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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055070	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seacrest Post-Acute Care Center	1416 West 6th Street San Pedro, CA 90732

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide enough time for one of one sampled resident (Resident 30) to enjoy their meals.This failure resulted in Resident 30 feeling sad and frustrated. Findings:During a review of Resident 30's admission Record, dated 3/12/2026, the admission Record indicated Resident 30 was admitted to the facility on [DATE] with diagnoses but not limited to diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (high blood pressure), and coronary artery disease (a narrowing or blockage of arteries supplying blood to the heart).During a review of Resident 30's Minimum Data Set (MDS -resident assessment tool), dated 3/19/2026, the MDS indicated Resident 30 was cognitively intact (ability to think, understand, learn, and remember).During an observation on 3/24/2026 at 12:51 p.m. in Resident 30's room, Certified Nursing Assistant (CNA) 5 was quickly feeding Resident 30 their lunch meal.During an interview on 3/25/2026 at 9:04 a.m. with Resident 30, Resident 30 stated yesterday they felt very sad and frustrated when the CNA rushed to feed them.During an interview on 3/25/2026 at 3:15 p.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated Resident 30 prefers to take their time eating. LVN 4 stated if a resident felt rushed while being fed by staff, the resident would feel they were not receiving compassionate care.During an interview on 3/27/2026 at 11:30 a.m. with the Director of Nursing (DON), the DON stated if a resident was not given enough time to finish their meal, the resident would feel frustrated, irritated, and dissatisfied.During a record review of the facility's policy and procedure, titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated April 2021, the P&P indicated the facility will maintain a culture of compassion and caring for all residents.

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident's (Resident 30) light cord was within reach.This failure resulted in Resident 30 feeling frustrated and the potential to increase the risk of the resident falling.Findings:During a review of Resident 30's admission record, dated 3/12/2026, the admission Record indicated Resident 30 was admitted to the facility on [DATE] with diagnoses but not limited to diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (high blood pressure), and coronary artery disease (a narrowing or blockage of arteries supplying blood to the heart).During a review of Resident 30's Minimum Data Set (MDS - a comprehensive resident assessment tool), dated 3/19/2026, the MDS indicated Resident 30 was cognitively intact (ability to think, understand, learn, and remember).During an observation on 3/24/2026 at 9:10 a.m. in Resident 30's room, Resident 30 was laying in bed and the light switch cord was behind the resident's bed.During a concurrent observation and interview on 3/25/2026 at 9:04 a.m. with Resident 30 in Resident 30's room, the light switch cord was on the floor behind the resident's bed. Resident 30 stated it was frustrating their light switch cord was out of reach.During an interview on 3/26/2026 at 3:15 p.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated a resident would feel frustrated if their light switch cord was out of reach.During an interview on 3/27/2026 at 11:30 a.m. with the Director of Nursing (DON), the DON stated if a light switch cord was not within reach of a resident, the resident would be at risk for falling if they tried to get out of bed.During a record review of the facility's policy and procedure, titled Homelike Environment, dated May 2017, the P&P indicated the facility shall provide the resident comfortable yet adequate lighting.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the quarterly Minimum Data Set (MDS-a comprehensive assessment and care screening tool) assessment dated [DATE] was transmitted to Centers for Medicare and Medicaid Services (CMS) within the 120-day time frame for one of six sampled residents (Resident 11).This failure had the potential for the delay in identifying resident care concerns needing an individualized care plan, providing residents interventions necessary to provide quality care and a delay in the reimbursement process.Findings:During a review of Resident 11's admission Record (face sheet) dated 3/26/2026, the admission record indicated Resident 11 was admitted on [DATE] and readmitted on [DATE] with diagnosis including depression (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), atrial fibrillation (irregular heartbeat) and difficulty in walking.During a review of Resident 11's History and Physical (H&P) dated 1/30/2026, the H&P indicated, Resident 11 was alert and oriented to name.During a review of Resident 11's MDS dated [DATE], the MDS indicated Resident 11 had moderate cognitive impairment (decline in memory, thinking, or language skills). The MDS indicated Resident 11 was dependent (helper does all the effort) with activities of daily living ([ADLs] daily self-care activities like toileting, bathing and dressing).During a review of Resident 11's MDS's batch statis (date the MDS was transmitted) dated 3/26/2026, the MDS batch statis indicated the last assessment was transmitted to CMS on 11/17/2025 and accepted on 11/25/2025.During a concurrent interview and record review on 3/25/2026 at 3:27 p.m. with the Minimum Data Set Nurse (MDS Nurse) Resident 11's MDS quarterly assessment dated [DATE] was reviewed. The MDS nurse stated she forgot to send Resident 11's MDS quarterly assessment dated [DATE]. The MDS nurse stated Resident 11's quarterly assessment was late and was going to send it right away.During an interview on 3/27/2026 at 11:19 a.m. with the Director of Nurses (DON), the DON stated she was aware Resident 11's MDS quarterly assessment dated [DATE] was not sent to CMS and was late. The DON stated there was a potential for a delay in care and services for Resident 11.During a review of the facility's policy and procedure (P&P) titled Resident Assessment dated 4/2025, the P&P indicated a comprehensive assessment of each resident is completed at intervals designated by OBRA regulations and PPS requirements. The P&P indicated OBRA-required assessments are federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. The P&P indicated OBRA assessments includes admission assessment, quarterly assessment, and annual assessment. Data from the Minimum Data Set (MDS) is submitted to the Internet Quality Improvement Evaluation System as required. The P&P indicated assessments are completed by staff members who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's strengths and areas of decline. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts a timely and appropriate resident assessment.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the assessment entries on the Minimum Data Set (MDS), a standardized assessment and care screening tool) was accurate for two of six sampled residents (Resident 12 and 75) by failing to:1. Ensure Resident 12's hearing status was accurately coded to reflect Resident12 wore a hearing aid.2. Ensure Resident 75's dental status was accurately coded to reflect Resident 75's missing bottom teeth.These deficient practices had the potential to negatively affect Resident 12 and 75's plan of care and delivery of necessary care and services. Findings:1. During a review of Resident 12's admission Record (face sheet) dated 3/26/2026, the admission record indicated, Resident 12 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including heart failure (heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen) , diabetes mellitus (a condition in which the body fails to process glucose (sugar) correctly), dementia (loss of memory, language, problem-solving and other thinking abilities).During a review of Resident 12's History and Physical (H&P) dated 1/30/2026, the H&P indicated, Resident 12 did not have the capacity to understand and make decisions.During a review of Resident 12's MDS dated [DATE], the MDS indicated Resident 12 did not have the capacity to understand and make decisions. The MDS indicated Resident 12 was dependent (helper does all the effort) with activities of daily living ([ADLs] daily self-care activities like toileting, bathing and dressing). The MDS indicated Resident 12 had minimal difficulty with hearing and did not wear a hearing aid.During an interview on 3/25/2026 at 7:40 a.m. with Resident 12 stated she was hard of hearing and only wore a hearing aid on the left side and the staff stored it in another room. 2. During a review of Resident 75's admission Record (face sheet) dated 3/26/2026, the admission record indicated Resident 75 was admitted to the facility on [DATE] with diagnosis including breast cancer (rapid growth of abnormal cells), atrial fibrillation (irregular heartbeat) and muscle weakness.During a review of Resident 75's (H&P) dated 1/30/2026, the H&P indicated Resident 75 was alert and oriented.During a review of Resident 75's Minimum Data Set MDS dated [DATE], the MDS indicated Resident 75's had moderate cognitive (decline in memory, thinking, or language skills) impairment. The MDS indicated Resident 75 needed substantial/maximal assistance (helper does more than half the work) with activities of daily living (ADLs] daily self-care activities like toileting, bathing and dressing). The MDS indicated Resident 75 had obvious or likely cavities or broken natural teeth.During a concurrent observation and interview on 3/24/2026 at 9:36 a.m. with Resident 75 at Resident 75's bedside. Resident 75's bottom teeth were observed to have two teeth, one was broken and one was loose. Resident 75 stated she would like to see a dentist, for some dentures so she would not have to eat baby food anymore.During a concurrent interview and record review on 3/25/2026 at 3:27 p.m. with the Minimum Data Set MDS nurse, Resident 12's hearing assessment dated [DATE] and Resident 75's Dental assessment dated [DATE] were reviewed. The MDS nurse stated MDS assessment are used to help formulate an individualized plan of care for the residents. The MDS nurse stated Resident 12's hearing assessment was inaccurate Resident 12's did wear a hearing aid. The MDS nurse stated Resident 75's dental assessment was inaccurate Resident 75 was missing her bottom teeth. The MDS nurse stated when assessments are inaccurate there is a potential for the Resident 12's needs not to be met and the health could decline.During an interview on 3/27/2026 at 11:19 a.m. with the Director of Nurses (DON), the DON stated she was aware Resident 12's hearing assessment and Resident 75's dental assessment was inaccurate. The DON stated MDS assessments help with developing an individualized plan of care for the residents. The DON stated there was a potential for a delay in care for Resident 75 when assessments are inaccurate.During a review of the facility's policy and procedure (P&P) titled Resident Assessment dated 4/2025, the P&P indicated, a comprehensive assessment of each resident is completed at intervals designated by OBRA regulations and PPS requirements. The P&P indicated data from the Minimum Data Set (MDS) is (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	submitted to the Internet Quality Improvement Evaluation System as required. The P&P indicated assessments are completed by staff members who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's strengths and areas of decline. Information in the MDS assessments will consistently reflect information in the progress notes, plans of care and resident observations/interviews. The P&P indicated the resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts a timely and appropriate resident assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to revise the communication plan of care for one of six sampled residents, (Resident 12) who was hard of hearing to reflect Resident 12's current care plan.This failure had the potential to negatively affect the care and services for Resident 12.Findings:During a review of Resident 12's admission Record (face sheet) dated 3/26/2026, the admission record indicated, Resident 12 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including heart failure (heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), diabetes mellitus (a condition in which the body fails to process glucose (sugar) correctly), dementia (loss of memory, language, problem-solving and other thinking abilities).During a review of Resident 12's History and Physical (H&P) dated 1/30/2026, the H&P indicated, Resident 12 did not have the capacity to understand and make decisions.During a review of Resident 12's Minimum Data Set (MDS) a standardized assessment and care screening tool) dated 2/5/2026, the MDS indicated Resident 12 did not have the capacity to understand and make decisions. The MDS indicated Resident 12 was dependent (helper does all the effort) with activities of daily living ([ADLs] daily self-care activities like toileting, bathing and dressing). The MDS indicated Resident 12 had minimal difficulty with hearing and did not wear a hearing aid.During a concurrent observation and interview on 3/25/2026 at 7:40 a.m. with Resident 12 at Resident 12's bedside. Resident 12 was observed not wearing hearing aids. Resident 12 stated Can you repeat yourself, I can't hear you, what I can't hear you, can you repeat yourself. Resident 12 stated she only needed her hearing aid on the left side when she talks to people.During an interview on 3/25/2026 at 11:43 a.m. with Family Member 1 (FM1), FM1 stated Resident 12 wore a hearing aid in her left ear and that the staff held on to it and only put it in when Resident 12 has visitors.During a concurrent interview and record review on 3/25/2026 at 3:04 p.m. with Licensed Vocational Nurse 4 (LVN 4) Resident 12's care plan titled Risk for Communication Deficit dated 7/17/2024 was reviewed, LVN 4 stated Resident 12 was hard of hearing and only wore a hearing aid in her left ear. LVN 4 stated Resident 12's care plan needed to be updated with Resident 12's current plan of care so the staff will be able to provide Resident 12 with good quality care by ensuring Resident 12 was communicating properly.During an interview on 3/27/2026 at 11:25 a.m. with the Director of Nursing (DON), the DON stated a care plan is a guide the staff uses to provide the residents with the appropriate care. The DON stated Resident 12's communication care plan needed to be revised to reflect Resident 12's current plan of care. The DON stated when care plans are not revised there may be missed opportunities for providing care to Resident 12.During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person - Centered dated 3/2022, the P&P indicated, the comprehensive, person-centered care plan, includes measurable objectives and timeframes. Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions changes

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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 who is unable to carry out activities of daily living receives services to maintain good grooming for one of three residents sampled residents (Resident 60) by failing to change Resident 60's soiled incontinent pad (absorbent pad worn by residents) for long period of time. This deficient practice resulted in Resident 60 feeling frustrated and embarrassed, due to lack of or delay in receiving sufficient services to maintain good grooming, and incontinent care and had the potential to lead to skin breakdown. Findings:During a review of Resident 60's admission Record, the admission Record indicated Resident 60 was admitted to the facility on [DATE] with diagnoses including, muscle weakness generalized (loss of power or function affecting most of the body), difficulty in walking, muscle wasting and atrophy (refers to the loss or thinning of muscle tissue).During a review of Resident 60's Minimum Data Set (MDS - a resident assessment tool) dated 03/01/2026, the MDS indicated Resident 60 had moderately cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 60, was dependent (helper does all the effort. Resident does none of the effect to complete the activity) with activities of daily living (ADL routine self-care tasks performed daily-such as eating, bathing, dressing, and toileting).During concurrent observation and interview on 03/24/2026 at 10:25 am, Resident 60 was observed in bed. Resident 60 stated he needs his incontinent pad change and he has not been changed since the previous shift (11 p.m. to 7 a.m.)During an observation on 03/24/2026 at 10:30, with Certified Nursing Assistant (CNA 4), CNA 4 performed personal care to Resident 60. During the observation of changing Resident 60's incontinent pad and cleaning Resident 60, Resident 60 incontinent pad was observed soiled with heavy bowel movement and redness around the buttocks area.During an interview on 03/24/26 at 2:28 p.m. with CNA 4, CNA 4 stated she normally changed Resident 60 after breakfast. CNA 4 stated today (3/24/2026) she was behind because she has orientee that slows her down. CNA 4 stated she noticed Resident 60 incontinent pad was full when Resident 60 lifted his gown up when she walked in his room, but she was busy with another resident and told Resident 60 she will come back in 15miniutes. CNA 4 stated she feels bad for Resident 60 filled with soiled incontinent pad full of heavy feces (stool). CNA 4 stated that was like a loss of dignity and staff cannot meet residents' needs. CNA 4 stated she feels bad and she will try to do better next time and prioritize her assignment. CNA 4 stated she should know which one needs the most care more and ask for help whenever she was behind because this could look like neglect.During an interview on 03/26/2026 at 3:40 p.m., with the Director of Nursing (DON), the DON stated that all CNAs were expected to clean and change residents in a timely manner and to request assistance if they fall behind with their workload. The DON stated she started working at the facility three weeks ago and has been observing CNA practices and implementing changes to better support resident care.During a review of the facility's P&P titled, Activities of Daily Living (ADLs) Supporting dated 03/2025, the P&P indicated Residents who are unable to carry out activities of daily living independently will receive the service necessary to maintain good nutrition, grooming and personal and oral hygiene.