealed pressure injury (pressure ulcer - injury to the skin or underlying tissue due to prolonged pressure).During an interview on 5/19/2026 at 10:26 a.m. with Resident 5, Resident 5 stated she had a pressure ulcer on her left heel and bilateral shin wounds which required daily dressing changes. Resident 5 stated she did not receive dressing changes from 5/15/2026 to 5/17/2026. Resident 5 stated she did not know why the dressing changes were not performed.During a concurrent interview and record review on 5/20/2026 at 1:45 p.m. with Treatment Nurse (TN) 1, Resident 5's physician's orders for May 2026 were reviewed. The physician orders indicated as follows: Left heel pressure injury unstageable- cleanse with wound cleanser, pat dry with gauze, apply betadine (topical used to kill or prevent the growth of bacteria) to wound bed, then cover with kerlix (gauze) and secure with tape every day shift for 14 days. Start date 5/1/2026, End date 5/15/2026. Left heel PI unstageable- cleanse with wound cleanser, pat dry with gauze, apply betadine to wound bed, then cover with kerlix and secure with tape every day shift for 14 days. Start date 5/18/2026 End date 6/1/2026. Left medial leg trauma wound (TW- sudden, unplanned injury to the skin caused by an external or mechanical force) cleanse with wound cleanser, pat dry with gauze, paint with betadine and cover with abdominal pad and kerlix, secure with tape every day shift for 14 days. Start date 5/1/2026 End date 5/15/2026. Left medial leg TW- cleanse with wound cleanser, pat dry with gauze, paint with betadine and cover with abdominal pad and kerlix, secure with tape every day shift for 14 days. Start date 5/18/2026 end date 6/1/2026. Right lateral shin TW- cleanse with wound cleanser, pat dry with gauze, apply betadine to wound bed, then cover with kerlix and secure with tape every day shift for 14 days. Start date 5/1/2026 end date 5/15/2026. Right lateral shin TW- cleanse with wound cleanser, pat dry with gauze, apply betadine to wound bed, then cover with kerlix and secure with tape every day shift for 14 days. Start date 5/18/2026 end date 6/1/2026.TN 1 stated the wound care Physician Assistant (PA) assessed the residents weekly, provided wound treatment recommendations to the Assistant Director of Nursing (ADON), and the ADON transcribed the orders onto the resident's electronic medical record (EMR- digital version of resident's medical chart). TN 1 stated Resident 5's treatment orders should have been placed with a start date of 5/16/2026 to ensure the resident received treatment as prescribed. TN 1 stated failure to transcribe the wound care orders resulted in Resident 5 not receiving dressing changes for three days. TN 1 stated lack of wound care orders placed Resident 5 at risk delayed care and delayed wound healing.During a review of Resident 5's Treatment Administration Record (TAR- documents resident treatments performed) for May 2026, the TAR did not indicate Resident 5 received dressing changes to the left heel PI, left medial leg TW and right lateral shin TW from 5/15/2026 to 5/17/2026.During a phone interview on 5/20/2026 at 12:26 p.m. with Physician Assistant (PA) 1, PA 1 stated he came to the facility weekly to assess residents with (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Post-Acute Care	3615 E. Imperial Hiwy Lynwood, CA 90262

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wounds. PA 1 stated if there were any treatment order updates, his wound care team would send the updates to the Director of Nursing (DON), ADON and the facility's treatment nurse. PA 1 stated the DON, ADON, and the treatment nurse were responsible for the transcribing orders into the resident's EMR. PA 1 stated the ADON typically accompanied him during his assessments and transcribed treatment updates into the residents charts. PA 1 stated he expected the treatment recommendations he made to be consistently carried out until he returned to the facility the following week to reassess the resident. PA 1 stated there should not be any periods of time where treatment orders were not active, and facility staff should have ensured Resident 5 was receiving daily dressing changes as ordered.During an interview on 5/20/2026 at 1:45 p.m. with the DON, the DON stated transcribing treatment orders in a timely manner was important to ensure residents were receiving the care and treatments that were indicated and ordered. The DON stated Resident 5's dressing changes should have been completed daily to ensure the plan of care was being followed.During a review of the facility's Policy and Procedure (P&P) titled, Physician Orders dated 1/2018, the P&P indicated the licensed nurse receiving the order must verify to ensure the order is complete and includes the date, time and any other information necessary to accurately and completely carry out the order.During a review of the facility's P&P titled, Wound Care dated 1/2018, the P&P indicated to verify that there is a physician's order for this procedure.During a review of the facility's Registered Nurse (RN) job description last revised 10/23/2025, the job description indicated the RN was to obtain/receive physicians' orders as required.During a review of the facility's Licensed Vocational Nurse (LVN) job description last revised 10/19/2015, the job description indicated to administer medications and perform treatments per physician orders.