STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055135	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montrose Healthcare Center	2123 Verdugo Blvd. Montrose, CA 91020

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 accurately code the Minimum Data Set (MDS, resident assessment tool) for two of 15 sampled residents (Resident 8 and 3) by failing to:1. For Resident 8, accurately code Section O for number of days Restorative Nursing Aide program (RNA, nursing aide program that help residents to maintain their function and joint mobility) provided bed mobility training on MDS dated [DATE] and 3/17/2026.2. For Resident 3, accurately code Section O for number of days RNA program provided transfer training on MDS dated [DATE]. This deficient practice had the potential to cause inaccurate care planning and provision of appropriate services for Residents 3 and 8. Findings: 1.During a review of Resident 8's Face Sheet (FS) dated 4/29/2026, the FS indicated Resident 8 was originally admitted to the facility 11/18/2020 and readmitted on [DATE] with diagnoses including but not limited to acute and chronic respiratory failure (any condition that affects breathing function and result in lungs not functioning properly) with hypoxia (low oxygen level in tissues) and spina bifida (birth disorder in which the spine does not fully develop). During a review of Resident 8's MDS dated [DATE], the MDS indicated Resident 8 was cognitively intact (sufficient judgement, planning, organization to manage average demands in one's environment). The MDS indicated Resident 8 had functional limitations in ROM on one side of the upper extremity (UE, shoulder, elbow, wrist/hand) and had functional limitations in ROM on both sides of the lower extremities (BLE, hip, knee, ankle/foot). The MDS indicated Resident 8 required partial assistance with eating and oral hygiene, dependent assistance with toileting, bathing, lower body dressing, and bed to chair transfers. The MDS, Section O0500, indicated Resident 8 received one day of Restorative Nursing Program training and skill practice in bed mobility. During a review of Resident 8's MDS dated [DATE], the MDS indicated Resident 8 was cognitively intact. The MDS indicated Resident 8 had functional limitations in ROM on one side of the upper extremity and had functional limitations in ROM on both sides of the lower extremities The MDS indicated Resident 8 required partial assistance with eating and oral hygiene, dependent assistance with toileting, bathing, lower body dressing, and bed to chair transfers. The MDS, Section O0500, indicated Resident 8 received one day of Restorative Nursing Program training and skill practice in bed mobility. During a review of Resident 8's Order Summary Report (OSR) dated 4/1/2026, the OSR indicated the following orders: -order date 2/2/2026: RNA for BUE active range of motion (AROM, movement at a given joint when the person moves voluntarily) exercises once a day five times a week as tolerated.-order date 12/5/2025: RNA for passive range of motion (PROM, movement at a given joint with full assistance from another person) BLE as tolerated once a day five times a week. During a review of Resident 8's Care Plan Report (CP) initiated on 2/2/2026 and revised on 4/17/2026, the CP indicated Resident 8 had difficulties with ROM, bed mobility, and activities of daily living. The CP goal indicated to reduce the risk of complications from having decreased mobility or contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) and will maintain functional ability. The CP interventions indicated provide RNA treatment as ordered, RNA for BUE AROM exercises once a day, five times a week as tolerated and RNA for PROM exercises BLE as tolerated once a day, five times a week. During an observation and interview on 4/27/2026 at 11:31 a.m., Resident 8 was lying in bed and was (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	watching tv and had a bedside table in front. Resident 8 was able to use her right arm to reach for the tv remote to turn off the volume. Resident 8 stated she could not walk and staff completed exercises with her arms and legs. Resident 8 stated she could move her arms but required assistance to help move her legs. Resident 8 was able to lift both arms up and down to about shoulder level. During a concurrent interview and record review on 4/29/2026 at 10:19 a.m. with the Minimum Data Set Nurse Coordinator (MDS 1), Resident 8's MDS dated [DATE] and 3/17/2026 were reviewed. MDS 1 reviewed Section O 0500 Restorative Nursing Program and stated both MDS dated [DATE] and 3/17/2026 coded Resident 8 as receiving one day of RNA program training in bed mobility. MDS 1 reviewed Resident 8's RNA orders and stated Resident 8 did not have any RNA program treatment orders for bed mobility training. MDS 1 stated Section O 0500 were coded incorrectly, and it should be coded as zero days, because Resident 8 did not receive any RNA training for bed mobility. MDS 1 stated all MDS should be accurate because the MDS was an assessment and it showed what the facility was providing for the residents. MDS 1 stated MDS assessment should accurately reflect what the facility was doing and a picture of the resident. During an interview on 4/29/2026 at 3:01 p.m., the Director of Nursing (DON) stated the MDS assisted with care planning and billing and the MDS was based on what the facility was providing the resident. DON stated the MDS assessments should be coded accurately and appropriately care planned. During a review of the facility's policies and procedures (P&P) revised 11/2019, titled, Certifying Accuracy of the Resident Assessment, the P&P indicated any person completing a portion of the MDS must sign and certify the accuracy of that portion of the assessment. 2. During a review of Resident 3's Face Sheet (FS) dated 4/29/2026, the FS indicated Resident 3 was admitted to the facility 11/16/2022 with diagnoses including but not limited to cerebrovascular disease (disease of the blood vessels, especially blood vessels to the brain), dementia (a progressive state of decline in mental abilities), and dysphagia (difficulty swallowing). During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 was severely impaired in cognitive skills for daily decision making (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving). The MDS indicated Resident 3 had functional limitations in ROM on both sides of the upper extremity) and had functional limitations in ROM on both sides of the lower extremities). The MDS indicated Resident 3 required dependent assistance with oral hygiene, toileting, bathing, lower body dressing, and bed to chair transfers. The MDS, Section O0500, indicated Resident 3 received three days of Restorative Nursing Program training and skill practice in transfers. During a review of Resident 3's Order Summary Report (OSR) dated 4/29/2026, the OSR indicated the following orders: -order date 4/6/2026: RNA for BUE AAROM exercises once a day three times a week as tolerated.-order date 4/6/2026: RNA for PROMs BLEs as tolerated once a day five times a week.