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Certified Nursing Assistant 4 (CNA 4) report changes in resident skin condition for one of four sampled residents (Resident 60).The facility failed to:1. Ensure CNA 4 completed required daily shift body check and skin assessment for Resident 60 on 3/24/2026.These failures placed Resident 60 at increased risk for delayed identification and treatment of skin breakdown.Findings:During a review of Resident 60's admission Record, the admission Record indicated Resident 60 was admitted to the facility on [DATE] with diagnoses including, muscle weakness generalized (loss of power or function affecting most of the body), difficulty in walking, muscle wasting and atrophy (refers to the loss or thinning of muscle tissue).During a review of Resident 60's Minimum Data Set (MDS - a resident assessment tool) dated 03/01/2026, the MDS indicated Resident 60 had moderately cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 60, was dependent (helper does all the effort. Resident does none of the effect to complete the activity) with activities of daily living (ADL routine self-care tasks performed daily-such as eating, bathing, dressing, and toileting).During an observation on 03/24/2026 at 10:30, with Certified Nursing Assistant (CNA 4), CNA 4 performed personal care to Resident 60. During the observation of changing Resident 60's incontinent pad and cleaning Resident 60, Resident 60 incontinent pad was observed soiled with heavy bowel movement and redness around the buttocks area. CNA 4 stated she will report the skin redness to the charge nurse and do Resident 60 daily shift body check per protocol.During the concurrent interview on 03/25/206 at 2:09 pm with CNA 4, Licensed Vocational Nurse (LVN) 5, and LVN 6 all together at the nursing station. CNA 4 stated she thought she reported Resident 60's redness around the buttocks to the charge nurse on 03/24/2026 but did not. CNA 4 stated she failed to do the daily shift body check skin assessment for Resident 60. CNA 4 stated by failing to report skin change of condition, it can make the condition worsen if not taking care off right away. During concurrent interviews with LVN 5 and LVN 6, both stated CNA 4 did not report Resident 60's redness around the buttocks on 3/24/2026.During an interview on 03/26/2026 at 3:40 p.m. with the Director of Nursing (DON), the DON stated skin assessments must be completed daily and any significant change in condition must be reported to the charge nurse and the treatment nurse. The DON stated failure to identify and report changes promptly may cause the condition to worsen and places residents at risk for skin breakdown.During a review of the facility's policy and procedure (P&P) titled, Pressure Injury Risk Assessment Revised 07/2025, the P&P indicated skin will be assess for the presence of developing pressure injury (injury to skin and underlying tissue resulting from prolonged pressure on the skin) on a weekly basis or more frequently if indicated. Staff will be maintaining a skin check performing routine skin inspection daily or on shower days as needed the skin completed worksheet will be retained for three months. Nurses are to be notified to inspect the skin if the skin changes are identified. Nurses will conduct skin assessment at least weekly to identify changes.

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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 assess one of four sampled residents (Resident 56) who had indwelling urinary catheter (a flexible plastic tube inserted into the bladder that remains there to provide continuous urinary drainage) upon admission to determine the indication for the catheter and whether it should be removed.This failure placed Resident 56 at risk for unnecessary indwelling urinary catheter use, potential infection, lose ability to regain control of bladder function and other complications related to improper catheter management.Findings:During a review of Resident 56's admission Record, the admission Record indicated Resident 56 was admitted to the facility on [DATE] with diagnoses including, muscle weakness generalized (a loss of power or function affecting most of the body), difficulty in walking, retention of urine, (the inability to completely or partially empty the bladder, causing pain, discomfort, and a strong urge to urinate without success). During a review of Resident 56's Minimum Data Set (MDS- a resident assessment tool) dated 03/10/2026 indicated Resident 56 with severe impairment in cognitive (ability to think, understand, learn, and remember) function. The MDS indicated Resident 56, is dependents (helper does all the effort. Residents do none of the effect to complete the activity) with activities of daily living (ADL- daily self-care activities).During a review of Physician Order Summary report, dated 03/10/2026, the report indicated an order for indwelling urinary catheter to straight drainage with no indication.During concurrent interview and record review on 3/25/26 at 12:12 pm with the Director of Nursing (DON), Physician Order Summary was reviewed. The DON stated there was no indication noted in the Physician Order for Resident 56's indwelling urinary catheter. The DON stated the physician order should specify the reason for using the indwelling urinary catheter.During an interview on 03/27/2026 at 10:58 a.m. with Registered Nurse 2 (RNS 2), RNS 2 stated all residents admitted with an indwelling urinary catheter should be assessed upon admission. RNS 2 stated staff should assess the catheter, determine the reason for its use, identify when it should be discontinued, notify the physician if removal was appropriate, and follow up with urologist (medical doctor specializes in diagnosis and treating diseases of the urinary tract) if needed. RNS 2 stated failing to assess the catheter places residents at risk for infections and discomfort. RNS 2 stated it was good practice to call and clarify orders and ask for the indication.During a followˆup interview on 03/27/2026 at 12:22 p.m. with the DON, the DON stated staff should ensure there was an order and an indication for any indwelling urinary catheter upon admission. The DON stated staff should clarify with the physician whether the catheter should be continued to prevent urinary tract infections (UTIs-infection in the urine) and to ensure residents receive an appropriate diagnosis and continued catheter use only when necessary.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seacrest Post-Acute Care Center	1416 West 6th Street San Pedro, CA 90732

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure one of three sampled residents (Resident 27) maintained adequate nutritional status. The facility failed to:1.Provide one-on-one feeding assistance (a staff member supports a single resident with eating for the entire meal) as ordered.2.Ensure Boost (nutritional supplement) was administered to Resident 27 as ordered.3.Monitor and respond to Resident 27's declining meal intake.4.Ensure effective communication and follow-through of Registered Dietician nutritional interventions.These deficient practices placed Resident 27 at risk for inadequate nutritional and fluid intake which could lead to malnutrition (a condition resulting from an unbalanced diet), significant weight loss, dehydration (not having enough water in the body), skin impairment, hypoglycemia (low blood sugar), aspiration (the accidental breathing in of food, liquid, saliva, or vomit into the airway and lungs), and subsequently resulted in Resident 27 being admitted to a General Acute Care Hospital (GACH) on 3/27/2026 for poor oral intake and abdominal distention (the visible swelling or enlargement of the belly).Findings:During a review of Resident 27's admission Record, the admission Record indicated Resident 27 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), and diabetes mellitus type 2 (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 27's Minimum Data Set (MDS ?a resident assessment tool) dated 2/1/2026, the MDS indicated Resident 27's cognition (ability to think, understand, learn, and remember) was severely impaired. The MDS indicated Resident 27 was dependent (helper does all of the effort) with eating, toileting, and showering. During a review of Resident 27's Order Summary Report dated 3/23/2023, the Order Summary Report indicated an order for feeding assists for all meals.During a review of Resident 27's Order Summary Report dated 3/24/2023, the Order Summary Report indicated an order for Aspiration Precautions (safety measures designed to prevent food, fluids, or vomit from entering the airway and lungs), head of bed (HOB) elevated at 75 to 90 degrees for meals, feeding assists for all meals.During a review of Resident 27's Care Plan titled Nutritional Status: Resident 27 has impaired nutritional status., dated 4/17/2023, the care plan goal indicated Resident 27 will remain wellˆnourished and hydrated, as evidenced by moist mucous membranes (tissues that line the mouth) through the review date. The care plan interventions indicated for staff to monitor oral intake, evaluate for any problems, and notify the physician as needed.During a review of Resident 27's Order Summary Report dated 1/11/2024, the Order Summary Report indicated, and order for Fortified diet (foods with extra nutrients), mechanical soft texture (a soft food diet intended to reduce or eliminate the need to chew food), regular liquid consistency three times a day.During an observation on 3/24/2026 at 12:55 p.m., Resident 27 was lying in bed