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled residents' (Resident 98) room was free of accidents and hazards when wheelchairs were observed blocking the room pathways and bathroom entrance.This deficient practice placed Resident 98 and other residents at risk for injury and an unsafe environment.Findings:During a review of Resident 98's admission Record, the admission Record indicated Resident 98 was admitted to the facility on [DATE]. Resident 98's diagnoses included Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), atrial fibrillation (irregular heart beat), acute embolism (a block in an artery caused by blood clots), and deep vein thrombosis of the right lower extremity (a sudden, newly formed blood clot is blocking blood flow in a deep vein within your right leg).During a review of Resident 98's History and Physical (H&P), dated 5/5/2026, the H&P indicated Resident 98 had fluctuating capacity (ability to think or make decisions changes from time to time) to understand and make decisions.During a review of Resident 98's Minimum Data Set (MDS- a resident assessment tool), dated 5/8/2026, the MDS indicated Resident 98's cognitive skills for daily decision making (the ability to think and process information) was impaired. The MDS indicated Resident 98 was dependent (helper does all the effort) on staff with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During an observation on 5/18/2026 at 9:12 a.m., at Resident 98's bedside, Resident 98 was observed lying awake in bed. One wheelchair was positioned at the resident's bedside, a second wheelchair was blocking the room entrance door, and a third wheelchair was obstructing the bathroom entrance with the footrests extended and resting on the floor. The placement of the wheelchairs obstructed clear pathways for resident mobility, transfers, and safe bathroom access, creating a potential accident and hazard.During a current observation and interview on 5/19/2026 at 8:17 a.m., with Certified Nursing Assistant (CNA) 4, in Resident 98 ?s room, Resident 98 observed lying asleep in bed. A wheelchair was blocking the room entrance door and another wheelchair was blocking the bathroom door. CNA 4 stated, wheelchairs should be placed properly and should not block the pathways inside residents' rooms. CNA 4 further stated blocked pathways including the bathroom entrance may place residents at risk for falls, injury, and difficulty with safe mobility and bathroom access.During an interview on 5/21/2026 at 9:20 a.m. with the Director of Nursing (DON), the DON stated that wheelchairs blocking the bedroom pathways and bathroom entrance may place residents at risk for falls, injuries, delayed bathroom access, and difficulty with safe mobility and transfers. The DON stated obstructed pathways may also prevent residents from moving freely and safely within their environmentDuring a review of the facility's policy and procedure (P&P) titled, Homelike Environment, dated 1/2026, the P&P indicated the facility would provide an environment that remained safe and orderly environment to residents.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide suprapubic urinary catheter care (a hollow tube inserted into the bladder through the lower abdomen to drain or collect urine) for one of two sampled residents (Resident 9).This deficient practice had the potential to result in Resident 9 developing a urinary tract infection (UTI- an infection in the bladder/urinary tract).Findings:During a review of Resident 9's admission Record (Face Sheet), the Face Sheet indicated Resident 9 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 9's diagnoses included neuromuscular dysfunction of the bladder (spinal cord or nerve damage that disrupts the signals to hold and release urine) and retention of urine.During a review of Resident 9's Minimum Data Set (MDS- a resident assessment tool), dated 2/27/2026, the MDS indicated Resident 9's cognitive skills for daily decision making (process of thinking) was intact. The MDS indicated Resident 9 required substantial (helper does more than half the effort) with eating, oral hygiene, bathing, upper/lower body dressing, and personal hygiene. 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 10/7/2025, the H&P indicated Resident 9 had the capacity to understand and make decisions.During a review of Resident 9's Physician Orders, dated 10/4/2025, the Physician Orders indicated to:1. Irrigate Resident 9's suprapubic urinary catheter (a hollow tube inserted into the bladder through the lower abdomen to drain or collect urine) daily with 60 milliliters (mL, unit of measurement) of normal saline (NS- a sterile mixture of salt and water).2. Clean Resident 9's suprapubic stoma (a small, surgically created opening in the lower abdomen) hypergranulation (overgrowth of healing tissue in a wound that extends beyond the surrounding skin level) daily with NS, pat dry, and cover with silver alginate dressing (a type of dressing made with seaweed and silver) and a dry dressing. During a review of Resident 9's Care Plan titled, Altered Bladder Function, revised 3/9/2026, the Care Plan indicated to provide daily indwelling urinary catheter care.During a concurrent observation and interview on 5/18/2026 at 9:41 a.m., with Resident 9, in Resident 9's room, Resident 9 was observed sitting on his wheelchair. The urinary