

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2025
NAME OF PROVIDER OR SUPPLIER Hollenbeck Palms		STREET ADDRESS, CITY, STATE, ZIP CODE 573 S. Boyle Ave. Los Angeles, CA 90033	
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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 the Low Air Loss mattress (LAL mattress, designed to prevent and treat pressure ulcer [localized damage to the skin and underlying soft tissue caused by prolonged pressure]) was set at the correct setting for two (2) of four (4) sampled residents (Residents 9 and 28) under pressure ulcer care area. This failure had the potential to result in the deterioration of Resident 9's pressure ulcer and development of Resident 28's pressure ulcer. Findings: 1. During a review of Resident 9's admission Record, the admission Record indicated the facility admitted Resident 9 on 8/31/2025. Resident 9's diagnoses included muscle weakness, dementia (progressive brain disorder that slowly destroys memory and thinking skills), abnormal posture, and full incontinence of feces. During a review of Resident 9's Minimum Data Set (MDS, standardized care and screening tool), dated 11/17/2025, the MDS indicated the resident was severely impaired (never/rarely made decision) with cognitive (ability to think, remember, and reason) skills for daily decision making. MDS indicated Resident 9 was dependent (helper does all the effort) on toileting and needed substantial /maximal assistance (helper does more than half of the effort) for personal hygiene. The MDS also indicated Resident 9 was at risk for developing pressure ulcer/ injuries. The MDS also indicated Resident 9's skin and ulcer/ injury treatment included pressure reducing device for bed and application of ointments/medications. The MDS also indicated Resident 9 had 1 Stage 3 pressure ulcer (full-thickness skin wound where fat may be visible, but bone, tendon, or muscle are not exposed). During a review of Resident 9's Order Summary Report, dated 12/10/2025, the Order Summary Report indicated a physician's order dated 9/10/2025 for a low air loss mattress for wound management. During a review of Resident 9's Care Plan, revised date 9/1/2025, the Care Plan indicated Resident 9 was diagnosed with full incontinence of feces, mixed incontinence, dementia. The care plan also indicated LAL mattress for wound management. During a review of Resident 9's Weights and Vitals, dated 12/12/2025, the Weights and Vitals indicated on 1/7/2025 at 11:20 AM, Resident 9's weight was 111.6 pounds (lbs. to measure weight or mass). During a review of Resident 9's Braden Scale (an assessment tool used for predicting the risk for developing pressure sores), dated 12/1/2025, the Braden Scale indicated a score of 15, meaning resident was at risk for developing pressure injury. During an observation on 12/9/2025 at 10:05 AM in Resident 9's room, observed resident lying in bed (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	more noticeable or sticks out that can be felt easily and is at higher risk for pressure sores) which can lead to skin breakdown (damage to the skin and underlying tissue, ranging from minor scrapes to severe pressure ulcers caused by factors including prolonged pressure, friction, and moisture). During an interview on 12/12/2025 at 9:39 AM with the ADON, ADON stated the purpose of a LAL was to provide optimal healing for skin breakdown and even distribution around the weight of the resident. The ADON stated Resident 28's LAL being set to 300 lbs or more poses a risk of the mattress being too firm and can cause the skin breakdown over the resident's bony prominences. During a review of the facility's policy and procedure (P&P) titled, Low Air Loss Mattress, dated 6/30/2022, the P&P indicated the Low Air Loss system is a high quality and affordable air support surface suitable for very high-risk pressure ulcer prevention and treatment. It has been specifically designed for prevention of incidence of pressure ulcers and treatment of existing pressure ulcers and offers an optimal solution for pressure redistribution. The P&P also indicated under it's procedure to, Turn the Pressure Adjust Knob to set a comfortable pressure level using the weight scale as a guide. During a review of the LAL User Manual (undated), the LAL User Manual indicated under product features that, This analog (physical) control unit includes and easy to use pressure dial that is adjustable to the patient's weight and comfort.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper food handling and the food service area was maintained in a clean and sanitary manner in accordance with the facility's policy and procedure (P&P) by failing to ensure: 1. One dented saltshaker was free of food residue and was not crusted. 2. One pepper shaker did not contain red food residue and had a dirty label. 3. 3 burgundy plate covers were not peeling, chipped, and scratched. 4. 