asleep. Resident 27's lunch tray was on the bedside table within Resident 27's reach. The tray contained food and beverages that appeared untouched, with all items unopened and in their original condition. No staff were present to provide assistance at the time of the observation.During an interview on 3/24/2026 at 3:07 p.m., with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 27 requires oneˆtoˆone feeding assistance and cannot eat independently. CNA 1 stated she left the tray at the bedside and intended to return to feed the resident. She stated that leaving the tray within reach without supervision could place the resident at risk because Resident 27 might attempt to eat independently, which could cause choking or food going down the wrong way. CNA 1 stated Resident 27 usually eats 25-40% of her meals but her intake had been declining. CNA 1 stated the resident had been extremely sleepy during meals. CNA 1 stated the charge nurse should be notified when a resident shows a decline in food intake. She also stated Resident 27 did not eat breakfast or lunch and did not drink any liquids during breakfast. CNA 1 stated she did not report this to the charge nurse. CNA 1 could not explain why she failed to report it and stated she should have notified the charge nurse immediately.During an interview on 3/24/2026 at 3:27 p.m., with Licensed (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Vocational Nurse (LVN) 1, LVN 1 stated Resident 27 requires oneˆtoˆone assistance with feeding and sometimes refuses to eat. LVN 1 stated staff should not leave meal trays at the bedside for residents who require oneˆtoˆone assistance. She stated that leaving a tray without supervision may result in the resident attempting to eat independently while lying in a reclined position without proper headˆofˆbed elevation. LVN 1 stated these places Resident 27 at risk for choking and aspiration, which could lead to aspiration pneumonia (lung infection caused by inhaling food or liquid), respiratory distress, or airway obstruction. LVN 1 stated Resident 27's nutritional intake had been declining for several weeks and the resident's average intake was about 25%. She stated when a resident does not consume enough food or supplements, such as Boost(supplements), staff were required to notify the physician and follow the care plan interventions. LVN 1 stated failing to provide ordered supplements or report decreased food intake to the physician places the resident at risk for malnutrition, significant weight loss, dehydration, hypoglycemia (low blood sugar), and skin impairment.During an observation on 3/25/2026 at 8:11 a.m., Resident 27 was asleep in bed with the head of the bed elevated approximately 20-30 degrees. No staff were present at the bedside to provide oneˆtoˆone feeding assistance. Resident 27's meal tray was within reach on the bedside table, and several food items, including the juice, remained unopened. At the time of the observation, there was no evidence that the resident had eaten any portion of the meal.During a concurrent observation and interview on 3/26/2026 at 8:00 a.m. with Certified Nurse Assistant (CNA) 1, Resident 27's breakfast tray was on the meal cart outside the resident's room. The tray appeared untouched, with all food and liquids unopened and in their original condition. It was placed with other completed trays and appeared ready for pickup by dietary staff. CNA 1 stated the breakfast tray belonged to Resident 27 and confirmed it had not been eaten. CNA 1 stated Certified CNA 2 assisted Resident 27 with breakfast.During an interview on 3/26/2026 at 8:30 a.m., with CNA 2, CNA 2 stated she assisted Resident 27 with breakfast. CNA 2 stated Resident 27 was extremely sleepy and did not want to eat that morning. She stated the resident usually eats about 25% of her meals. CNA 2 stated she informed LVN 2, and LVN 2 told her she would notify CNA 1, who was assigned to Resident 27, to provide Boost to the resident.During an interview on 3/26/2026 at 9:04 a.m. with CNA 1, CNA 1 stated she was not informed by LVN 2 Resident 27 needed Boost. CNA 1 stated she did not provide the Boost supplement to Resident 27.During a concurrent interview and record review on 3/26/2026 at 9:25 a.m. with LVN 2, Resident 27's Medication Administration Record (MAR) dated 3/2026 was reviewed. The MAR indicated, Boost (237 milliliters) three times a day for supplement with medication pass. LVN 2 stated she had not been administering the Boost supplement to Resident 27 during medication passes and could not explain why she failed to give it as ordered. LVN 2 stated Resident 27 requires oneˆtoˆone assistance with meals and had experienced a decline in oral intake. LVN 2 stated a decline in a resident's oral intake constitutes a change in condition and requires physician notification. LVN 2 stated she did not remember to instruct CNA 1 to administer the resident's ordered Boost after CNA 2 informed her that Resident 27 did not eat breakfast. LVN 2 stated failing to provide oneˆtoˆone feeding assistance, failing to administer ordered supplements, and failing to notify the physician of a change in condition places the resident at risk for malnutrition, weight loss, dehydration, hypoglycemia, aspiration, and other complications that could lead to aspiration pneumonia, respiratory distress, or hospitalization.During a concurrent interview and record review on 3/26/2026 at 3:02 p.m. with the Registered Dietitian (RD), reviewed Resident 27's Nutrition/Dietary Note dated 3/22/2026. The note indicated, Body Mass Index (BMI medical screening tool to calculate person body fat) = 18.1 (underweight). otherwise oral intake is poor for most meals. Refusing Remeron (medication used for appetite stimulant) to stimulate appetite. The RD stated Resident 27's nutritional status does not meet nutritional standards, and the resident is at risk for malnutrition. The RD stated Resident 27's oral intake does not meet her daily caloric needs. The RD stated the resident typically consumes only 25-50% of meals. The RD stated Resident 27 was supposed to receive Boost three times a day with the medication pass and Remeron 30 milligram (mg-unit of measurement) at bedtime; however, (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing staff were not implementing these interventions consistently or on time. The RD stated that based on the resident's low caloric intake, the Remeron does not appear to be effective. The RD stated she communicates her recommendations to nursing staff by emailing the Director of Nursing (DON), the Director of Staff Development (DSD), the Dietary Supervisor (DS), and the Administrator. She stated that interventions such as supplements (Boost) were not consistently being carried out by nursing staff and staff do not provide followˆup to her. The RD stated that if a resident is not eating and supplements are ordered, staff are expected to notify her so she can re-evaluate the plan of care and involve the family if necessary. The RD stated if Resident 27 continues to consume only about 25% of meals, she is at risk for malnourishment, significant weight loss, dehydration, skin impairment, and hypoglycemia. The RD further stated that without proper feeding assistance, the resident is also at risk for poor oral intake, choking, weight loss, and aspiration pneumonia. The RD stated Resident 27's intake had declined and no longer met her nutritional needs and acknowledged this decline constitutes a change in condition that should have been communicated to the physician. The RD stated she did not notify the physician and was unsure why it was not communicated. She stated timely communication with the physician is necessary to ensure appropriate interventions and prevent further decline in the resident's condition.During a concurrent interview and record review on 3/27/2026 at 10:10 a.m. with the Director of Nursing (DON), reviewed Resident 27's Priority Reports dated 3/8/2026, 3/15/2026, and 3/22/2026. The Priority Reports indicated Decreased Meal + Weight Loss. The DON stated she was aware Resident 27 had poor intake and the resident's nutritional intake had recently declined. She stated residents who require oneˆtoˆone feeding must be assisted during meals and properly positioned, and staff are expected to ensure they are fed safely. The DON stated when residents are not eating, staff should notify the physician, offer supplements such as Boost, document intake, and monitor them closely. She stated staff should have given Resident 27 the ordered Boost when she did not eat. The DON there was a breakdown in communication regarding Resident 27's interventions. The DON stated LVNs are responsible for supervising CNAs, ensuring interventions were implemented, and following up on resident care. She stated LVNs must ensure ordered interventions were carried out. She stated that if LVNs do not check residents' trays or review CNA intake documentation, this would not meet facility expectations. The DON stated a decline in a resident's nutritional intake was considered a change in condition and should be reported to the physician immediately. She stated that based on the information provided, it does not appear Resident 27's condition was communicated to the physician in a timely manner. The DON stated Resident 27 who require oneˆtoˆone assistance and do not receive it are at risk for weight