catheter bag hung on the right side of his wheelchair. Resident 9 exposed his suprapubic catheter and was observed without a dressing over his suprapubic stoma. Resident 9 stated, on 5/17/2026, he did not receive his suprapubic urinary catheter care or irrigation. Resident 9 stated the licensed nurses were supposed to provide his suprapubic urinary catheter care every day.During an interview on 5/19/2026 at 2:13 p.m., with Resident 9, Resident 9 stated, on 5/18/2026, he did not receive his suprapubic urinary catheter care or irrigation.During a concurrent interview and record review on 5/19/2026 at 4:02 p.m., with Registered Nurse (RN) 2, Resident 9's Treatment Administration Record (TAR), dated 5/1/2026 through 5/31/2025, was reviewed. The TAR indicated, on 5/17/2026, Resident 9 was absent from the facility and, on 5/18/2026. The TAR did not indicated daily suprapubic catheter irrigation and cleansing was performed. RN 1 stated, on 5/17/2026, Resident 9 was out of bed and kept telling her, Later, later regarding his suprapubic urinary catheter treatment and irrigation. RN 1 stated she should have approached Resident 9 at the end of her shift and endorsed to the oncoming shift to provide Resident 9 with his suprapubic urinary catheter treatment and irrigation. RN 1 stated providing Resident 9's suprapubic urinary catheter treatment and irrigation was essential in preventing a urinary tract infection (UTI- an infection in the bladder/urinary tract).During a telephone interview on 5/20/2026 at 11:37 a.m., with Treatment Nurse (TN) 2, TN 2 stated, on 5/18/2026, she did not perform Resident 9's suprapubic urinary catheter treatment and irrigation during her shift. TN 2 stated she was occupied with the wound specialist and thought she endorsed Resident 9's treatment to RN 1. During an interview on 5/20/2026 at 3:46 p.m., with RN 1, RN 1 stated, on 5/18/2026, he did not provide Resident 9's suprapubic urinary catheter treatment and irrigation. RN 1 stated cleansing (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 9's suprapubic stoma was important to keep the area clean and ensuring the dressing was intact to prevent bacteria from entering Resident 9's bladder. RN 1 stated irrigating Resident 9's suprapubic urinary catheter was necessary to keep the tubing patent (unobstructed) and ensure urine flowed into the collection bag. During an interview on 5/21/2026 at 10:48 a.m., with the Director of Nursing (DON), the DON stated Resident 9's suprapubic urinary catheter went directly into Resident 9's bladder, which increased Resident 9's chance for a UTI. The DON stated cleansing treatment was performed daily to prevent infection and maintain integrity of the site. The DON stated irrigation was performed daily to prevent sediment (solid particles that could collect in urine) build up and keep the catheter patent. The DON stated if Resident 9's treatment and irrigation were not completed and were not refused; the treatment and irrigation should be endorsed to the following shift to ensure they were completed. The DON stated by not completing Resident 9's suprapubic urinary catheter treatment and irrigation, Resident 9 was at risk for developing a UTI. During a review of the facility's Policy and Procedure (P&P) titled, Catheter Care, Urinary, dated 1/2018, the P&P indicated routine hygiene was appropriate to prevent infection and catheter irrigation may be ordered to prevent urinary obstruction. The P&P indicated if the resident refused catheter care, the licensed nurse was to notify the supervisor.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure oxygen therapy was administered continuously via the nasal cannula (a thin, flexible plastic tube that delivers supplemental oxygen directly into the nostrils), as ordered by the physician, for one of one sampled residents (Resident 83) receiving oxygen therapy. The deficient practice had the potential to place Resident 83 at risk for inadequate oxygenation, shortness of breath, respiratory distress, decreased cardiopulmonary function, altered mental status, fatigue, dizziness, and other adverse outcomes associated with interruption of prescribed oxygen therapy.Findings:During a review of Resident 83's admission Record, the admission Record indicated Resident 83 was admitted to the facility on [DATE]. Resident 83's diagnoses included dysphagia (difficulty swallowing), muscle weakness, acute kidney failure (rapid loss of your kidneys' ability to filter waste from your blood), anemia (a blood condition that occurs when not enough healthy red blood cells exist to carry adequate oxygen to your body's tissues), encephalopathy (a term for any disease, damage or malfunction of the brain), chronic obstructive pulmonary disease (COPD- a progressive lung disease that restricts airflow causing significant breathing difficulties), and acute respiratory failure with hypoxia (a sudden, sever drop in blood oxygen levels).During a review of Resident 83's Minimum Data Set (MDS, a resident assessment tool), dated 2/11/2026, the MDS indicated Resident 83 cognitive skills for daily decision making (the ability to think and process information) was severely impaired. The MDS indicated Resident 83 was dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 83's History and Physical (H&P), dated 9/1/2025, the H&P indicated that Resident 83 did not have the capacity to understand and