27 black food trays were not peeling and chipped. These deficient practices have the potential to result in pathogen (germ) exposure to residents, which could place the residents at risk for developing foodborne illness ([food poisoning] with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever) and can lead to other serious medical complications and hospitalization. Findings: During an observation in the kitchen at 8:07 AM, the saltshaker was observed to be dented and dirty with crusted food residue. During an observation in Dining room [ROOM NUMBER] at 12/11/2025 at 8:01 AM, 3 burgundy plate covers were observed to be peeling, chipped, and scratched. During an observation in Dining room [ROOM NUMBER] at 12/11/2025 at 11:49 AM, 27 black serving trays were observed to be peeling and chipped. During a concurrent observation and interview on 12/12/2025 at 10:06 AM with the Assistant Director of Nursing (ADON), the ADON stated that the saltshaker appeared rusted, dented, and crusted with dry left-over food residue. The ADON added the saltshaker's lid area was dirty with brown colored food residue. During a concurrent observation and interview on 12/12/2025 at 10:07 AM with the ADON, the ADON stated the pepper shaker was cracked and contained green colored food residue. ADON also stated this was unsanitary (dirty or unhealthy and therefore likely to cause disease). During a concurrent observation and interview on 12/12/2025 at 10:10 AM with the ADON, ADON stated the burgundy plate covers showed wear and tear (deterioration or damage of objects), with multiple areas of rubber peeling from the lid and rough edges. The ADON stated this was not acceptable. During a concurrent observation and interview on 12/12/2025 at 10:12 AM with the ADON, the ADON stated the black food trays had uneven edges, appears melted and chipped with exposed brown -color metal. ADON stated these were not acceptable, as they can possibly harbor bacteria. ADON also stated the plastic peel can possibly fall in the food. ADON also stated the residents can possibly have plastic ingestion (eating plastic) that can cause sickness or harm to residents. During a concurrent observation and interview on 12/12/2025 at 10:38 AM with the Registered Dietitian (RD) and the Director of Dining (DD), the RD stated metal saltshaker was dirty, crusted with brown colored food residue, and dented. The DD stated pepper shaker contained red food residue and had a dirty label. The DD confirmed the burgundy plate covers were observed to be peeling, chipped, and scratched and the black serving trays in Dining room [ROOM NUMBER] were observed to be peeling and chipped. The RD stated this condition was 100 percent unacceptable. RD stated this increased the risk for potential cuts to the residents and staff and could cause material contamination (foreign or unsafe materials get into the food or onto contact surfaces, making the food unsafe to eat). RD also stated that plastic peel could be ingested by residents and that damaged surface could harbor bacteria. During a concurrent interview and record review on 12/12/2025 at 10:50 AM with the RD, the facility's P&P titled, Sanitation and Infection Control Receiving and Storage, revised 5/2023 was reviewed. The RD stated that the P&P indicated all items are to be checked to detect unacceptable items, example dented, swollen or rusted can. During a concurrent interview and record review on 12/12/2025 at 10:52 AM with the RD, the facility's P&P titled, Damage Dishware, revised 5/2023 was reviewed. The RD stated the P&P indicated any plates, cups, dishes or other dishware including meal trays that are cracked, chipped, or in any way has its surface disrupted, shall be disposed of in proper manner. The P&P also indicated it is the responsibility of all persons who handle dishware to inspect for chipped or cracks on the (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	surface. Any piece of dishware that is chipped, cracked, or had any other interruptions of the glazed surface should be immediately removed from service. The P&P also indicated meal service trays used for the resident meal should be inspected for broken or cracked corners which can be injurious to residents. These trays should be removed from service.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure two (2) of four (4) sampled residents (Residents 65 and 6) under the environment care area, had their call light within reach in accordance with the care plan. This failure had the potential to put Residents 65 and 6 at risk for experiencing a delay in receiving assistance from facility staff which could lead to a fall or accident.1. During a review of Resident 65's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of obstructive hypertrophic cardiomyopathy (when the heart muscle thickens abnormally making it hard for it to pump blood out to the body, essentially blocking the outflow) and generalized muscle weakness (a widespread lack of strength affecting many muscles throughout the body).During a review of Resident 65's Minimum Data Set (MDS - a resident assessment tool), dated 12/11/2025, the MDS indicated the resident had intact (ability to think, remember, and reason) cognitive skills for daily decision making. Resident 65 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with personal hygiene. Resident 65 needed partial/moderate assistance (helper does less than half the effort) with walking 10 and 50 feet, chair/bed-to-chair transfers, going from lying down to sitting on the side of the bed, and upper and lower body dressing (the ability to dress and undress above and below the waist). Resident 65 needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with rolling left and right in bed and needed setup or clean-up assistance (helper sets up and cleans up; resident completes activity) with eating. During a review of Resident 65's Care Plan, dated 12/6/2025, Resident 65's Care Plan indicated Resident 65 was at high risk for falls related to gait/balance problems and vision/hearing problems. The care plan interventions