loss, malnutrition, dehydration, skin breakdown, aspiration, and overall decline. She stated based on the information presented, Resident 27 needs were not fully met.During a review of Resident 27's Task: Amount Eaten, the amount eaten indicated the following:2/25/2026 at 9:00 a.m. 26% - 50%2/25/2026 at 1:00 p.m. 26%- 50%2/25/2026 at 6:30 p.m. 26% - 50%2/25/2026 at 6:52 p.m. 0-25%2/27/2026 at 10:08 p.m. 0-25%3/8/2026 at 2:04 p.m. 0-25%3/10/2026 at 2:04 p.m. 0-25%3/11/2026 at 10:23 p.m. 0-25%3/12/2026 at 2:26 p.m. 0-25%3/19/2026 at 1:40 p.m. 0-25%3/22/2026 at 1:58 p.m. 0-25%3/22/2026 at 7:39 p.m. 0-25%During a review of Resident 27's Transfer Form, dated 3/27/2026, the Transfer Form indicated, Resident 27 was transferred to General Acute Care Hospital (GACH) due to abnormal lab test, abdominal distention, and poor oral intake.During a review of the facility's policy and procedure (P&P) titled, Assistance with Meals, dated 2022, the P&P indicated Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity.During a review of the facility's P&P titled, Change in a Resident's Condition or Status, dated 2021, the P&P indicated The nurse will notify the resident's attending physician or physician on call when there has been a(an).specific instruction to notify the physician of changes in the resident's condition.During a review of the facility's P&P titled, Dysphagia, dated 20212, the P&P indicated In addition, the nurse shall assess and document/report the following: Decreased intake with potential for dehydration or malnutrition.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure medications were not left open and unattended for one of four sampled residents (Resident 63)'s bedside.This deficient practice placed Resident 63 at risk for medication errors, including missed, duplicated, or inappropriate administration.Findings:During a review of Resident 63's admission Record, the admission Record indicated Resident 63 was admitted to the facility on [DATE] with diagnoses including chronic kidney disease (lasting damage to the kidneys), and transient ischemic attack ([TIA]-brief episode of neurologic [relating to the nervous system] dysfunction).During a review of Resident 63's Minimum Data Set (MDS ?a resident assessment tool) dated 3/11/2026, the MDS indicated Resident 63 required dependent assistance (helper does all of the effort) with toileting, oral hygiene, bathing, and showering.During a concurrent observation and interview on 3/24/2026 at 10:53 a.m. with Resident 63, open medications (nine pills) were observed to be left unattended at Resident 63's bedside. No licensed nurse or staff member was present at the time of observation. Resident 63 was observed lying in bed with the medications within reach. Resident 63 stated the medications had been sitting at the bedside for a while but were unable to specify the exact length of time. Resident 63 stated leaving medications at the bedside was a usual practice, and that he sometimes takes the medications and sometimes does not, depending on how he feels.During a review of Resident 63's Medication Administration Record (MAR) dated 3/2026, the MAR indicated, on 3/24/2026, for the 9:00 a.m. administration time there were staff initials in the box for Resident 63's indicating that the following medications were administered:Cholecalciferol (helps maintain strong bones and teeth) oral tablet 50 microgram (mcg-unit of measurement)Clopidogrel Bisulfate (used to prevent dangerous blood clots) oral tablet 75 milligram (mg-unit of measurement)Cyanocobalamin (helps maintain nerve health) oral tablet 1000 mcgFerrous Sulfate (iron [mineral supplement]) oral tablet 325 mgFolic Acid (vitamin) oral tablet 800 mcgMagnesium Oxide (mineral supplement) oral tablet 400 mgRena-Vite (used to treat or prevent vitamin deficiency due to poor diet) oral tabletDuring a concurrent observation, and interview, on 3/24/2026 at 11:00 a.m. with License Vocational Nurse (LVN) 3 observed opened medications at Resident 63's bedside within the resident's reach. LVN 3 stated the medications were left by him. LVN 3 was unable to provide an explanation as to why the medications were left at the bedside. LVN 3 stated Resident 63 was not approved for self-administration of medications. LVN 3 stated per facility policy, medications should not be left at the bedside because there was no assurance the residents will take them as prescribed. LVN 3 stated medications are to be administered directly to the residents and should remain secure and not accessible to others to ensure safe and proper administration. LVN 3 stated medications left unattended could be accessed by others or become contaminated, compromising resident safety. During an interview on 3/27/2026 at 12:00 p.m. with the Director of Nursing (DON), the DON stated that, per facility policy, medications should not be stored or left at the resident's bedside. The DON stated the nurse was expected to remain with the resident until the medications were administered. The DON stated only residents who have been assessed and approved may self-administer medications. The DON stated unauthorized access to medications by visitors or roommates is prevented by ensuring medication was not left unattended at the bedside. The DON stated that compliance with federal and state regulations is ensured through ongoing monitoring, including daily oversight and additional review as needed. The DON stated leaving medications at the bedside creates potential risks, including the possibility of medications being taken by others, medications not being taken in a timely manner, and delay or ineffective therapeutic outcomes. During a review of the facility's policy and procedure (P&P) titled, Self-Administration of Medication revised 2/2021, the P&P indicated, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appropriate and safe for the residents to do so. If the team determines that a resident cannot safely self-administer medications, the nursing staff administer the resident's medication.During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated 2023, the P&P indicated, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls.

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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 observation, interviews and record review, the facility failed to ensure a monthly Medication Regimen Review ([MRR]- a thorough evaluation of a patient's complete medication list to ensure the medication therapy is safe, necessary, and effective) was conducted and maintained by a licensed pharmacist for one of three residents Resident (27). This failure resulted in a lack of professional oversight to identify potential medication irregularities and placed the residents at risk for adverse drug events, excessive sedation, and the continued use of potentially unnecessary medications.Findings: During a review of Resident 27's admission Record, the admission Record indicated Resident 27 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), and diabetes mellitus type 2 (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 27's Minimum Data Set (MDS ?a resident assessment tool) dated 2/1/2026, the MDS indicated Resident 27's cognition (ability to think, understand, learn, and remember) was severely impaired. The MDS indicated Resident 27 was dependent (helper does all of the effort) with eating, toileting, and showering. During a review of Resident 27's Order Summary Report, dated 7/24/2024, the Order Summary Report indicated, Remeron (medication used for patients with depression [persistent sadness and loss of interest], insomnia [difficulty sleeping], and poor appetite) oral tablet 30 milligrams ([mg]- unit of measurement) give one tablet by mouth at bedtime for depression manifested by poor appetite. During an interview on 3/26/2026 at 8:30 a.m. with Certified Nurse Assistant (CNA) 2, CNA 2 stated she assisted Resident 27 with breakfast. CNA 2 stated Resident 27 was extremely sleepy and did not want to eat this morning. CNA 2 stated the residents usually eat 25% of her meals.During an observation on 3/26/2026 at 10:30 a.m. Resident 27 lying in bed with eyes closed, sleepy, and responded only to tactile stimuli (by touch). During a concurrent interview and record review on 03/26/2026 at 11:20 a.m. with the Director of Nursing (DON), Resident 27's MRR dated 1/2026 and 2/2026 was reviewed, the MRR indicated no evidence of a pharmacist conducted monthly medication review for Resident 27. The DON stated she was unable to provide documentation of completed MRR's for Resident 27 for the following months: September 2025, October 2025, November 2025, December 2025, January 2026, and February 2026. The DON was unable to explain why the required reviews were not conducted. The DON stated MRR was required to ensure a licensed pharmacist evaluates each resident's medications monthly in order to identify medication irregularities, prevent adverse drug reactions, ensure medications were clinically appropriate, and recommend changes to the physician when needed. The DON stated lack of a monthly MRR places residents at risk for undetected adverse drug reactions, continued use of unnecessary or inappropriate medication, excessive sedation, and decline in condition. During an interview on 3/26/2026 at 3:02 p.m. with the Registered Dietician (RD), the RD stated despite the resident being prescribed Remeron for depression manifested by poor appetited, the resident continues to demonstrate consistently low caloric intake (the total amount of energy an individual consumes from food and beverages each day) , indicating the medication has not been effective in improving Resident 27's appetite. During a review of the facility's policy and procedure (P&P) title, dated, Medication Monitoring Drug Regimen Review (Monthly Report) [undated], the P&P indicated, Reviewing the medication regimen (drug regimen review) of each resident at least monthly, incorporating federally mandated standards of care in addition to other applicable professional standards, and documenting the review and findings in the consultation report.