make decisions.During a review of Resident 83's Physician's Order dated 4/25/2026, the physician's order indicated to administer continuous oxygen at two liters per minute via nasal cannula every shift for COPD.During a review of Resident 83's Oxygen Saturation Vitals Summary record (document indicating the percentage of oxygen in the resident's blood), the record indicated the following oxygen saturation values on the following dates:a. On 4/16/2026 at 8:30 p.m., Resident 83's oxygen saturation was 96 % on room air.b. On 4/16/2026 at 11:30 p.m., Resident 83's oxygen saturation was 96 % on room air.c. On 4/17/2026 at 3:38 a.m., Resident 83's oxygen saturation was 96 % on room air.d. On 4/20/2026 at 3:22 p.m., Resident 83's oxygen saturation was 96 % on room air.e, On 5/4/2026 at 1:40 p.m., Resident 83's oxygen saturation was 96 % on room air.During an observation on 5/18/2026 at 11:25 a.m., in Resident 83's room, Resident 83 was observed lying in bed. Resident 83's nasal cannula was observed wrapped around the oxygen concentrator machine (a medical device that pulls in regular air, purifies it, and delivers concentrated oxygen to the user). The oxygen concentrator machine was off. Resident 83 was not receiving supplemental oxygen.During a concurrent interview and record review on 5/20/2026 at 11:22 a.m., with Registered Nurse (RN) 3, Resident 83's physician's order dated 4/25/2026 and the oxygen saturation vitals summary records dated 4/16/2026, 4/17/2026, 4/20/2026, and 5/4/2026 were reviewed. The physician's order indicated Resident 83 was to receive oxygen continuously without interruption unless otherwise directed by the physician. The oxygen saturation vitals summary record indicated Resident 83's oxygen saturation levels were recorded while on room air. RN 3 stated that continuous oxygen therapy meant the oxygen was to remain in use at all times as ordered. RN 3 stated that the physician order was not being followed as the nasal cannula was wrapped around the oxygen concentrator and turned off. RN 3 stated Resident 83 was on room air and not receiving supplemental oxygen on 4/16/2026, 4/17/2026, 4/20/2026, and 5/4/2026. RN 3 stated the oxygen saturation vitals summary record documentation further indicated Resident 83 was not receiving oxygen continuously as ordered by the physician. RN 3 stated it was important for nursing staff to follow the physician orders exactly as written and administer oxygen therapy as ordered to ensure the resident received the prescribed (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment. RN 3 stated failure to administer oxygen continuously as ordered could place the resident at risk for decreased oxygenation, shortness of breath, respiratory distress, worsening cardiopulmonary status, changes in mental status, fatigue, dizziness, and other adverse outcomes related to inadequate oxygen delivery.During a review of the facility's policy and procedures (P&P) titled Oxygen Administration, dated 1/2018, the P&P indicated The purpose of this procedure is to provide guidelines for safe oxygen administration. Review the physician's order or facility protocol for oxygen administration. Oxygen therapy is administered by way of oxygen mask, nasal cannula. Place appropriate oxygen device on the resident (i.e., nasal cannula).During a review of the facility's P&P titled Physician Orders dated 1/2018, the P&P indicated Physician orders are obtain to provide a clear direction in the care of the resident.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the pharmacist's recommendation for valproic acid (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), comprehensive metabolic panel (CMP- a routine blood test that measures 14 different substances in the blood to help determine overall health), and complete blood count (CBC- a blood test that measures the amount and types of cells in the blood) laboratory tests were ordered for one of five sampled residents (Resident 79).This deficient practice resulted in the delay in valproic acid level, CMP, and CBC being ordered which would result in a delay in identifying and treating abnormal laboratory values.Findings:During a review of Resident 79's admission Record (Face Sheet), the Face Sheet indicated Resident 79 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 79's diagnoses included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), dementia (a progressive state of decline in mental abilities), anxiety disorder (persistent, excessive fear and worry), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 79's Minimum Data Set (MDS- a resident assessment tool), dated 3/13/2026, the MDS indicated Resident 79's cognitive skills for daily decision making (process of thinking) was severely impaired. The MDS indicated Resident 79 Resident required supervision or touching assistance with toileting, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 79 received 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). During a review of Resident 79's History and Physical (H&P), dated 12/9/2025, the H&P indicated Resident 79 had fluctuating capacity to understand and make decisions.During a review of Resident 79's Physician Order, dated 3/17/2026, the Physician Order indicated to administer Divalproex Sodium (an anticonvulsant medication) 125 milligrams (mg, a unit of measurement), by mouth daily for mood stabilizer related