included were to ensure the resident's call light to be within reach and encourage the resident to use it for assistance as needed. The care plan indicated Resident 65 needs prompt response to all requests for assistance.During a concurrent observation in Resident 65 ?s room and interview on 12/9/2025 at 8:53 AM, Resident 65 was observed in bed. Resident 65's call light was observed wrapped around and hanging off the left siderail (adjustable metal or rigid plastic bars that attach to the bed) of the resident's bed and touching the floor. Resident 65 stated she could not reach the call light and that she has a hard time reaching for things.During a concurrent observation and interview on 12/9/2025 at 9:06 AM with Licensed Vocational Nurse 1 (LVN 1) inside Resident 65's room, Resident 65's call light was observed wrapped around and hanging off the left siderail of Resident 65's bed and touching the floor. LVN 1 stated Resident 65's call light was hanging off the left side of Resident 65's bed and was not within reach. During an interview on 12/10/2025 at 1:19 PM with LVN 1, LVN 1 stated the purpose of a call light is for the residents to be able to call for help and get assistance if needed and if a resident's call light is out of reach, it poses a risk for the resident to get up out of bed without assistance and fall. During an interview on 12/12/2025 at 9:32 AM with Assistant Director of Nursing (ADON), ADON stated the purpose of a call light is by being the priority safety lifeline of the resident to reach the staff in case of an emergency and if it is not within reach, then the resident cannot be heard and could potentially sustain a fall or change of condition. 2. During a review of Resident 6's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of muscle weakness, Acute kidney failure (when the kidneys suddenly become unable to filter waste products from the body), edema (swelling caused by too much fluid trapped in the body's tissues).During a review of Resident 6's MDS, dated [DATE], the MDS indicated the resident had intact cognitive skills for daily decision making. Resident 6 was dependent on oral hygiene, toileting hygiene, and personal hygiene. The MDS also indicated Resident 6 was dependent on toilet transfer (the ability to get on and off the toilet or commode), and from sit to lying (the ability (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to move from sitting on side of bed to lying flat on the bed). During a review of Resident 6's Care Plan, dated 9/13/2025, the Care Plan indicated Resident 6 was diagnosed with generalized muscle weakness. The care plan interventions included were to ensure the resident's call light to be within reach and encourage the resident to use it for assistance. During an observation on 12/09/2025 at 10 AM in Resident 6's room, Resident 6 was observed lying on bed and the resident's call light was observed on the floor. During an observation on 12/9/2025 at 10:57 AM in Resident 6's room, Resident 6 was observed lying on bed and the resident's call light was observed on the floor. During a concurrent observation and interview on 12/9/2025 at 11:20 AM with LVN 2 in Resident 6's room, Resident 6's call light was observed on the floor. LVN 2 stated Resident 6's call light should be within residents' reach all the time. During an interview on 12/12/2025 at 12:43 PM with LVN 2, LVN 2 stated call lights are supposed to be within resident's reach at all times and not on the floor. LVN 2 added the call light was the primary means of communication to alert staff when residents need assistance. LVN 2 stated unreachable call light could possibly lead to fall, unattended emergencies or trust issues, causing residents to feel neglected or helpless. During a record review of the facility's policy and procedures (P&P) titled, Use of Call light, revised 1/2019, the P&P indicated purpose was to respond to resident's call for assistance. The P&P also indicated to ensure all call lights/ hand bells are placed on the bed at all times, never on the floor or bedside stand. During a record review of the facility's P&P titled, Baseline Care Plans, revised 7/13/2022, the P&P indicated that the interdisciplinary team shall develop and implement a baseline care plan for each resident that includes the instruction needed to provide effective and person-centered care of the resident.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to promote respect and dignity for one (1) of 1 sampled resident (Residents 19) under the dignity care area by failing to ensure that Resident 19 was free from visible food stains on her clothing and dry, crusted discharge on her left eye. This deficient practice had the potential to negatively impact Resident 19's self-esteem and psychosocial well-being (state of mental, emotional, and social health of an individual). Findings: During a review of Resident 19's admission Record, the admission Record indicated Resident 19 was initially admitted to the facility on [DATE]. Resident 19's diagnoses included depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), difficulty in walking, and osteoarthritis (the cartilage within a joint begins to break down and the underlying bone begins to change causing reduced function and disability). During a review of Resident 19's Minimum Data Set (MDS, a resident assessment tool), dated 11/15/2025, the MDS indicated Resident 19's cognitive skills (processes of thinking and reasoning) for daily decision making was severely impaired (never/rarely made decisions). The MDS also indicated Resident 19 was dependent on personal hygiene (ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing /drying face and hands). During a review of Resident 19's Care Plan, revised 12/2/2025, the Care Plan indicated Resident 19's Activities of Daily Living (ADL) selfcare deficit and dependence on staff for personal hygiene. The care plan included interventions for the staff to work around her to accommodate her needs, respect her dignity and residents' rights. Other interventions were to assist out of bed and help with personal hygiene, dressing, ask resident her preference, give a choice, provide grooming, and assist with clean clothes daily as needed. During a concurrent observation and interview on 12/9/2025 at 1:50 PM at the hallway with the Activity Director (AD), Resident 19 was observed sitting in the wheelchair. Resident 19's left eye was observed with dry, yellowish colored crusted eye discharge and visible cranberry stains on her white shirt. AD stated Resident 19 should be wearing a shirt without stains and her eyes should have been cleaned and free from discharge. During an interview on 12/10/2025 at 1:38 PM with the licensed vocational nurse 2 (LVN 2), LVN 2 stated the residents should not have any food stains on their clothes. LVN 2 stated, Residents are supposed to be well kept for dignity. It is important for the residents to be properly groomed. During a concurrent interview and record review on 12/12/2025 at 8:21 AM with the Assistant Director of Nursing (ADON), the facility's policy and procedure (P&P) titled, Grooming and Personal Hygiene, revised 1/2010 was reviewed. The ADON stated the P&P indicated, all nursing and other skilled nursing staff have a responsibility to monitor and contribute to residents' grooming and hygiene. During a concurrent interview and record review on 12/12/2025 at 8:25 AM with the ADON, the facility's P&P titled, Baseline Care Plans revised 7/13/2022 was reviewed. The ADON stated the P&P indicated the interdisciplinary team shall develop and implement a baseline care plan for each resident that includes the instruction needed to provide effective and person-centered care of the resident. During a concurrent interview and record review on 12/12/2025 at 8:26 with the ADON, the facility's P&P title Quality of life -Dignity revised 3/2025 was reviewed. The ADON stated the P&P indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. The P&P also indicated residents shall be treated with dignity and respect at all times. The Residents shall be groomed as they wish to be groomed. During an interview on 12/12/2025 at 8:32 AM with the ADON, the ADON stated lunch was served at 12 PM and the residents should be clean and well-groomed all the time. The ADON stated there should not be any food stain on the residents' clothing, and yellow, crusted, dry discharge on the residents' eyes for the purpose of maintaining the resident's dignity.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one (1) of five (5) sampled residents (Resident 17) under unnecessary medication care area was free from unnecessary use of psychotropic drug (any medication capable of affecting the mind, emotions, and behavior) by failing to ensure Resident 17's hours of sleep was monitored for the use of Trazodone (a medicine used to improve mood, energy, and focus), in accordance with the facility's policy and procedure (P&P). This deficient practice had the potential to place Resident 17 at risk for significant adverse consequences (unwanted, uncomfortable, or dangerous effects that a drug may have) from the use of unnecessary psychotropic drug, which could result to impairment or decline in the resident's mental, physical condition, functional, and psychosocial status. Findings: During a review of Resident 17's admission Record, the admission Record indicated Resident 17 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnosis included dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety disorder (a natural human emotion characterized by feelings of worry, nervousness, or unease). During a review of Resident 17's Minimum Data Set (MDS - a resident assessment tool), dated 10/9/2025, the MDS indicated Resident 17's cognitive skills for daily decision making was moderately impaired (decisions poor, cues/supervisions required). The MDS indicated Resident 17 required setup or clean up assistance (helper set up or cleans up) with eating. The MDS indicated Resident 17 was dependent (helper does all the effort) with oral hygiene, toileting hygiene, shower, upper body dressing, lower body dressing, putting on/off footwear and personal hygiene. Resident 17 did not have any mood symptoms. The MDS indicated Resident 17 was taking antidepressant During a review of Resident 17 's Order Summary Report dated 12/11/2025, the Order Summary Report indicated the following: Trazadone 50 milligrams (mg, unit of measurement) tablet, give 1 tablet by mouth at bedtime, for depression manifested by insomnia (inability to sleep), with order date of 11/14/2025. Trazodone 25 mg, by mouth one time a day for depression manifested by insomnia, with order date of 12/9/2025. During a concurrent record review of Resident 17 's Medication Regimen Review (MRR), dated 12/8/2025 for the month of December 2025, and interview with the Pharmacist Consultant (PC) on 12/12/2025 at 8:39 AM, the PC stated to check the effectiveness of Trazodone, Resident 17 should have had a physician's order to