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interview and record review the facility failed to ensure one of six sampled residents (Resident 75) was seen by a dentist for her broken, loose missing teeth.This failure had the potential to result in the inability to effectively chew foods, weight loss, lack of energy and loss of muscle mass for Resident 75.Findings:During a review of Resident 75's admission Record (face sheet) dated 3/26/2026, the admission record indicated Resident 75 was admitted to the facility with diagnosis including breast cancer (rapid growth of abnormal cells), atrial fibrillation (irregular heartbeat) and muscle weakness.During a review of Resident 75's History and Physical (H&P) dated 1/30/2026, the H&P indicated, Resident 75 was alert and oriented.During a review of Resident 75's Minimum Data Set (MDS) a standardized assessment and care screening tool) dated 3/6/2026, the MDS indicated Resident 75 had moderate cognitive impairment. The MDS indicated Resident 12 needed substantial/maximal assistance (helper does more than half the work) with activities of daily living ([ADLs] daily self-care activities like toileting, bathing and dressing). The MDS indicated Resident 75 had obvious or likely cavities or broken natural teeth.During a concurrent observation and interview on 3/24/2026 at 9:36 a.m. with Resident 75 at Resident 75's bedside. Resident 75's bottom teeth were observed to have two teeth, one was broken and one was loose. Resident 75 stated she had not seen a dentist in a long time and would like to see about getting some dentures. Resident 75 stated it would be easier to eat with dentures, and she would like to not have to eat baby food anymore.During an interview on 3/27/2026 at 11:33 a.m. with Registered Nurse Supervisor1 (RNS 1), RNS 1 stated she was the nurse who admitted Resident 75 to the facility and she was aware Resident 75 was missing teeth and forgot to put in the order for Resident 75 to see a dentist. RNS1 stated Resident 75 was at risk for malnutrition and needed to see a dentist.During an interview on 3/27/2026 at 11:33 a.m. with the Director of Nurses (DON), the DON stated residents with missing teeth need to be seen by a dentist to have an oral assessment to provide interventions. The DON stated Resident 75 may not be able to chew or eat well and may feel self-conscious about how they look.During a review of the facility's policy and procedure (P&P) titled Dental Consultant dated 4/2007, the P&P indicated, a consultant dentist is retained by our facility and is responsible for providing consultation to physicians and providing other services relative to dental matters. Providing a dental assessment of each resident within ninety (90) days of admission. Performing or supervising an annual dental reevaluation for each resident. Providing staff in-service education assuring that emergency dental services are available. Providing necessary information concerning residents to appropriate staff, care planning conferences, and/or committees.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure the accuracy of the medical record for one of three residents (Resident 63). As evidence by documentation indicating medications were administered on 3/24/2026 at 8:08 a.m., while observation revealed medications were left opened/unattended at the bedside and not confirmed as administered.This deficient practice resulted in inaccurate documentation of medication administration and had the potential to affect Resident 63's treatment and care.Findings:During a review of Resident 63's admission Record, the admission Record indicated Resident 63 was admitted to the facility on [DATE] with diagnoses including chronic kidney disease (lasting damage to the kidneys), and transient ischemic attack ([TIA]-brief episode of neurologic [relating to the nervous system] dysfunction).During a review of Resident 63's Minimum Data Set (MDS ?a resident assessment tool) dated 3/11/2026, the MDS indicated Resident 63 required dependent assistance (helper does all of the effort) with toileting, oral hygiene, bathing, and showering.During a concurrent observation and interview on 3/24/2026 at 10:53 a.m. with Resident 63, open medications (nine pills) were observed to be left unattended at Resident 63's bedside. No licensed nurse or staff member was present at the time of observation. Resident 63 was observed lying in bed with the medications within reach. Resident 63 stated the medications had been sitting at the bedside for a while, but were unable to specify the exact length of time. Resident 63 stated leaving medications at the bedside was a usual practice, and that he sometimes takes the medications and sometimes does not, depending on how he feels.During a review of Resident 63's Medication Administration Record MAR dated 3/2026, the MAR indicated, on 3/24/2026, for the 9:00 a.m. administration time there were staff initials in the box for Resident 63's indicating that the following medications were administered:Cholecalciferol (helps maintain strong bones and teeth) oral tablet 50 microgram (mcg-unit of measurement)Clopidogrel Bisulfate (used to prevent dangerous blood clots) oral tablet 75 milligram (mg-unit of measurement)Cyanocobalamin (helps maintain nerve health) oral tablet 1000 mcgFerrous Sulfate (iron [mineral supplement]) oral tablet 325 mgFolic Acid (vitamin) oral tablet 800 mcgMagnesium Oxide (mineral supplement) oral tablet 400 mgRena-Vite (used to treat or prevent vitamin deficiency due to poor diet) oral tabletDuring a review of Resident 63's Medication Administration Audit Report dated 3/24/2026 at 11:08 a.m., the Medication Administration Audit Report indicated the following medications administered:Cholecalciferol oral tablet 50 mcgClopidogrel Bisulfate oral tablet 75 mgCyanocobalamin oral tablet 1000 mcgFerrous Sulfate oral tablet 325 mgFolic Acid oral tablet 800 mcgMagnesium Oxide oral tablet 400 mgRena-Vite oral tabletDuring an interview on 3/24/2026 at 11:30 a.m. with License Vocational Nurse (LVN) 3, LVN 3 stated he documented the administration of Resident 63's medications on 3/24/2026 at 8:08 a.m. before the medications were administered. LVN 3 stated the medications were left at Resident 63's bedside and had not been administered at the time of documentation. LVN 3 stated this practice could result in medications being missed, delayed, or duplicated. LVN 3 stated inaccurate documentation could place the resident at risk for ineffective therapy, adverse drug events, or other medications errors. LVN 3 stated medications must be administered directly to the resident and accurately documented at the time of administration.During a concurrent interview and record review on 3/37/2026 at 12:00 p.m. with the Director of Nursing (DON), Resident 63's Medication Administration Audit Report dated 3/24/2026 at 8:08 was reviewed, the Medication Administration Audit Report indicated LVN 3 documented administration of Resident 63's medications. The DON stated documentation of medication administration must accurately reflect the time and action of administration. The DON stated documenting medications before they are actually given was not in accordance with facility policy or professional standards. The DON stated medications should be administered directly to the residents, verified, and immediately documented in the MAR. The DON (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated inaccurate documentation could lead to missed, delayed, or duplicated doses, creating a risk of ineffective therapy, adverse drug events, or other medication errors. The DON stated inaccurate records compromise resident safety and could place the facility at risk for regulatory non-compliance.During a review of the facility's policy and procedure (P&P) titled, Administering Medications dated 2019, the P&P indicated, Medications are administered in accordance with prescriber order, including any required time frame.During a review of the facility's P&P titled, Administering Medications dated 2029, the P&P indicated, If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose.During a review of the facility's P&P titled, Administering Medications dated 2029, the P&P indicated The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.Cross reference F755