-order date 4/6/2026: RNA application of both knee splints up to four hours as tolerated five times a week. During a review of Resident 3's Care Plan Report (CP) initiated on 2/4/2025 and revised on 8/25/2025, the CP indicated Resident 3 had increased risk for loss of motion on BUE. The CP goal indicated to reduce the risk for loss of motion on BUE. The CP interventions indicated provide RNA treatment as ordered, RNA for BUE AAROM exercises once a day, three times a week as tolerated. During a review of Resident 3's Care Plan Report (CP) initiated on 2/5/2025 and revised on 8/25/2025, the CP indicated Resident 3 had tightness and contractures on BLE. The CP goal indicated to maintain ROM on BLE. The CP interventions indicated RNA for both knee splinting up to four hours a day once a day, five times a week as tolerated, RNA for both heel protectors application as tolerated once a day, three times a week as tolerated, and PROMES BLE as tolerated once day, five times a week as tolerated. During an observation and interview on 4/28/2026 at 9:26 a.m. in Resident 3's room, Restorative Nursing Aide (RNA 1) provided RNA treatment for Resident 3. Resident 3 was lying in bed and RNA 1 performed PROM to BUE and BLE. RNA 1 put on knee splints on both knees and both soft heel protectors. RNA 1 did not perform any transfer training. During a concurrent interview and record review on 4/29/2026 at 2:29 p.m. with the Minimum Data Set Nurse Coordinator (MDS 1), Resident 3's MDS dated [DATE] (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was reviewed. MDS 1 stated Resident 3's MDS dated [DATE] Section O 0500 indicated Resident 3 received three days of RNA training for transfers and MDS 1 stated this was not accurate. MDS 1 reviewed Resident 3's orders and stated Resident 3 did not have any orders for RNA treatment for transfer training and the MDS assessment should have indicated zero days of RNA program for transfer training. MDS 1 stated MDS assessments should be accurate and demonstrate what treatments the resident was actually receiving from the facility. During an interview on 4/29/2026 at 3:01 p.m., the Director of Nursing (DON) stated the MDS assisted with care planning and billing and the MDS was based on what the facility was providing the resident. DON stated the MDS assessments should be coded accurately and appropriately care planned. During a review of the facility's policies and procedures (P&P) revised 11/2019, titled, Certifying Accuracy of the Resident Assessment, the P&P indicated any person completing a portion of the MDS must sign and certify the accuracy of that portion of the assessment.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure three of five sampled residents (Residents 21, 3, and 7) received appropriate services to prevent a decline in range of motion (ROM, full movement potential of a joint) and mobility by failing to: 1. For Resident 21, provide a Restorative Nursing Aide program (RNA, nursing aide program that help residents to maintain their function and joint mobility) for active range of motion (AROM, movement at a given joint when the person moves voluntarily) to both lower extremities (BLE, hip, knee, ankle/foot) upon discharge of Physical Therapy (PT, a rehabilitation profession that restores, maintains, and promotes optimal physical function) services on 4/30/2025. 2a. For Resident 3, ensure Physical Therapy established a safe wear time for both knee splints (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) prior to starting an RNA program to put on both knee splints for four hours. 2b. Complete an annual Occupational Therapy (OT, rehabilitative profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Joint Mobility Screen (JMS, assessment of joint range of motion to monitor for changes in ROM) for Resident 3 in 2025. 3. Ensure Resident 7 received RNA program treatment as ordered and Restorative Nursing Aide (RNA 1) did not put on a right knee splint after an RNA order to put on a right knee splint was discontinued on 4/6/2026. These deficient practices had the potential to cause a decline in ROM and mobility in Resident 21, had the potential to cause injury and pain due to prolonged wearing of knee splints for Resident 3 and Resident 7, and prevent accurate monitoring of ROM and mobility for Resident 3.1. During a review of Resident 21's Face Sheet (FS), the FS indicated Resident 21 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including but not limited to myocardial infarction (heart attack) and chronic obstructive pulmonary disease (a chronic lung disease causing difficulty in breathing). During a review of Resident 21's Minimum Data Set (MDS, resident assessment tool) dated 3/9/2026, the MDS indicated Resident 21 was cognitively intact (sufficient judgement, planning, organization to manage average demands in one's environment). The MDS indicated Resident 21 did not have any functional impairments in ROM on either side of the upper extremity (UE, shoulder, elbow, wrist/hand) or lower extremity. The MDS indicated Resident 21 required set up assistance for eating, partial assistance for oral hygiene, sit to lying, and sit to stand. During a review of Resident 21's Order Summary Report (OSR) dated 4/29/2026, the OSR indicated the following orders:-order dated 11/18/2025 for RNA for both upper extremities (BUE) AROM exercises once a day, five times a week as tolerated. During a review of Resident 21's Care Plan Report (CP) revised on 1/2/2025, the CP indicated Resident 21 had difficulties with ROM. The CP goal indicated to minimize risk of decline in physical functioning and maintain functional ability. The CP interventions indicated RNA for active assistive range of motion (AAROM, movement at a given joint with a person's own effort and assistance from an external force or another person) for BLE as tolerated once a day five times a week. During a review of Resident 21's Physical Therapy Discharge Summary (DC) dated 4/30/2025, the PT DC indicated a discharge recommendation for RNA and PT established an RNA program for AROM exercises for BLE with return demonstration from the RNA. During an observation and interview on 4/27/2026 at 11:31 a.m., Resident 21 was lying in bed and stated she could move both her arms and legs by herself. During an interview and record review on 4/29/2026 at 8:20 a.m. with Physical Therapist (PT 1), PT 1 reviewed Resident 21's PT DC dated 4/30/2025 and stated PT 1 recommended an RNA ROM program for Resident 21. PT 1 reviewed Resident 21's orders and stated Resident 21 did not currently have any orders for RNA program for ROM to BLE. PT 1 stated he was not sure why Resident 21 did not have orders for RNA program for ROM to BLE, but Resident 21 should be on RNA for ROM for BLE, because PT 1 wanted Resident 21 to maintain her ROM in her lower extremities and needed encouragement to (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	do exercises. During an interview and record review on 4/29/2026 at 10:19 a.m. with Minimum Data Set (MDS 1), MDS 1 reviewed Resident 21's orders and stated Resident 21 did not have any RNA orders for ROM for BLE. During an interview on 4/29/2026 at 12:15 p.m., PT 1 stated PT should have written an order for RNA program for ROM for BLE when Resident 21 was discharged from PT services on 4/30/2025. PT 1 stated Resident 21 could have a decline in ROM and functional mobility if Resident 21 did not receive an RNA program that PT recommended. During an interview on 4/29/2026 at 3:01 p.m. with the Director of Nursing (DON), DON stated the RNA program was a restorative nursing program that helped to maintain a resident's ROM, mobility, and activities of daily living. DON stated therapists recommended and input the orders for the RNA program, usually after therapy services have ended. DON stated if PT recommended an RNA program upon discharge, then the RNA program should be ordered and carried out so that the residents did not decline and maintained their mobility. During a review of the facility's policies and procedures (P&P) revised 7/2017, titled Restorative Nursing Services, the P&P indicated residents will receive restorative nursing care as needed to help promote optimal safety and independence. 