to anxiety disorder.During a concurrent interview and record review on 5/21/2026 at 11:22 a.m., with the Director of Nursing (DON), Resident 79's Medication Regiment Review (MRR- a thorough evaluation of a resident's medication list to ensure necessity and provide recommendations), dated 3/23/2026 through 3/26/2026, was reviewed. The MRR indicated Divalproex Sodium for behavior control. The MRR indicated to obtain an order from Resident 79's physician for valproic acid level (also known as Divalproex Sodium), Comprehensive Metabolic Panel (CMP- a routine blood test that measures 14 different substances in the blood to help determine overall health), and Complete Blood Count (CBC- a blood test that measures the amount and types of cells in the blood) on the next available lab day to monitor for toxicity (accumulation of an excessive or harmful amount of a medication in the bloodstream). The MMR indicated a handwritten done under the Follow-Through column. The DON stated the pharmacist reviewed Resident 79's medication list monthly and made recommendations they felt were necessary. The DON stated the pharmacist's recommendations were relayed to Resident 79's physician, who would agree or disagree with the recommendation. The DON stated according to the MMR, the valproic acid level, CMP, and CBC were approved by Resident 79's physician, therefore, an order should have been inputted by a licensed nurse.During a concurrent interview and record review on 5/21/2026 at 11:24 a.m., with the DON, Resident 79's Physician Laboratory Orders, dated 3/23/2026 through 5/21/2026, were reviewed. The Laboratory Orders did not indicate for Resident 79's valproic acid level, CMP, and CBC to be drawn. The DON stated the order for Resident 79's valproic acid level, CMP, and CBC were never inputted after the MMR recommendation was approved by Resident 79's physician. The DON (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated ordering Resident 79's valproic acid level, CMP, and CBC were important to ensure Resident 79's Divalproex Sodium treatment did not cause any abnormal blood levels. The DON stated monitoring Resident 79's valproic acid level, CMP, and CBC would help identify any medication toxicity and to adjust as needed. During a review of the facility's Policy and Procedure (P&P) titled, Medication Regimen Review, dated 1/2022, the P&P indicated the consulting pharmacist's recommendations were acted upon and documented by the facility staff and/or the physician.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to honor food preferences and offer meal substitutes of the same nutritive value (food that gives the body enough nutrients to stay healthy) for one of one sampled resident (Resident 122). These deficient practices had the potential to alter Resident 122's nutritional status. Findings:During a review of Resident 122's admission Record (Face Sheet), the Face Sheet indicated Resident 122 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 122's diagnoses included osteoarthritis of the right knee (a progressive disorder of the joint, caused by a gradual loss of cartilages), diabetes mellitus (DM -a disorder characterized by difficulty in blood sugar control and poor wound healing), and mild protein-calorie malnutrition (not getting enough protein and food to stay healthy).During a review of Resident 122's Minimum Data Set (MDS- a resident assessment tool), dated 4/2/2026, the MDS indicated Resident 122's cognitive skills for daily decision making (process of thinking) was intact. The MDS indicated Resident 122 required setup and clean-up assistance when eating meals. The MDS indicated Resident 122 required moderate assistance (helper does less than half the effort) with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 122's History and Physical (H&P), dated 5/7/2026, the H&P indicated Resident 122 had the capacity to understand and make decisions. During an interview on 5/18/2026 at 9:47 a.m., at Resident 122's bedside, Resident 122 stated she did not like the breakfast meals being served and reported skipping breakfast because she was unhappy with the food provided. Resident 122 stated that no staff asked for her food preferences and no meal substitutes with adequate nutritive value was offered. During a concurrent observation and interview on 5/20/2026 at 9:00 a.m., with Certified Nursing Assistant (CNA) 4, inside Resident 122's room, observed untouched and covered breakfast tray with scrambled eggs and oatmeal at the bedside table. CNA 4 stated Resident 122 declined her breakfast tray. CNA 4 stated she had to take the tray back to the kitchen and did not offer a meal alternative or honor the resident's food preferences. During an interview on 5/20/2026 at 10:01 a.m., with the Regional Dietary Manager (RDM), the RDM stated not providing meal alternatives could lead to poor intake. During an interview on 5/20/2026 at 10:50 a.m., with the Registered Dietician (RD), the RD stated it was important to offer other food choices when a resident refused a meal to help meet their nutrition needs and food preferences. The RD stated not offering meal alternatives may lead to poor health. During a review of the facility's Policy and Procedure (P&P) titled, Dignity dated 1/2026, the P&P indicated, the facility culture supports dignity and respect for residents by honoring resident food choices and preferences.