monitor sleep. During a concurrent record review of Resident 17's physician's orders, and interview with the Assistant Director of Nursing (ADON) on 12/12/2025 at 11:10 AM, the ADON stated Trazadone was ordered for Resident 17's inability to sleep because resident has insomnia. The ADON stated the licensed nurses should have monitored Resident 17's number of hours of sleep to monitor the effectiveness of Trazodone and the need for medication adjustment if necessary. The ADON stated Resident 17 was not and should have been monitored for hours of sleep for resident's use of Trazodone since 11/14/2025. During a review of facility's P&P, revised on 4/2025, the P&P indicated unnecessary drug is any drug used without adequate monitoring and without indications for its use. During a review of the facility's P&P titled, Psychotropic Drugs, revised on 4/2024, the P&P indicated Residents have the right to be free from chemical restraints (the use of medications such as psychotropic medications imposed for purposes of discipline or staff convenience and not required to treat the resident's medical symptoms). Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record.		

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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 care plan (a formal process that correctly identifies existing needs and recognizes a resident's potential needs or risks to achieve healthcare outcomes) for one (1) of 1 sampled resident (Resident 17) under care planning care area to manage the resident's behavioral problems with manifestations of striking at staff and others, crying, and danger to self and others. This deficient practice had the potential to prevent Resident 17 from receiving care that addressed the resident's specific needs, which could negatively affect the residents' overall wellbeing. Findings: During a review of Resident 17's admission Record, the admission Record indicated Resident 17 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnosis included dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (a natural human emotion characterized by feelings of worry, nervousness, or unease). During a review of Resident 17's Care Plan focusing on behavior problems manifested by crying, striking at staff and others, been danger to self and others like kicking, initiated on 10/3/2025, the Care Plan indicated the following interventions: Behavior monitoring Psychiatric evaluation and follow up treatment as indicated. Will anticipate and meet needs Will encourage to attend group activities that is of interest Will explain purpose of procedure before starting During a review of Resident 17's Minimum Data Set (MDS - a resident assessment tool), dated 10/9/2025, the MDS indicated Resident 17's cognitive skills for daily decision making was moderately impaired (decisions poor, cues/supervisions required). The MDS indicated Resident 17 required setup or clean up assistance (helper set up or cleans up) with eating. The MDS indicated Resident 17 was dependent (helper does all the effort) with oral hygiene, toileting hygiene, shower, upper body dressing, lower body dressing, putting on/off footwear and personal hygiene. During a review of Resident 17 's Interdisciplinary Team meeting (IDT, is a collaborative session in healthcare) notes, dated 10/9/2025, the IDT notes indicated currently has a companion who attends to her needs. During a concurrent observation and interview with Resident 17 on 12/9/2025 at 8:30 AM, Resident 17 was observed sitting in the wheelchair, and moving up and down the hallway. Resident 17 was observed alone. Resident 17 stated, I do not know their plans for me here. During a concurrent record review and interview with MDS nurse (MDSN) on 12/12/2025 at 9:16 AM, Resident 17's care plans and IDT notes, dated 10/9/2025, were reviewed. MDSN stated the IDT meeting notes indicated that Resident 17 had a companion, which was an intervention to address the resident's behavior. MDSN stated having a companion was not and should have been documented in Resident 17's care plan to manage behavior problems of crying, striking staff and others, and danger to self and others like kicking. During a concurrent record review and interview with the Assistant Director of Nursing (ADON) on 12/12/2025 at 11:26 AM, Resident 17's Care Plan was reviewed. The ADON stated all licensed nurses can initiate and revise care plans. The ADON stated Resident 17's care plan interventions to address resident's behavioral problems of striking at staff and others, crying, and danger to self and others like kicking should have included the presence of a companion with the resident at all times or during designated times as agreed upon with the Resident's representative. The ADON emphasized that updating or revising care plans is important to ensure staff members caring for Resident 17 have the necessary knowledge to provide appropriate care During a review of the facility's Policy and Procedure titled, Resident Assessment Instrument: Minimum Data Set and Comprehensive Care Plan, revised 7/13/2022, the P&P indicated comprehensive care plan is developed and revised by the IDT, with the participation of the resident and/or resident's representative, and include measurable objectives and time frames to meet the resident's needs. It also indicated care plans are updated as the resident conditions change and as revision is needed, and after each assessment, including the comprehensive and quarterly review assessment.		