2. During a review of Resident 3's Face Sheet (FS) dated 4/29/2026, the FS indicated Resident 3 was admitted to the facility 11/16/2022 with diagnoses including but not limited to cerebrovascular disease (disease of the blood vessels, especially blood vessels to the brain), dementia (a progressive state of decline in mental abilities), and dysphagia (difficulty swallowing). During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool) dated 1/26/2026, the MDS indicated Resident 3 was severely impaired in cognitive skills for daily decision making (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving). The MDS indicated Resident 3 had functional limitations in ROM on both sides of the upper extremity and had functional limitations in ROM on both sides of the lower extremities. The MDS indicated Resident 3 required dependent assistance with oral hygiene, toileting, bathing, lower body dressing, and bed to chair transfers. During a review of Resident 3's Order Summary Report (OSR) dated 4/29/2026, the OSR indicated the following orders: -order date 4/6/2026: RNA application of both knee splints up to four hours as tolerated five times a week. During a review of Resident 3's Care Plan Report (CP) initiated on 2/5/2025 and revised on 8/25/2025, the CP indicated Resident 3 had tightness and contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) on BLE. The CP goal indicated to maintain ROM on BLE. The CP interventions indicated RNA for both knee splinting up to four hours a day once a day, five times a week as tolerated, RNA for both heel protectors application as tolerated once a day, three times a week as tolerated, and passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises BLE as tolerated once day, five times a week as tolerated. During an observation and interview on 4/28/2026 at 9:26 a.m. in Resident 3's room, Restorative Nursing Aide (RNA 1) provided RNA treatment for Resident 3. Resident 3 was lying in bed and RNA 1 performed PROM to BUE and BLE. RNA 1 put on knee splints on both knees and both soft heel protectors. 2a. During a review of Resident 3's Physical Therapy Evaluation and Plan of Treatment dated 1/21/2025, the PT Evaluation and Plan of Treatment indicated a goal to establish an effective RNA for splinting both knees. During a review of Resident 3's PT Treatment Encounter Notes (TEN) dated 1/21/2025, 1/24/2025, 1/28/2025, and 1/31/2025, the PT TEN did not indicate trials of knee splint wear times or tolerance to knee splints. During a review of Resident 3's PT DC dated 1/31/2025, the PT DC did not indicate a safe wear time for knee splints. During an interview and record review on 4/29/2026 at 8:20 a.m. with Physical Therapist (PT 1), PT 1 stated a splint was to help prevent further contractures and PTs had to perform an evaluation for a splint for each resident. PT 1 stated during PT treatment sessions, PT would try the splint on the resident for a few sessions to see if it was effective for the resident. PT 1 stated that PTs assessed for pain, pressure sores, redness and any discomfort the splints may cause the resident. PT 1 stated it was important to assess every splint to know if the splint was causing any discomfort. PT 1 stated PTs usually start with putting on the splint for 30 minutes, then one hour, and progress to no (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	more than six hours. PT 1 reviewed Resident 3's PT documentation and stated there was no documentation regarding splinting trials with knee splints during PT sessions or that PT established a safe wear time for the knee splints. PT 1 stated PT staff should document the splint trials, because it was part of the PT's treatment to check and assess whether a resident can safely tolerate the specific time wearing the splint. PT 1 stated if a resident wore a splint longer than the resident can tolerate, it could cause a wound or pressure sores. During a review of the facility's policies and procedures (P&P) created 2025, titled, Splinting, the P&P indicated to document the wearing schedule and splint care in the medical record and readjust wearing schedule as needed. When the resident is able to tolerate the splint for designated wear schedule, instruct nursing and the resident. 2b. During a review of Resident 3's OT JMS, the review indicated the last OT JMS was completed on 11/17/2022. During an interview and record review on 4/29/2026 at 10:19 a.m. with MDS 1, MDS 1 reviewed Resident 3's OT JMS and stated the last OT JMS was completed on 11/17/2022. DSD stated therapy was supposed to complete the OT JMS annually. DSD stated the facility monitored ROM to ensure residents did not have a decline and to prevent contractures. DSD stated contractures and limited ROM can affect a resident's ability to walk and participate in activities and that facility wants to prevent any declines. During a phone interview on 4/29/2025 at 11:45 a.m. with Occupational Therapist (OT 1), OT 1 stated OTs completed OT JMS to monitor if a resident had any decline or limitations in ROM that could impact activities of daily living. OT 1 stated OTs also monitor ROM to identify any residents who were at risk for developing contractures. OT 1 stated JMS should be completed annually. During a review of the facility's undated P&P titled, Joint Mobility Assessment, the P&P indicated a physical therapist and/or occupational therapist shall assess each joint for ROM and document findings on the joint mobility assessment sheet annually. 3. During a review of Resident 7's Face Sheet (FS) dated 4/29/2026, the FS indicated Resident 7 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including but not limited to cerebrovascular disease (disease of the blood vessels, especially blood vessels to the brain), hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following cerebral infarction (blockage of the flow of blood brain, causing or resulting in brain tissue death) affecting right dominant side. During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7 had severe cognitive impairments (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving). The MDS indicated Resident 7 indicated Resident 7 had functional limitation in ROM on one side of the upper extremity and one side of the lower extremity. The MDS indicated Resident 7 required dependent assistance with oral hygiene, toileting, bathing, dressing, and bed to chair transfers. During a review of Resident 7's Order Summary Report (OSR) dated 4/29/2026, the OSR indicated the following orders:-order date: 4/6/2026 RNA for AAROM exercises BLE as tolerated once a day, five times a week-order date: 4/7/2026 RNA for BUE PROM exercises once a day, five times a week-order date: 4/8/2026 RNA for splinting right pressure relief ankle foot orthosis (PRAFO, an orthotic device designed to correct or address problems with the ankle and foot and provide pressure relief at heels) five times a week up to six hours or as tolerated-order date: 4/10/2026 RNA to apply right elbow