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	055052	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Post-Acute Care	3615 E. Imperial Hiwy Lynwood, CA 90262

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 63), who did not have decision-making capabilities, was not listed as self-responsible on their admission Record (Face Sheet).This deficient practice resulted in the facility discussing the plan of care with Resident 63 instead of with an individual who could make medical decisions on his behalf. Cross Reference F551 and F580.Findings:During a review of Resident 63's admission Record (Face Sheet), the Face Sheet indicated Resident 63 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 63'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 and aphasia (a disorder that makes it difficult to speak) following cerebral infarction. During a review of Resident 63's Minimum Data Set (MDS, a resident assessment tool) dated 3/5/2026, the MDS indicated Resident 63's cognitive skills for daily decision making was severely impaired (ability to think and reason). The MDS indicated Resident 63 was dependent on staff's assistance with oral hygiene, toileting, bathing, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. During a review of Resident 63's History and Physical (H&P), dated 8/29/2025, the H&P indicated Resident 63 did not have the capacity to understand and make decisions. During an interview on 5/20/2026 at 8:27 a.m., with the Social Services Director (SSD), the SSD stated Resident 63 was aphasic (impaired speech) and communication regarding his health and any changes of condition were to be communicated with Emergency Contact (EC) 1. The SSD stated Resident 63 did not have decision-making capabilities and was unable to understand his plan of care nor make medical decisions. During a concurrent interview and record review on 5/20/2026 at 10:35 a.m., with Registered Nurse (RN) 1, Resident 63's Face Sheet was reviewed. The Face Sheet indicated Resident 63 was self-responsible. The Face Sheet listed three family members as Resident 63's emergency contacts and two other family members without a contact type. RN 1 stated Resident 63's Face Sheet was incorrect and could cause confusion if the licensed nurse was not familiar with Resident 63's mentation. RN 1 stated the Face Sheet was the facility's primary tool to determine the individual to notify of any changes. During a concurrent interview and record review on 5/20/2026 at 10:38 a.m., with RN 1, Resident 63's Situation, Background, Assessment, Recommendation (SBAR) form, dated 3/4/2026 and 5/4/2026, were reviewed. The SBARs indicated Resident 63 was self-responsible. RN 1 stated Resident 63 did not have decision-making capabilities and was unable to advocate for his own care. RN 1 stated EC 1 or other family members should have been contacted to discuss Resident 63's plan of care. During an interview on 5/21/2026 at 10:36 a.m., with the Director of Nursing (DON), the DON stated the residents' Face Sheet should be accurate and updated as information changed. The DON stated Resident 63 did not have decision-making capabilities and his Face Sheet should not have indicated him as self-responsible. The DON stated the licensed nurses referred to the Face Sheet to determine who to discuss the resident's plan of care with. The DON stated Resident 63's plan of care was discussed with the incorrect individual. During a review of the facility's Policy and Procedure (P&P) titled, Charting and Documentation Accuracy, dated 1/2018, the P&P indicated, All services to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, or psychosocial condition, shall be documented in the resident's medical record.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the most recent plan of care was obtained for hospice (services that address physical, spiritual and emotional needs of terminally ill residents) services for one of one sampled residents (Resident 12) under hospice care. This deficient practice had the potential to result in a delay or lack of coordination in the delivery of hospice care and services to Resident 12.Findings:During a review of Resident 12's admission Record, the admission Record indicated Resident 12 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 12's diagnoses included dysphagia (difficulty swallowing), schizophrenia (a mental illness that is characterized by disturbances in thought) and hypertension (HTN- high blood pressure).During a review of Resident 12's Minimum Data Set (MDS, a resident assessment tool), dated 4/24/2026, the MDS indicated Resident 12 had severely impaired cognitive skills for daily decision making (ability to think and understand). The MDS indicated Resident 12 was dependent on staff for toileting, bathing, and personal hygiene. The MDS indicated Resident 12 was receiving hospice care (services that address physical, spiritual and emotional needs of terminally ill residents).During a phone interview on 5/19/2026 at 2:25 p.m. with the Hospice Case Manager (HCM), the HCM stated the hospice plan of care should be present in the resident's hospice binders. The HCM stated either she, or another nurse that visited hospice residents during the week, would ensure the plan of care was updated weekly in the residents' hospice binder.During a concurrent interview and record review on 5/19/2026 at 2:30 p.m. with Registered Nurse (RN) 1, Resident 12's hospice binder was reviewed. The hospice binder did not indicate Resident 12's most recent plan of care. RN 1 stated ensuring hospice residents' most recent plan of care was accessible was important because it addressed and included interventions and measured resident specific goals.During an interview on 5/21/2026 at 10:15 a.m. with the Social Services Director (SSD), the SSD stated she was the hospice coordinator and she had not been checking to ensure the hospice binders had the residents most recent plan of care. The SSD stated she should be checking the hospice binders to ensure the most recent plan of care was obtained. During an interview on 5/21/2026 at 12:15 p.m. with the Director of Nursing (DON), the DON stated the hospice plan of care was important because it ensured a collaborative effort was being made between the facility and the hospice agency and the needs of the resident were being followed and addressed.During a review of the facility's Policy and Procedure (P&P), titled, Hospice Program dated 1/2026, the P&P indicated, the SSD was responsible for coordinating resident care by facility and hospice staff and obtaining the most recent hospice pan of care for each resident. The P&P indicated resident care plans receiving hospice services should include the most recent hospice plan of care as well as the care and services provided by the facility to maintain the resident's highest practicable physical, mental and psychosocial well-being.