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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 ensure infection control measures were observed for three of six sampled residents (Residents 6, 12 and 79). The facility failed to:1.Ensure signage for Enhanced Barrier Precautions (EBP- infection control intervention using gown and gloves during high contact resident care activities designed to reduce the transmission of multi-drug-resistant organisms {microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents}) was in place for Resident 6.2.Ensure the laundry staff cleaned and documented the dryer lint trap screens every two hours.3.Ensure the kitchen staff monitored and documented the refrigerator temperatures.4. Ensure staff member wore personal protective equipment (PPE-gown, gloves) before providing patient care to Resident 12 who was on EBP for stasis ulcers (open sores).5. Ensure Resident 79's care giver removed PPE before exiting Resident 79's room to walk down the hallway after providing personal care.These deficient practices had the potential to result in cross contamination (physical movement or transfer of harmful bacteria from one person, object, or place to another) and place residents at risk for the spread of infection.Findings: 1.During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was admitted to the facility on [DATE] with diagnoses including 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 6's Order Summary Report, the Order Summary Report indicated an order dated 2/26/2026 for EBP for a left heel wound. During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool) dated 3/6/2026, indicated Resident 6's cognition (ability to think, understand, learn, and remember) for daily decision making was severely impaired. The MDS indicated Resident 6 was dependent (helper does all the effort) with activities of daily living (ADLs- routine tasks such as bathing, dressing, and toileting a person performs daily to care for themselves). During a concurrent observation and interview on 3/24/2026 at 1:01 p.m. with Certified Nurse Assistant (CNA) 3, in Resident 6's room, CNA 3 indicated Resident 6 was on EBP but there was no signage indicating Resident 6 was on isolation. CNA 3 stated there should be signage outside the room to indicate the type of isolation Resident 6 was on and what precautions to take. During an interview on 3/25/2026 at 12:09 p.m., with the Infection Prevention Nurse (IPN), IPN stated the isolation precaution signage is placed outside the resident's rooms to indicate what type of isolation and what precautions to take. IPN stated there should be signage for all residents on isolation to ensure the staff are taking proper precautions and to prevent the spread of infection. 2.During a concurrent observation and interview on 3/26/2026 at 7:10 a.m., in the laundry room, Laundry Aide (LA) 1 was observed cleaning the dryer lint trap screens which were full of lint. LA 1 stated he last cleaned the lint trap at 2:00 a.m. and 4:00 a.m. but did not document that he cleaned it. During an interview on 3/26/2026 at 7:59 a.m., with the Laundry Supervisor (LS) 1, LS 1 stated the dryer lint trap screens are supposed to be cleaned every two hours and documented on the log sheet. LS 1 stated it's important to clean the dryer lint trap screen to ensure the clothes dry at the right (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	temperature and for safety because not doing so is a fire hazard. 3.During an observation on 3/24/2026 at 8:17 a.m., in the kitchen, the snack refrigerator temperature log was not up to date. Dates missing were 3/22/3026 and 3/23/2026. During an interview on 3/26/2026 at 2:41 p.m., [NAME] © 1, C 1 stated it is her responsibility to check the refrigerator temperatures and document on the log sheet. C 1 stated I messed up the other day and should have made sure to check the temperatures because not doing so could result in food being served at the wrong temperatures which could cause the residents to get sick. During an interview on 3/27/2026 at 9:38 a.m., with the Dietary Supervisor (DS), DS stated it is her process to check and document the refrigerator temperatures per shift in a timely manner. DS stated it is important that the refrigerator temperatures are monitored per shift for the safety of the residents; they could get sick and possibly die. During an interview on 3/27/2026 at 1:07 p.m., with the Director of Nursing (DON), DON stated it's important to have isolation precaution signage present to alert the staff and visitors to ensure the appropriate isolation precautions are being taken. The DON stated dryer lint trap screens should be cleaned for infection control because if the lint accumulates, the linens will not dry properly and because it's also a fire hazard. The DON stated the refrigerator temperatures should be checked and documented to ensure the food does not spoil because it could lead to the residents getting sick. During a review of the facility's policy and procedure (P&P) titled, Policies and Practices- Infection Control dated 10/2018, the P&P indicated, The facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. During a review of the facility's P&P titled, Maintenance of the Laundry Room and Laundry Equipment, undated, Clean lint filters after each use of washer or dryer every three hours.: During a review of the facility's P&P titled, Refrigerators and Freezers, dated 11/2022, the P&P indicated, The facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. The P&P indicated, Food service supervisors or designated employees check and record refrigerator and freezer temperatures daily with first opening and first closing in the evening. 4. During an observation on 3/24/2026 at 12:49 p.m. in Resident 12's room, the Director of Staff Development (DSD) was observed repositioning Resident 12 not wearing PPE. During an observation on 3/25/2026 at 7:10 a.m. outside of Resident 79's room, Resident 79's care giver was observed not removing her PPE before leaving Resident 79's room to walk down the hallway to access the dirty linen cart. During a review of Resident 12's admission Record (face sheet) dated 3/26/2026, the admission record indicated, Resident 12 was admitted on [DATE] and readmitted on [DATE], with diagnosis including heart failure (heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), diabetes mellitus (a condition in which the body fails to process glucose (sugar) correctly), dementia (loss of memory, language, problem-solving and other thinking abilities). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 12's History and Physical (H&P) dated 1/30/2026, the H&P indicated, Resident 12 did not have the capacity to understand and make decisions. During a review of Resident 12's Minimum Data Set (MDS) a standardized assessment and care screening tool) dated 2/5/2026, the MDS indicated Resident 12 did not have the capacity to understand and make decisions. The MDS indicated Resident 12 was dependent (helper does all the effort) with activities of daily living ([ADLs] daily self-care activities like toileting, bathing and dressing). During a review of Resident 12's Order Summary Report dated 3/26/2026, the order summary report indicated Resident 12 was on EBP for stasis ulcers. The order summary report indicated betadine (antiseptic) solution apply to left leg topically (on the skin) every day shift for stasis dermatitis (skin condition) for 21 days, cleanse with normal saline (ns), pat dry, apply betadine solution, cover with an abdominal pad (absorbent pads) followed by a bandage roll. The order summary report indicated Silvadene cream (topical antibiotic) apply to right leg topically every day shift for stasis dermatitis for 21 days, cleanse with ns, pat dry, apply Silvadene cream cover with abdominal pad followed by bandage roll. During a review of Resident 79's admission Record (face sheet) dated 3/26/2026, the admission record indicated, Resident 79 was admitted on [DATE], with diagnosis including fracture of left tibia (broken shinbone), anemia (a condition in which there is lack of enough red blood cells) and muscle weakness. During a review of Resident 79's History and Physical (H&P) dated 1/10/2026, the H&P indicated, Resident 79's had normal level of consciousness. During a review of Resident 79's Minimum Data Set (MDS) a standardized assessment and care screening tool) dated 1/13/2026, the MDS indicated, Resident 79 had the capacity to understand and make decisions. The MDS indicated Resident 79 needed substantial/maximal assistance (helper does more than half the effort) with activities of daily living (ADLs] daily self-care activities like toileting, bathing and dressing. During an interview on 3/24/2025 at 1:13 p.m. with the DSD, the DSD stated Resident 12 was on EBP for her leg wounds. The DSD stated she should have been wearing PPE when repositioning Resident 12. The DSD stated Resident 12 was at an increased risk for infection when not wearing PPE while providing direct patient care. 5.During an interview on 3/25/2026 at 7:20 a.m. with Resident 79's care giver, the care giver stated she had finished caring for Resident 79 and walked down the hallway to put the dirty linen in the linen cart. The care giver stated she was not educated by the staff about PPE and she was not aware she should take of her dirty PPE before walking in the hallway. During an interview on 3/27/2026 at 8:48 p.m. with the infection preventionist (IP), the IP stated EBP is an infection control measure used to protect the resident from bacteria and germs. The IP stated residents are at risk for cross contamination when staff are not wearing PPE. The IP stated PPE is not to be worn in the hallway it is to be removed in the room and put in a closed trash receptacle to prevent