splint once a day, five times a week up to six hours as tolerated. During an observation and interview on 4/28/2026 at 9:04 a.m. in Resident 7's room, Restorative Nursing Aide (RNA 1) performed PROM exercises to Resident 7's upper extremity and lower extremity. RNA 1 put on a right elbow splint, right knee splint, and right PRAFO on Resident 7. RNA 1 stated Resident 7 could not move the right arm and leg that much. RNA 1 stated Resident 7 had three splints: a right elbow splint, a right knee splint, and right PRAFO for six hours or as tolerated. During an interview and record review on 4/29/2026 at 8:20 a.m., PT 1 stated PT recently discharged Resident 7 from PT and PT 1 did not recommend a right knee splint anymore, because Resident 7's knee was mostly in a straight position. PT 1 reviewed Resident 7's current RNA orders and stated there was no RNA order to put on a right knee splint. PT 1 stated if RNA was still putting on a right knee splint and PT did not recommend it, then it could cause (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, interview, and record review, the facility failed to complete annual competencies for putting on and taking off splints (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) and braces (an external device to support, align, or correct a movable part of the body) for two of two Restorative Nursing Aides (RNA 1 and RNA 2) who perform Restorative Nursing Aide program (RNA, nursing aide program that help residents to maintain their function and joint mobility) tasks that include putting on and taking off splints and braces. This deficient practice had the potential to result in injury, worsening contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion), and skin breakdown for residents who require splints and braces during RNA.Findings: During an observation on 4/28/2026 at 9:04 a.m. in Resident 7's room, Restorative Nursing Aide (RNA 1) completed an RNA treatment session with Resident 7. RNA 1 performed passive range of motion exercises to Resident 7's upper and lower extremities. After RNA 1 performed ROM exercises, RNA 1 put on a right elbow splint, a right knee splint, and a right pressure relief ankle foot orthosis (an orthotic device designed to correct or address problems with the ankle and foot and provide pressure relief at heels) on Resident 7. During a concurrent interview and record review on 4/29/2026 at 2:29 p.m. with Director of Staff Development (DSD), the Supervised Clinical Practice (RNA) Competency Checklist for RNA 1 and RNA 2 were reviewed. DSD reviewed RNA 1's Competency Checklist dated 8/6/2025 and RNA 2's Competency Checklist dated 8/7/2025 and DSD stated the annual RNA Competency Checklists did not assess and check the RNA skill of putting on and taking off splints and braces. DSD stated putting on and taking off splints and braces was a daily skill that RNAs had to perform and this skill should be reviewed and checked annually. DSD stated an annual competency checklist was performed for every staff member to evaluate staff on their daily job responsibilities and to make sure that staff perform those skills correctly. DSD stated the purpose of the competency checklist was to ensure that residents were treated properly and did not develop contractures. DSD stated the RNA competency checklist should include demonstrating RNA staff could properly put on and take off a splint to make sure RNA staff stay competent and learning for resident safety. During an interview on 4/29/2026 at 3:01 p.m. with the Director of Nursing (DON), DON stated RNA staff should be competent and ready to implement an RNA program. DON stated it was important to evaluate RNA staff skills and for skills to be updated so residents do not decline and RNA staff were comfortable to perform the RNA program. During a review of the facility's policies and procedures (P&P) dated 5/2023, titled, Competency Assessments, the P&P indicated employees will be assessed for competency upon hire and annually. Each employee must demonstrate competency requirement related to skills, technique, and training necessary to provide nursing and related care and services for all residents in accordance with resident care plans.

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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. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices were followed in the kitchen by failing to: 1.Ensure one seasoning salt was labeled with an open date and use by (the last date recommended for consuming a product at peak quality and safety), date. 2.Ensure one dirty meal tray was not placed on top of clean cups placed and then placed into the clean food cart. This deficient practice had the potential to result in cross- contamination and expose resident to foodborne illness (any sickness caused by consuming food or beverages contaminated with harmful microorganisms, toxins, or chemicals). Findings: During a concurrent observation and interview on 4/29/2026 at 1:21PM with Dietary Supervisor (DS) in staff lounge, the ice machine air gap (the open space between the ice machine's drain line and the floor drain or sewer line) was observed to be blocked with a black, slimy solidified substance obstructing the drain and appeared to be very close to or extending into the drain receptor. There were small droplets of water noted, and a swage (wastewater that contains human waste, used water, and other contaminants that flow through drains and sewer systems, and may contain harmful bacteria and viruses) - like odor was present. DS stated she did not know who was responsible for cleaning the air gap but acknowledged that the pipe with dripping water should not contact the sewage system. DS further stated this could be an infection control issue. During a concurrent observation and interview on 4/29/2026 at 1:26 PM with Maintenance Supervisor (MS) in staff lounge, the ice machine air gap was observed. MS stated the drainage pipe was not maintained in a clean and sanitary condition and should not appear as observed. After wiping the pipe with a white paper napkin, thick, oily, black residue was observed on the napkin. Additional observation revealed water dripping out of Ice machine drainage pipe following the blockage. During a review of the facility's policy and procedure titled Ice Machine and Ice Storage Chests dated 4/2023, indicated ice machines are to be maintained in a clean and sanitary manner to prevent contamination by microorganisms.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure two garbage containers located outside of the facility was maintained in sanitary condition without garbage contents overflowing outside of the garbage container. This failure had the potential to attract pests and rodents, create foul odors, and contribute to environmental contamination, increasing the risk of infection transmission. Findings: During a concurrent observation and interview on 4/27/2026 at 8:20 AM with Maintenance Supervisor (MS), two exterior garbage containers were observed overflowing with lids not closed. The Trash bags and loose garbage contents were observed on the ground surrounding the dumpster area, along with discarded gloves. MS confirmed that dumpster lids must remain closed and secured and that trash should not overflow due to risk of attracting pests and creating an infection control concern. During a review of the facility's policy and procedure (P&P) titled, Sanitation dated 11, 2022, the P&P indicated that garbage and refuse containers are to be maintained in good condition, without leaks, and waste is to be properly contained in dumpsters/ compactors with lids secured or otherwise covered. The policy further requires that areas used for garbage disposal be maintained free from odors and waste and kept in a manner that prevents pests.