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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 four sampled residents (Resident 124 and Resident 5) by failing to:1. Ensure an Enhanced barrier precaution (EBP- an infection control measure to protect residents at high risk for multidrug-resistant organisms [MDRO- bacteria resistant to multiple classes of antibacterial medication]) sign was displayed in front of Resident 124's room. 2. Ensure Treatment Nurse (TN) 1 wore an isolation gown, performed hand hygiene, and applied new gloves after removing a soiled dressing and prior to cleaning a wound during a wound dressing change for Resident 5.These deficient practices had the potential to result in the avoidable spread of bacteria and disease to Residents 124 and 5, and other residents residing in the facility. Findings:1. During a review of Resident 124's admission Record, the admission Record indicated Resident 124 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 124's diagnoses included dysphagia (difficulty swallowing), chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing) and osteomyelitis (inflammation of bone or bone marrow, usually due to infection). During a review of Resident 124's History and Physical (H&P) dated 4/28/2026, the H&P indicated Resident 124 did not have the capacity to understand or make decisions. During a review of Resident 124's Minimum Data Set (MDS-a resident assessment tool) dated 4/21/2026, the MDS indicated Resident 124 had severe cognitive (ability to think and understand) impairment. The MDS indicated Resident 124 was dependent on staff for eating, toileting and bathing. During a concurrent observation and interview on 5/18/2026 at 10:26 a.m. with Certified Nursing Assistant (CNA) 3, the entrance of Resident 124's room was observed. There was no Enhanced Barrier Precaution (EBP- infection control intervention designed to stop the spread of multidrug-resistant organisms) sign displayed. CNA 3 stated Resident 124 had a gastrostomy tube (G-tube- surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) which would require Resident 124 to be placed on EBP. CNA 3 stated there should be a sign displayed outside of Resident 124's room to alert staff to use personal protective equipment (PPE-clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) when providing direct resident care. During an interview on 5/20/2026 at 11:28 a.m. with the Infection Prevention Nurse (IPN), the IPN stated all residents on EBP should have signage displayed outside of their room. The IPN stated EBP signage was important to ensure staff knew to wear PPE when providing direct resident care. The IPN stated failure to display EBP signage for residents on EBP placed residents at risk for infection. During an interview on 5/21/2026 at 12:15 p.m. with the Director of Nursing (DON), the DON stated residents on EBP should always have EBP signage displayed outside of room to ensure resident safety and infection prevention. During a review of the facility's Policy and Procedure (P&P) titled, Enhanced Barrier Precaution dated 6/2022, the P&P indicated, Post clear signage at the door or wall outside the resident room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 5's diagnoses included chronic kidney disease (CKD- kidney damage effecting its ability to filter blood), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5's cognitive skills for daily decision making was intact. The MDS indicated Resident 5 required substantial staff assistance for toileting and bathing. The MDS indicate Resident 5 required setup assistance for eating and personal hygiene. The MDS indicated Resident 5 had an unhealed pressure injury (injury to the skin or underlying tissue due to prolonged pressure). During a review of Resident 5's physician orders dated 3/25/2026, the physician order indicated enhanced barrier precaution related to dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) site central line/permacath (flexible, long-term tube inserted under the skin and into a major vein in the neck or chest, used for dialysis access) and wound. During an observation on 5/20/2026 at 10:12 a.m. with Treatment Nurse (TN) 1, in Resident 5's room, observed TN 1 begin Resident 5's wound dressing change without donning (to put on) an isolation gown. TN 1 was observed removing Resident 5's old dressing and cleaned the wound without removing her soiled gloves and performing hand hygiene. During an interview on 5/20/2026 at 10:54 a.m. with TN 1, TN 1 stated she should have donned an isolation gown prior to performing Resident 5's dressing change. TN 1 stated wearing an isolation gown during high-contact resident care activities was important to ensure infection prevention. TN 1 stated she should have removed her soiled gloves and washed her hands after removing Resident 5's old dressing and prior to