cross contamination. During an interview on 3/27/2026 at 11:47 a.m. with the Director of Nursing (DON), the DON stated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was aware the DSD did not wear PPE before providing care to Resident 12. The DON stated she was aware the care giver for Resident 79 did not take off her PPE before leaving Resident 79's room after providing care. The DON stated there was a risk for cross contamination when infection control measures are not followed. During a review of the facility's policy and procedure (P&P) titled Standard Precautions, Enhanced Barrier Precautions and Transmission dated 5/25/2025, the P&P indicated it provided guidelines for infection control practices to reduce the potential for transmission of pathogens including COVD-19 and multi-drug-resistant organisms and viruses. Enhanced Barrier Precautions (EBP- primarily is the use of gowns and gloves for specific high contact care activities, based on the resident's characteristics associated with a high risk of [NAME] colonization and transmission. Presence of indwelling medical devices (e.g., urinary catheter, feeding tube, endotracheal or tracheostomy tube, central/vascular catheters, etc.). Chronic and open non-healing wounds (Vascular, Diabetic Venous open ulcer/s) or chronic non healing pressure ulcer stage 3/stage 4. A resident with Stage 1 or Stage 2 pressure ulcer/s will not be placed on EBP unless indicated and ordered by the attending physician. Any care activity where close contact with the resident is expected to occur such as bathing, peri-care, assisting with toileting, changing incontinence briefs, respiratory care. Changing bed linens. Any care activity involving contact with environmental surfaces is likely contaminated by the resident. Visitors and volunteers shall be educated and instructed in hand hygiene protocols, PPE use, and other infection control practices.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their protocol for Antibiotic Stewardship (refers to a set commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use) for two of three sampled residents (Resident 54 and Resident 66).This deficient practice had the potential for Resident 54 and Resident 66 to develop antibiotic resistance (not effective to treat infection) from unnecessary or inappropriate antibiotic use.Findings:1. During a review of Resident 54's admission Record, the admission Record indicated Resident 54 was admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 54 was admitted with diagnoses including cerebral infarction (stroke, loss of blood flow to a part of the brain) and hypertension (HTN- high blood pressure).During a review of Resident 54's Minimum Data Set (MDS- a resident assessment tool) dated 2/28/2026, the MDS indicated Resident 54's cognition (ability to think, understand, learn, and remember) for daily decision making was intact. The MDS indicated Resident 54 was dependent (helper does all the effort) with toileting, bathing, and dressing.During a review of Resident 54's Order Details dated 2/25/2026, the Order Details indicated an order for Levaquin (medication to treat an infection) 250 milligrams (mg- unit of measurement) by mouth daily for a urinary tract infection (UTI- an infection in the bladder).During a review of Resident 54's Infection Surveillance Form dated 3/1/2026, the Infection Surveillance Form indicated Resident 54 had an antibiotic (medication to treat an infection) order for UTI. The Infection Surveillance Form indicated Resident 54 was asymptomatic and did not meet McGeer's criteria (a standardized set of rules used in nursing homes and long-term care facilities to consistently identify and track infections) for antibiotic usage. 2. During a review of Resident 66's admission Record, the admission Record indicated Resident 66 was admitted to the facility on [DATE] with diagnoses including HTN and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities).During a review of Resident 66's MDS dated [DATE], the MDS indicated Resident 66's cognition was severely impaired. The MDS indicated Resident 66 required supervision (helper provides verbal cues) with activities of daily living (ADLs- routine tasks such as bathing, dressing, and toileting a person performs daily to care for themselves).During a review of Resident 66's Order Details dated 2/6/2026, the Order Details indicated an order for Macrobid (medication to treat an infection) 100mg twice a day for UTI.During a concurrent interview and record review on 3/25/2026 at 12:09 p.m., with the Infection Prevention Nurse (IPN), the IPN stated Resident 54 and Resident 66 did not meet McGeer's criteria and neither Resident 54 nor Resident 66's doctors were informed but should have been. IPN stated continuing an antibiotic when it does not meet McGeer's criteria puts Resident 54 and Resident 66 at risk for antibiotic resistance and developing multidrug resistant infections (MDROs- are microorganisms that have developed resistance to multiple classes of antibiotics).During an interview on 3/27/2026 at 1:07 p.m., with the Director of Nursing (DON), the DON stated when a resident does not meet McGeer's criteria the residents' doctor should be notified to possibly discontinue the antibiotic. DON stated residents on antibiotics without meeting McGeer's criteria could result in unnecessary usage and resistance to antibiotics.During a review of the facilities policy and procedure (P&P) titled, Antibiotic Stewardship, dated 10/2016, the P&P indicated, Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The P&P indicated The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents. The P&P indicated Training of staff will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects individual residents and the overall community.During a review of the facility's P&P titled, Surveillance for Infections, dated 9/2017, the P&P indicated, The criteria for such infections are based on current standard definitions of infections. The facility is using McGeer's criteria to determine infection. McGeer's criteria is a standardized evidenced based definitions used for surveillance of healthcare associated infections.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to:1. Ensure adequate room size and space to support the comfort and wellˆbeing for one of six sampled residents (Resident 59).2. Ensure 6 of 26 residents' rooms (Rooms 21, 22, 23, 25, 26 and 27) met the requirements of 80 square feet for each resident.This failure had the potential to negatively impact Resident 59's quality of life by limiting his ability to move freely and safely within his living space and had the potential to result in inadequate provision of safe nursing care and a lack of privacy for residents.Findings:During a concurrent observation and interview on 3/26/2026 at 8:22 a.m. with Resident 59 at bedside, Resident 59's television (TV) stand was observed to be blocking Resident 59 from being able to maneuver his w/c to the left side of his bed. Resident 59 stated this room is way too small for him. Resident 59 TV stand had to be moved for him to get to the left side of his bed. Resident 59 stated there was nothing he could do about it, this was the room the facility gave him.During a review of Resident 59's admission Record (face sheet) dated 3/26/2026, the admission record indicated, Resident 59 was admitted to the facility with diagnosis including hemiplegia (paralysis of one side of the body), diabetes mellitus (a condition in which the body fails to process glucose (sugar) correctly) and difficulty walking.During a review of Resident 59's History and Physical (H&P) dated 4/30/2025, the H&P indicated, Resident 59's cognition was intact.During a review of Resident 59's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 12/18/2025, the MDS indicated Resident 59's cognition was intact. The MDS indicated Resident 59 needed substantial/maximal assistance (helper does more than half the effort) with activities of daily living (ADLs] daily self-care activities like toileting, bathing and dressing. The MDS indicated Resident 59 used a wheelchair (w/c) for mobility (moving around).During a review of the facility's Client Accommodation Analysis (CAA-room measurements) dated 3/25/2026, the CAA indicated room [ROOM NUMBER] (4 beds) was 292.87 sq. ft., room [ROOM NUMBER] (4 beds) was 306.40 sq. ft., room [ROOM NUMBER] (4 beds) was 308.81 sq. ft., room [ROOM NUMBER] (4 beds) was 307.20 sq. ft., room [ROOM NUMBER] (4 beds) was 310.22 sq. ft., and room [ROOM NUMBER] (4 beds) was 310.22 sq. ft.During an interview on 3/27/2026 at 8:31 a.m. with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated Resident 59's room was small. CNA 2 stated she had to move the TV stand every time she needed to get to the left side of Resident 59's bed. CNA 2 stated there were safety concerns with the small space.During an interview on 3/27/2026 at 8:46 a.m. with the plant supervisor (PS), the PS stated Resident 59's room was small and did not meet the 80 sq ft for each resident. The PS stated there were safety hazards and tripping concerns with a smaller room.During an interview on 3/27/2026 at 2:11 p.m. with the Administrator (ADM), the ADM stated she was aware of some of the rooms in the facility were smaller. The ADM stated there were safety concerns with small rooms. The ADM stated residents could bump into things if there is not enough space.