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 , interview and record review, the facility failed to maintain timely and accurate completion of residents medical records for 2 of eight sampled residents (Residents 3 and 7) when: 1. Resident 3's Physical Therapy (PT, a rehabilitation profession that restores, maintains, and promotes optimal physical function) Joint Mobility Screens (JMS, assessment of joint range of motion to monitor changes in ROM) dated 4/28/2025 and 10/28/2025 were not completed and documented until 11/4/2025 and the PT JMS dated 7/28/2025 was not completed until 9/22/2025. 2. Resident 7's Physical Therapy Joint Mobility Screen dated 3/3/2025 was not completed and documented until 4/2/2025 and the PT JMS dated 6/2/2025 was not completed and documented until 11/4/2025. These deficient practices had the potential for inaccurate medical documentation and cause a delay in provision of appropriate interventions and had the potential to result in decreased quality of life. Findings: 1. During a review of Resident 3's Face Sheet (FS) dated 4/29/2026, the FS indicated Resident 3 was admitted to the facility 11/16/2022 with diagnoses including but not limited to cerebrovascular disease (disease of the blood vessels, especially blood vessels to the brain), dementia (a progressive state of decline in mental abilities), and dysphagia (difficulty swallowing). During a review of Resident 3's Minimum Data Set (MDS, resident assessment tool) dated 1/26/2026, the MDS indicated Resident 3 was severely impaired in cognitive skills for daily decision making (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving). The MDS indicated Resident 3 had functional limitations in range of motion (ROM, full movement potential of a joint) on both sides of the upper extremity (BUE, shoulder, elbow, wrist/hand) and had functional limitations in ROM on both sides of the lower extremities (BLE, hip, knee, ankle/foot). The MDS indicated Resident 3 required dependent assistance with oral hygiene, toileting, bathing, lower body dressing, and bed to chair transfers. During a review of Resident 3's PT JMS with effective date of 4/28/2025, the PT JMS indicated Resident 3 had severe loss of ROM in both hips, knees, and ankles. The PT JMS indicated a signed date of 11/4/2025. During a review of Resident 3's PT JMS with effective date of 7/28/2025, the PT JMS indicated Resident 3 had severe loss of ROM in both hips, knees, and ankles. The PT JMS indicated a signed date of 9/22/2025. During a review of Resident 3's PT JMS with effective date of 10/28/2025, the PT JMS indicated Resident 3 had severe loss of ROM in both hips, knees, and ankles. The PT JMS indicated a signed date of 11/4/2025. During an observation and interview on 4/28/2026 at 9:26 a.m. in Resident 3's room, Restorative Nursing Aide (RNA 1) provided RNA treatment for Resident 3. Resident 3 was lying in bed and RNA 1 performed PROM to BUE and BLE. RNA 1 put on knee splints on both knees and both soft heel protectors. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 4/29/2026 at 8:20 a.m., Physical Therapist (PT 1) stated it was PT's role to monitor resident's ROM and PT assessed a resident's ROM annually. PT 1 stated PT should document and complete JMS on time, because if PT noticed any changes, PT staff should act accordingly. PT 1 stated if the JMS were completed very late, then it may not be accurate. PT 1 stated the effective date was not accurate because he did not perform the assessment until the day JMS was documented. During a review of the facility's policies and procedures (P&P) revised 7/2017, titled, Charting and Documentation, the P&P indicated documentation in the medical record will be objective, complete, and accurate. Documentation will include details including the date and time the procedure was provided. 2. During a review of Resident 7's Face Sheet (FS) dated 4/29/2026, the FS indicated Resident 7 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including but not limited to cerebrovascular disease (disease of the blood vessels, especially blood vessels to the brain), hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following cerebral infarction (blockage of the flow of blood brain, causing or resulting in brain tissue death) affecting right dominant side. During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7 had severe cognitive impairments. The MDS indicated Resident 7 indicated Resident 7 had functional limitation in ROM on one side of the upper extremity and one side of the lower extremity. The MDS indicated Resident 7 required dependent assistance with oral hygiene, toileting, bathing, dressing, and bed to chair transfers. During a review of Resident 7's PT JMS with effective date of 3/3/2025, the PT JMS indicated Resident 7 had severe loss of ROM in both hips, knees, and ankles. The PT JMS indicated a signed date of 4/2/2025. During a review of Resident 7's PT JMS with effective date of 6/2/2025, the PT JMS indicated Resident 7 had severe loss of ROM in both hips, knees, and ankles. The PT JMS indicated a signed date of 11/4/2025. During an observation and interview on 4/28/2026 at 9:04 a.m. in Resident 7's room, Restorative Nursing Aide (RNA 1) performed PROM exercises to Resident 7's UE and LE. RNA 1 put on a right elbow splint, right knee splint, and right PRAFO on Resident 7. RNA 1 stated Resident 7 could not move the right arm and leg that much. During an interview and record review on 4/29/2026 at 8:20 a.m., Physical Therapist (PT 1) stated it was PT's role to monitor resident's ROM and PT assessed a resident's ROM annually. PT 1 stated PT should document and complete JMS on time, because if PT noticed any changes, PT staff should act accordingly. PT 1 stated if the JMS were completed very late, then it may not be accurate. PT 1 stated the effective date was not accurate because he did not perform the assessment until the day JMS was documented. During a review of the facility's policies and procedures (P&P) revised 7/2017, titled, Charting and Documentation, the P&P indicated documentation in the medical record will be objective, complete, and accurate. Documentation will include details including the date and time the procedure was provided.