cleaning the resident's wound to prevent cross contamination. TN 1 stated failure to follow wound care and EBP procedures placed Resident 5 at risk for infection. During an interview on 5/20/2026 at 11:28 a.m. with the IPN, the IPN stated nurses should wear isolation gowns when performing wound dressing changes and wash their hands and don new gloves after removing an old soiled dressing. The IPN stated failure to follow EBP and wound care policies placed residents at risk for cross contamination and infection. During a review of the facility's P&P titled, Enhanced Barrier Precautions dated 6/2022, the P&P indicated to use EBP for high-contact resident care activities by using gown and glove during wound care and any skin opening requiring a dressing. During a review of the facility's P&P titled, Wound Care dated 1/2018, the P&P indicated after loosening tape and removing a dressing, pull the glove over the dressing and discard into the appropriate receptacle. The P&P indicated to wash and dry hands thoroughly and put on new gloves.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure resident call lights were within reach for two of two sampled residents (Resident 3 and Resident 51). This deficient practice had the potential to place Residents 3 and 51 at risk for delayed staff response, unmet needs, accidents, falls, injuries, and an inability to timely request assistance.'Findings:1. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE]. Resident 3's diagnoses included dysphagia (difficulty swallowing), paranoid schizophrenia (a mental illness that can affect thoughts, mood, and behavior), chronic obstructive pulmonary disease (COPD- a progressive lung disease that restricts airflow causing significant breathing difficulties), hemiplegia (complete or near complete paralysis of one side) and hemiparesis (partial muscular weakness).During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 3/20/2026, the MDS indicated Resident 3's cognitive skills for daily decision making (the ability to think and process information) was severely impaired. The MDS indicated Resident 3 was dependent on staff for assistanceDuring an observation on 4/18/2026 at 10:54 a.m., at Resident 3's bedside, Resident 3 was observed lying in bed. The call light was hanging behind and under Resident 3's bed. Resident 3's call light was not within reach of Resident 3.2. During a review of Resident 51's admission Record, the admission Record indicated Resident 51 was admitted to the facility on [DATE]. Resident 51's diagnoses included muscle weakness, acute kidney failure (rapid loss of your kidneys' ability to filter waste from your blood), difficulty in walking, hearing loss, and anemia (a blood condition that occurs when not enough healthy red blood cells exist to carry adequate oxygen to your body's tissues).During a review of Resident 51's MDS, dated [DATE], the MDS indicated Resident 51 cognitive skills for daily decision making was intact. The MDS indicated Resident 51 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) to complete daily activities.During an observation on 4/20/2026 at 11:36 a.m., at Resident 51's bedside, Resident 51 was observed sitting on a wheelchair next to the bed. The call light was observed on the floor on the opposite side from Resident 51. Resident 51's call light was not within reach of Resident 51.During an interview on 5/20/2026 at 3:39 p.m., with the Director of Nursing (DON), the DON stated that call lights should be placed within each resident's reach at all times to ensure residents are able to request assistance as needed. The DON stated that residents who are unable to independently access their call lights may be placed at risk for unmet needs, delayed staff response, falls, injuries, and potential safety concerns. The DON stated that staff were expected to ensure call lights remained accessible during and after resident care, transfers, repositioning, housekeeping activities, and routine rounds. The DON stated that Resident 3's call light being observed hanging behind and underneath the bed, and Resident 51's call light being observed on the floor out of reach on the opposite side of the resident, were not acceptable practices and did not meet the facility's expectations for resident safety and supervision. The DON stated that maintaining call lights within resident reach was important to promote resident dignity, timely assistance, accident prevention, and a safe environment of care. The DON stated that nursing staff were responsible for routinely checking resident accessibility to call lights during rounds and throughout the shift.During a review of the facility's policy and procedures (P&P) titled Answering the Call Light, dated 1/2018, the P&P indicated, When the resident is in bed, or confined to a chair be sure the call light is within easy reach of the resident.