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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 provide grooming services for one (1) of seven (7) sampled residents (Resident 48) under activities of daily living (ADLs- are activities related to personal care that include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating) care area, in accordance with the facility's policy and procedures (P&P) titled Grooming and Personal Hygiene . This deficient practice resulted in Resident 48's unkempt and dirty fingernails potentially leading to skin injury, infection, and scarring. Findings: During a review of Resident 48's admission Record, the admission Record indicated Resident 48 was initially admitted to the facility on [DATE] with diagnosis which dementia (progressive brain disorder that slowly destroys memory and thinking skills), muscle weakness, depression (severe feelings of sadness and hopelessness). During a review of Resident 48's Minimum Data Set (MDS, a resident assessment tool), dated 11/1/2025, the MDS indicated Resident 48's cognitive skills (processes of thinking and reasoning) for daily decision making was severely impaired (never/rarely made decisions). The MDS also indicated Resident 48 was dependent on personal hygiene (he ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing /drying face and hands.) During a review of Resident 48's care plan initiated on 3/8/2023, date revised 11/11/2025, the care plan indicated Resident 48's ADL selfcare deficit staff to work around the resident to accommodate the resident's needs and respect her dignity and residents' rights. The care plan also indicated Resident 48 was dependent on staff for personal hygiene and intervention includes: to help with personal hygiene, provide grooming and to check nails daily and report to licensed charge nurse for any brittleness, cracked or splitting or hang nails. The care plan indicated will provide grooming and assist with clean clothes daily and as needed. During a concurrent observation of Resident 48 and interview on 12/10/2025 at 9:57 AM in the activity room with the Activity Director (AD), observed Resident 48's fingernails were jagged, and with yellowish and brownish discoloration and jagged. AD stated Resident 48's fingernails were dirty, yellowish and brownish in color. During a concurrent observation of Resident 4 and interview on 12/10/2025 at 1:42 PM with the License Vocational Nurse (LVN) 2, observed Resident 48's fingernails were jagged, with yellowish and brownish discoloration. LVN 2 stated Resident 48's nails were dirty, with brownish yellowish color substance on the nail, and the resident's fingernails were jagged. LVN 2 also stated Resident 48's fingernails need to be trimmed. LVN 2 stated this can possibly cause skin injury, and the fingernails can harbor bacteria. LVN 2 also stated Resident 48 was dependent on personal hygiene and it should have been provided by the facility staff. During a concurrent interview and record review on 12/12/2025 at 8:21 AM with the Assistant Director of Nursing (ADON), the facility's policy and procedures (P&P) titled Grooming and Personal Hygiene revised date 1/2010 was reviewed. ADON stated the P&P indicated, all nursing and other skilled nursing staff have a responsibility to monitor and contribute to residents' grooming and hygiene. ADON also stated the P&P also indicated observed nails for signs of brittleness, cracked or splitting, or hang nails; report to licensed charge nurse for follow up. The P&P also indicated check nails on daily basis and refer to the grooming nurse.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to measure the external catheter length (insertion site to hub) for Peripherally Inserted Central Catheter (PICC, a thin, flexible tube inserted into a small arm vein and guided to a large central vein near the heart) line for one of 28 sampled residents (Resident 24), in accordance with Facility's policy and procedure (P&P) titled PICC Dressing Change. This failure had the potential to put Resident 28 at risk for PICC line dislodgement (the act of being forced or moved from a secure, fixed) and developing complications like thrombosis (the formation of a blood clot [clump of blood] inside a blood vessel [vein or artery] that blocks or slows blood flow), and infection (when harmful germs invade the body). Findings: During a review of Resident 24's admission Record, it indicated the resident was admitted to the facility on [DATE], admitting diagnoses of malnutrition, weight loss and encounter for adjustment and management of vascular access device (a thin, flexible tube placed into a blood vessel to provide long-term or repeated access for giving medications, fluids and nutrition). During a review of Resident 24's Minimum Data Set (MDS - a resident assessment tool) dated 12/1/2025, the MDS indicated Resident 24's cognitive skills for daily decision making was modified independence (some difficulty in new situations only). The MDS indicated Resident 24 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, shower, upper body dressing, lower body dressing, putting on/off footwear and personal hygiene. During a review of Resident 24's Order Summary Report, dated 11/28/2025, indicated the following orders:- order of PICC line insertion with double lumen right upper arm, ordered on 11/26/2025.- Total Parenteral Nutrition (TPN, a way to give a person complete liquid nutrition directly into a vein via a catheter) feeding, infusion rate of 64 milliliters (ml, unit of measurement) per hour for 24 hours, total volume of 1536 ml per day, ordered on 11/26/2025. During a review of Resident 24's Care Plan titled TPN, dated 11/26/2025, indicated an approach to measure the external catheter length for PICC upon admission and with each dressing change. During a review of TPN/ Peripheral Parenteral Nutrition (PPN, short-term intravenous [a medical method to deliver fluids, meds, nutrients] feeding) medication record (same as intravenous therapy medication record), indicated an order for central line dressing, securement device, cap change and measure external catheter length every seven days, with order date of 12/5/2025. During a review of Resident 24's intravenous therapy medication record, for the month of December 2025, it indicated Resident 24 has a right upper arm PICC line that was inserted on 11/26/2025, with two lumens (port), and external catheter length of 39 centimeters. It also indicated the PICC line dressing, secure device, cap change and measure external catheter length every 7 days and as needed was signed on 12/9/2025 by Registered Nurse 1 (RN 1). The record did not indicate a PICC line's external catheter measurement for 12/9/2025. During an observation on 12/9/2025 at 2:02 PM, Resident 24 was in bed, with ongoing IV therapy connected to the resident's PICC line. During an observation on 12/10/2025 at 11 AM, Resident 24's PICC line in right upper arm was observed. PICC line dressing was dated 12/9/2025. During a concurrent record review of Resident 24's TPN/PPN medication record (same as intravenous therapy medication record) for the month of December 2025, and an interview with MDS nurse (MDSN) on 12/12/2025 at 10:30 AM, MDSN verified there is no measurement of Resident 24's external catheter documented on 12/9/2025. MDSN stated it is important to measure the external catheter length every after dressing changed to ensure that the PICC line was not dislodged during dressing change. During a concurrent record review of Resident 24's medical records dated 12/9/2025 to 12/12/2025, and an interview with the Assistant Director of Nursing (ADON) on 12/12/2025 at 10:43 AM, the ADON stated there is no documented evidence that Resident 24's external catheter length was measured after dressing changed on 12/9/2025. ADON stated RN 1 documented in Resident 24's progress notes on 12/9/2025 at 11:25 PM that PICC line dressing was changed, site clean, dry, and intact, no redness, swelling or pain noted. The ADON stated RN 1 did not and should have documented (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the length of the external catheter on that note. The ADON stated it was important to measure the external catheter length and compare it to the baseline measurement on 11/26/2026 that was 39 cm, to ensure the length is the same, and that there was no accidental pulling of the catheter during dressing change procedure. During a review of Facility's P&P titled PICC Dressing Change, dated March 2023, indicated length of external catheter is obtained upon admission and during dressing changes. The P&P also indicated to document in the medical records the date and time, site assessment and length of external catheter.		