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to obtain an informed consent (a process of communication between a person and the health care provider that often leads to agreement or permission for care, treatment, or services) for psychotropic/psychotherapeutic (any drug that affects behavior, mood, thoughts, or perception) drug for one of three sampled resident (Resident 20) who was prescribed Donepezil (cholinesterase inhibitor (drug used to manage cognitive symptoms) medication used for dementia). This deficient practice violated Resident 20's rights to be informed when choosing the type of care or treatment to be received, making decisions on alternative measures that the resident or responsible party preferred, which can negatively affect Resident 20's quality of life. During a review of Resident 20's admission Record (AR), the AR indicated was admitted to the facility on [DATE] with a diagnosis with a diagnosis that included dementia (decline in mental abilities such as memory, thinking, and reasoning) and type 2 diabetes mellitus (high blood sugar). During a review of Resident 20's History & Physical signed and^dated^3/30/2026, indicated that Resident 20 did not have the capacity to understand and make decisions. During a review of Resident 20's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated^4/4/2026, Resident 20 cognition (thinking) was severely impaired. During a review of Resident 20's Order Summary Report dated 12/8/2023, indicated Resident 20 had a physician order for Donepezil 5 mg (unit of measurement) to give 1 tablet by mouth at bedtime for dementia. During a concurrent interview and record review on 4/29/2026 at 1:23 PM with Minimum Data Set Coordinator (MDS 1), Resident 20's physical chart under the consent section and electronic health record (EHR) were reviewed. MDS 1 stated that Resident 20's physical medical record did not contain signed informed consent for the administration of donepezil, a medication prescribed for dementia. MDS 1 stated she acknowledged that signed informed consent is required prior to the initiation of such medications and must be maintained in the resident's medical record. MDS 1 further stated that informed consent was necessary to ensure the resident and/or responsible party is informed of the medication's purpose, potential benefits, risks, and possible side effects, and has agreed to the treatment plan. During a concurrent interview and record review on 4/29/2026 at 1:32 PM with the Director of Nursing (DON), Resident 20's physical chart under the consent section and electronic health record (EHR) were reviewed. DON stated that residents prescribed psychotropic or cognition-affecting medications are required to have signed informed consent in the medical record prior to or upon initiation of the medication. The DON confirmed that Resident 20, who was prescribed donepezil for dementia, did not have a signed informed consent present in the medical record at the time of review. The DON further acknowledged that maintaining a signed informed consent is essential to ensure the resident and/or responsible party has been informed of the medication's purpose, potential benefits, risks, and possible side effects, and has consented to the treatment. A review of the facility's P&P titled Informed Consent revised 12/2024, indicated that to ensure that residents and/or their representatives are fully informed of the benefits, risks, frequency/duration, and alternatives before initiating the administration of psychotherapeutic drugs or physical restraints. The P&P indicated that the physician and/or prescriber must sign an informed consent form after explaining all necessary information to the residents or their representatives. The P&P indicated that the informed consent form shall be maintained in the resident's clinical record.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a homelike, orderly environment for one out of three sampled residents (Resident 43) when the resident's wall clock inside the room showed an incorrect time. This deficient practice compromises the comfort and orderliness of the resident's environment. During a review of Resident 43's admission Record (AR), the AR indicated that the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included Alzheimer's disease (a brain disorder affecting memory, thinking, and behavior), anxiety disorder (persistent, excessive fear or worry that interferes with daily life), and schizophrenia (a mental health condition that affects how people think, feel and behave). During a review of Resident 43's History and Physical (H&P), dated 2/11/2026, the H&P indicated that the resident does not have the capacity to understand and make decisions. During a review of Resident 43's Minimum Data Set (MDS, a resident assessment tool), dated 3/10/2026, the MDS indicated that the resident has intact cognition (the ability to process thoughts and emotions). During an observation on 4/27/2026 at 8:52 AM with Certified Nursing Assistant (CNA) 1 inside Resident 43's room, the wall clock inside the resident's room was observed. CNA 1 stated that the clock is wrong because it reads 11:50 AM, which was not the correct time of 8:52 AM. CNA 1 stated that the clock should show the correct time. During an interview on 4/27/2026 at 8:54 AM with Resident 43, Resident 43 stated that she would prefer that the clock be at the correct time because she would like to know the correct time while inside his room. During an interview on 4/30/2026 at 10:04 AM with the Maintenance Supervisor (MS), the MS stated that if the clock shows the wrong time, then it must be fixed and adjusted to show the correct time. During an interview on 4/30/2026 at 10:09 AM with Director of Nursing (DON), the DON stated that it is important that the resident's clock is orderly by displaying the correct time. The DON stated that having the wrong time could confuse the resident. The DON also stated that having the correct time helps in ensuring that residents understand their current situation, such as the time of the day. During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, revised 2/2021, the P&P indicated that residents are provided a safe, clean, comfortable, and homelike environment. The P&P indicated that the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. The P&P further indicated that homelike characteristics include clean, sanitary, and orderly environment.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure for one of three sampled residents (Resident 61) that a written bed-hold policy was provided to the resident and/or resident representative prior to transfer to the General Acute Care Hospital (GACH) on 3/28/2026 for a change of condition (COC). Thisˆdeficient practiceˆresultedˆinˆResidentˆ61ˆand/or their representatives not being informed of their rightsˆregardingˆbed reservation during hospitalization, which could lead to confusion and disruption in continuity of care.ˆ Findings: During a review of Resident 61's admission Record (AR), the AR indicated was admitted to the facility on [DATE] with a diagnosis with a diagnosis that included fracture of the right femur (longest and heaviest bone in the body) and dementia (decline in mental abilities such as memory, thinking, and reasoning). During a review of Resident 61's History & Physical signed andˆdatedˆ3/24/2026, indicated that Resident 61 did not have the capacity to understand and make decisions. During a review of Resident 61's Minimum Data Set (MDS - a federally mandated resident assessment tool) datedˆ3/28/2026, Resident 61 cognition (thinking) was severely impaired. During a review of Resident 61's Physician Discharge Summaryˆ Report datedˆ3/28/2026, the summaryˆindicatedˆthat Resident 61 was transferred toˆthe GACHˆonˆ3/28/2026ˆfor an elevated level of sodium (salt level in the blood). ˆDuring a review of Resident 61'sˆmedical recordsˆHard Chart & Electronic Chartˆonˆ4/28/2026ˆatˆ1:55 PM,ˆResident 61's records were reviewedˆfor bed hold documentation. Theˆhard chart did notˆindicateˆany documentation for a bed hold. ˆˆ During a concurrent record review on 4/28/2026 at 2:45 PM with the Social Services Designee (SSD), Resident 61's physical and electronic medical record was reviewed. SSD confirmed that a completed 7-day bed-hold document was not present in Resident 61's physical and electronic chart. SSD stated she was unable to provide documentation demonstrating that the resident and/or resident representative had been provided with or had acknowledged receipt of the required written bed-hold policy notification prior to transfer. SSD stated she had acknowledged that failure to maintain a completed bed-hold document places the resident at risk for violation of rights related to transfer and discharge. During a concurrent record review on 4/28/2026 at 3:00 PM with the Director of Nursing (DON), Resident 61's physical and electronic medical record was reviewed. The DON stated that she had confirmed that a completed 7-day bed-hold document was not present in Resident 61's physical and electronic chart. The DON stated that implementation of the bed-hold policy prior to transfer or discharge was necessary to ensure residents and/or their responsible parties are informed of their rights during t hospitalization. The DON stated that timely notification allows residents to make informed decisions regarding bed reservations and supports continuity of care upon return to the facility. The DON further stated that the bed-hold policy is required to maintain compliance with regulatory requirements and to prevent disruption in resident placement and services. A review of the facility's P&P titled Bed-Hold and Return revised on 10/2022, indicated that Residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold policies. The P&P indicated that all residents/representatives are provided written information regarding the facility and state bed-hold policies which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave), residents, regardless of payer source, are provided with written notice about these policies at least twice: well in advance of any transfer (e.g., in the admission packet); and at the time of transfer (or, if the transfer was an emergency, within 24 hours).

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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 update one of 15 sampled residents (Resident 7) Restorative Nursing Aide program's (RNA, nursing aide program that help residents to maintain their function and joint mobility) care plan to reflect Resident 7's updated and current RNA treatment program. This deficient practice had the potential for Resident 7 to receive improper treatment and services and minimize the facility's ability to review the effectiveness of Resident 7's RNA program.Findings: During a review of Resident 7's Face Sheet (FS) dated 4/29/2026, the FS indicated Resident 7 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including but not limited to cerebrovascular disease (disease of the blood vessels, especially blood vessels to the brain), hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following cerebral infarction (blockage of the flow of blood brain, causing or resulting in brain tissue death) affecting right dominant side. During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool) dated 2/27/2026, the MDS indicated Resident 7 had severe cognitive impairments (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving). The MDS indicated Resident 7 indicated Resident 7 had functional limitation in range of motion (ROM, full movement potential of a joint) on one side of the upper extremity (UE, shoulder, elbow, wrist/hand) and one side of the lower extremity (LE, hip, knee, ankle/foot). The MDS indicated Resident 7 required dependent assistance with oral hygiene, toileting, bathing, dressing, and bed to chair transfers. During a review of Resident 7's Order Summary Report (OSR) dated 4/29/2026, the OSR indicated the following orders: -order date: 4/6/2026 RNA to provide active assistive range of motion (AAROM, movement at a given joint with a person's own effort and assistance from an external force or another person) BLE as tolerated once a day, five times a week. -order date: 4/7/2026 RNA to provide BUE passive range of motion (PROM, movement at a given joint with full assistance from another person) once a day, five times a week. -order date: 4/8/2026 RNA for splinting right pressure relief ankle foot orthosis (PRAFO, an orthotic device designed to correct or address problems with the ankle and foot and provide pressure relief at heels) five times a week up to six hours or as tolerated. -order date: 4/10/2026 RNA to apply right elbow splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) once a day, five times a week up to six hours as tolerated. During a review of Resident 7's Care Plan Report (CP), the CP initiated 4/30/2024 indicated Resident 7 was at risk of joint mobility and decline in ROM due to sedentary lifestyle and lack of self movement. The CP goal indicated bilateral ankle PRAFO for contracture management. The CP intervention indicated bilateral ankle PRAFO once a day, five times a week up to six hours. During a review of Resident 7's CP initiated on 5/31/2024 and revised on 4/1/2026, the CP indicated Resident 7 was limited in ROM/contractures related to limited mobility. The CP goal indicated to minimize complications related to decreased mobility or contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) through appropriate interventions through the next assessment and will maintain or show improvement with ROM. The CP interventions indicated RNA for right elbow splint application for up to four hours as tolerated five times a week, RNA for both ankle PRAFO up to 6 hours once a day, five times a week, RNA for application of right knee splint four hours five times a week, restorative nursing referral by rehab, RNA treatment as ordered. During an observation and interview on 4/28/2026 at 9:04 a.m. in Resident 7's room, Restorative Nursing Aide (RNA 1) performed PROM exercises to Resident 7's UE and LE. RNA 1 put on a right elbow splint, right knee splint, and right PRAFO on Resident 7. RNA 1 stated Resident 7 could not move the right arm and leg that much. RNA 1 stated Resident 7 had three splints: a right elbow splint, a right knee splint, and right PRAFO for six hours or as tolerated. During an (continued on next page)

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	055135	A. Building B. Wing	04/30/2026

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Montrose Healthcare Center	2123 Verdugo Blvd. Montrose, CA 91020