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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 facility staff donned (put on) proper personal protective equipment (PPE; clothing and equipment that is worn or used to protect against hazardous substances and/or environments) prior to entering a contact isolation (a transmission based precaution used to stop germs from spreading through direct touch with a resident or indirect touch with contaminated objects in their environment) room for two (2) of nine (9) sampled residents (Residents 28 and 45) in accordance with the facility's policy and procedure (P&P) This failure had the potential to result in the spread of infection to other residents in the facility. Findings: 1. During a review of Resident 28's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of cerebral ischemia (when blood flow to the brain is reduced, cutting off oxygen and nutrients, which can damage or kill brain cells) and dementia (a progressive state of decline in mental abilities) with anxiety (a normal feeling of unease, worry or fear often a reaction to stress). During a review of Resident 28's Minimum Data Set (MDS - a resident assessment tool), dated 11/23/2025, the MDS indicated the resident was severely impaired (never/rarely made decision) with cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 28 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) with chair/bed-to-chair transfers, rolling left and right in bed, upper and lower body dressing (the ability to dress and undress above and below the waist), putting on/taking off footwear, personal hygiene and eating. 2. During a review of Resident 45's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of atherosclerotic (the buildup of fats and cholesterol in the artery [blood vessel] walls) heart disease (problems with the heart or blood vessels) of native (original) coronary artery (one of the heart's blood vessels that wraps around it's surface, branching off the aorta [the body's largest artery] to deliver vital oxygen-rich blood to the heart muscle itself) without angina pectoris (chest pain or discomfort) and dementia. During a review of Resident 45's MDS, dated [DATE], the MDS indicated the resident was severely impaired with cognitive skills for daily decision making. Resident 45 needed supervision or touching assistance (helper provides verbal cues and/or touching/ steadying and/or contact guard assistance as resident completes activity) with walking 10 and 50 feet and with putting on/taking off footwear. Resident 45 needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with upper and lower body dressing and eating and was independent with chair/bed-to-chair transfers, going from sitting to standing, personal hygiene and eating. During a review of Resident 45's Order Summary Report, dated 12/12/2025, Resident 45's Order Summary Report indicated an order initiated 12/5/2025 to place Resident 45 on contact isolation due to Herpes Zoster (Shingles; a painful, blistering rash caused by the reactivation of the chickenpox virus [Varicella-Zoster Virus; a highly contagious disease marked by an itchy, blister-like rash] that lies dormant in your nerves after one has had the chickenpox, appearing as a stripe or patch on only one side of the body) During a review of Resident 45's Care Plan, dated 12/5/2025, Resident 45's Care Plan indicated Resident 45 was on contact isolation due to Herpes Zoster and included an intervention to wear proper PPE. During an observation on 12/9/2025 at 8:18 AM in the hallway outside of Residents 28 and 45's room, a contact precautions sign was observed outside the room and indicated to clean hands on room entry, wear a gown on room entry, wear gloves on room entry and to clean hands when exiting. During an observation on 12/9/2025 at 9:16 AM in the hallway right outside the doorway to Residents 28 and 45's room, Certified Nurse's Aide 1 (CNA 1) was observed inside the room not wearing a gown and cleaning up around Resident 45's bed and bedside and removing and changing the linen of Resident 45's bed. During an interview on 12/9/2025 at 9:20 AM with CNA 1, (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA 1 stated he was not wearing a gown while in Residents 28 and 45's room while cleaning up around the bedside and changing the linen for Resident 45. CNA 1 stated he thought he only had to wear a gown while providing the residents with direct care. During an interview on 12/10/2025 at 3:13 PM with Infection Preventionist (IP), IP stated Resident 45 was on contact isolation for having shingles and before entering the room, staff are expected to don full PPE including a gown and gloves regardless of what they are doing inside the room. IP stated if staff do not properly don PPE prior to entering the room, it poses a risk for that staff member, especially if they are not vaccinated for chickenpox to contact the chickenpox virus themselves as well as spreading it to another resident, their co-workers or at home. During a concurrent observation and interview on 12/11/2025 at 10:40 AM outside the doorway of Residents 28 and 45's room, Licensed Vocational Nurse 1 (LVN 1) was observed inside the room not wearing a gown picking up something off the ground next to Resident 28's bedside and throwing it away in the trash can. LVN 1 stated she was not wearing a gown and should have been. During an interview on 12/11/2025 at 11:10 AM with LVN 1, LVN 1 stated that she should have been wearing a gown prior to entering Residents 28 and 45's room earlier that day since the room is under contact isolation and her not wearing a gown poses a risk for spreading infection. During an interview on 12/12/2025 at 9:34 AM with the Assistant Director of Nursing (ADON), ADON stated the expectation of staff before entering a contact isolation room is to don full PPE (gown and gloves), regardless of what they plan to do inside the room to create a barrier for infection so that they do not take whatever the resident may have outside of the room to the other residents and staff. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control - Transmission Based Precautions, revised 10/2022, the P&P indicated: A. Contact - The purpose of contact precautions is to prevent transmission of infections that are spread by direct (e.g. [for example] person-to-person) or indirect contact with the resident or environment. Contact precautions require the use of appropriate Personal Protective Equipment (PPE), including a gown and gloves upon entering the room or making contact with the resident or the resident environment. B. Gowns. a. [NAME] gown upon entry into the room or cubicle. b. Gowns should also be worn when body contact with the environmental surfaces and items in the room that may be contaminated is anticipated.		