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medication was adequately administered as ordered for one out of three sampled residents (Resident 15), by failing to: Ensure licensed vocational nurse (LVN) 1 remained with Resident 15 until the entire administered medication, Simethicone (medication used to relieve symptoms of excess gas, such as bloating) tablet chewable 80 MG (milligram, a unit of measuring weight), was swallowed. Ensure LVN 1 applied pressure over Resident 15's tear duct after the administration of Cyclosporine (eye drop medication that is administered directly to the eyes and is used to increase tear production) eye drops. This deficient practice placed Resident 15 at risk of not receiving the intended effects of the medications and could lead to the mismanagement of the resident's diseases. Findings: During a review of Resident 15's admission Record (AR), the AR indicated that the resident was admitted on [DATE] with diagnoses that included muscle weakness, dysphagia (difficulty in swallowing), and hypertension (elevated blood pressure). During a review of Resident 15's History and Physical (H&P), dated 4/13/2026, the H&P did not indicate if the resident has the capacity to understand and make decisions. During a review of Resident 15's Minimum Data Set (MDS, a resident assessment tool), dated 4/17/2026, the MDS indicated that the resident has intact cognition (the ability to process thoughts and emotions). During a review of Resident 15's physician's orders, the orders indicated included the following medications: Cyclosporine emulsion 0.05% Instill 1 drop in both eyes two times a day for dry eyes, ordered on 4/11/2026. Simethicone tablet chewable 80 MG (milligram, a unit of measuring weight) give 1 tablet by mouth four times a day for gas, ordered on 4/11/2026. During a medication administration observation on 4/27/2026 at 10 AM with Licensed Vocational Nurse LVN 1 inside Resident 15's room, LVN 1 administered the resident's Cyclosporine eye drops. LVN 1 did not apply pressure to Resident 15's tear duct after administering the Cyclosporine eye drops. During the same medication administration observation on 4/27/2026 at 10 AM with LVN 1 inside Resident 15's room, LVN 1 administered the resident's Simethicone. LVN 1 placed the Simethicone tablet inside Resident 15's mouth. Resident 15 stuck out his tongue, showing the Simethicone tablet. LVN 1 then stated he was done with the medication administration and left the resident's room. Resident 15 had not swallowed the medication. During an interview on 4/27/2026 at 10:26 AM, LVN 1 stated that he forgot to wait until Resident 15 swallowed his Simethicone. LVN 1 stated that nurses must ensure that the resident had completely swallowed the medication prior to leaving the beside to ensure the entire dose of the medication was administered to the resident for effectiveness. During the same interview on 4/27/2026 at 10:26 AM with LVN 1, LVN 1 stated that he did not know that he was supposed to apply pressure over the resident's tear duct after the administration of the resident's Cyclosporine eye drops. During an interview on 4/30/2026 at 10:09 AM with the Director of Nursing (DON), the DON stated that when administering oral medications, nurses must ensure that the residents have swallowed the administered medication before leaving the resident. The DON stated that leaving prior to ensuring that the resident has swallowed the entire medication could present a choking hazard and could place the resident at risk of aspirating the medication. During another interview on 4/30/2026 at 11:50 AM with the DON, the DON stated that after nurses administer eye drops, the nurses must apply pressure over the resident's tear duct. The DON added that applying pressure over the tear duct ensures that the medication stays in the eye where it is needed. The DON also added that applying pressure over the tear duct prevents the medication from going systemic (or circulating inside the body) and prevents the effect of the medication in other parts of the body. During a review of the facility's policy and procedure (P&P) titled, Specific guidelines for Safe and Accurate Administration [Ophthalmic Administration], undated, the P&P indicated to apply gentle pressure to the tear duct for one minute or have the resident keep their eyes closed for 3 minutes to minimize systemic effects of (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the medication. During a review of the facility's P&P titled, Specific Medication Administration Procedures, dated 2/2016, the P&P indicated for staff to administer medication and remain with resident while medication is swallowed.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow the prescribed diet order for one out of four sampled residents (Resident 66) when the resident's meal tray contained food items that did not follow the physician's order and resident care plan of Soft and Bite sized texture diet due to difficulty swallowing. This deficient practice placed the resident at risk of choking. During a review of Resident 66's admission Record (AR), the AR indicated that the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included diabetes mellitus (prolonged elevated blood sugar levels), Alzheimer's Disease (a brain disorder affecting memory, thinking, and behavior), and psychosis (a collection of symptoms involving a loss of contact with reality, characterized by hallucinations (seeing/hearing things not there) and delusions (false beliefs). During a review of Resident 66's History and Physical (H&P), dated 4/23/2026, the H&P indicated that the resident does not have the capacity to understand and make decisions. During a review of Resident 66's Speech Therapy Evaluation and Plan of Treatment Note, dated 4/23/2026, the Note indicated that Resident 66 exhibits signs or symptoms of dysphagia (difficulty swallowing) and coughing or choking during oral intake. The Note also indicated that the resident is at risk of aspiration (occurs when food, liquids, saliva, or stomach contents enter the airway and lungs instead of the esophagus, causing coughing, choking, wheezing, or fever). The Note further indicated that the resident is recommended a diet of Soft and Bite sized. During a review of Resident 66's physician's orders, the orders included a diet order, dated 4/20/2026, for NAS (No Added Salt) diet Soft and Bite-sized texture, thin consistency. During a review of Resident 66's Baseline Care Plan, dated 4/20/2026, the care plan indicated a diet order of Soft and Bite-sized texture. The care plan also included an intervention to provide diet and fluids as ordered. During a concurrent observation and interview on 4/27/2026 at 12:43 PM with Infection Preventionist Nurse (IPN), the IPN was observed inspecting the residents' meal trays. IPN stated that the meal trays contained food items that were in accordance with the residents' diet orders except for Resident 66's meal tray. IPN stated that Resident 66's meal tray contained grilled cheese that was not bite size. The IPN stated that Resident 66's diet order indicated for food items to be bite sized. The IPN further stated that the grilled cheese should have been cut into bite-sized pieces prior to leaving the kitchen During an interview on 4/30/2026 at 9:59 AM with the Dietary Supervisor (DS), the DS stated that it is the cook's responsibility to prepare food items in accordance with each resident's dietary requirements. The DS stated that if the resident's diet order indicated a bite-sized texture, the food must be cut up before it leaves the kitchen. During an interview on 4/30/2026 at 10:09 AM with the Director of Nursing (DON), the DON stated that the resident's diet is ordered by the physician for the safety and the nutritional needs of the resident. The DON stated that the texture of the resident's food must be in accordance with the diet order because not following the order could pose a choking hazard to the resident. During a review of the facility's policy and procedure (P&P) titled, Therapeutic Diets, undated, the P&P indicated the following: Therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. Diet will be determined in accordance with the resident's informed choices, preferences, treatment goals, and wishes. A ?therapeutic diet' is considered a diet ordered by a physician, practitioner or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet. Snacks will be compatible with the therapeutic diet.