STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055142	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Gardens Convalescent Hospital	17922 San Fernando Mission Rd Granada Hills, CA 91344

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 safe homelike environment for three of three sampled residents (Resident 12, 71, and Resident 10) during an initial pool observation by failing to:a. Ensure the black pipe insulation wrapped around Resident 12's side rails were not frayed, torn and had a large piece missing on the right-side rail.b. Ensure the black pipe insulation wrapped around Resident 71's side rails were not frayed and torn.c. Ensure the black pipe insulation wrapped on the side rails and foot board were not torn and frayed for Resident 10.These deficient practicesˆhadˆthe potentialˆto affect the resident`s self-esteem and self-worth while living in an environment that is not in good repair. Findings: a. During a review of Resident 12's Face Sheet, the Face Sheet indicated the facility admitted Resident 12 on 11/29/2022 and readmitted on [DATE] with diagnosis including cerebral infarction (CVA-stroke, loss of blood flow to a part of the brain) and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). ˆ During a review of Resident 12's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 5/9/2026, the MDS indicated Resident 12 had the ability to make herself understood and had the ability to understand others. The MDS indicated that Resident 12 required substantial assistance (helper does more than half the effort) from staff for oral hygiene, toileting, bathing, upper and lower body dressing, personal hygiene and putting on and taking off footwear.ˆ During a concurrent observation and interview on 4/06/2026 at 8:22 A.M., in Resident 12`s room in the presence of the Minimum Data Set Coordinator (MDS), the MDS observed Resident 12's bed with black pipe insulation wrapped on the side rails and stated there was a large piece missing on the right side and the rest were worn down and frayed. The MDS stated the pipe insulation should have been reported and replaced right away for safety, cleanliness and so it would look nice. During an interview on 4/09/2026 at 10:17 A.M., with the Assistant Director of Nursing (ADON), the ADON stated the black pipe insulation should not be torn and frayed because they are harder to keep clean and should be in good repair, especially because they are in the resident's room. The ADON stated staff should have reported it to maintenance right away so they could be replaced. During a review of the facility`s policy and procedures (P&P) titled, Homelike Environment,, last reviewed on 3/9/2026, the P&P indicated that Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.clean, sanitary and orderly environment; clean bed and bath linens that are in good condition. b. During a review of Resident 71's Face Sheet, the Face Sheet indicated the facility admitted Resident 12 on 7/10/2016 with diagnosis including seizures (a sudden, uncontrolled electrical (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) and dementia (a progressive state of decline in mental abilities). During a review of Resident 71's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 1/24/2026, the MDS indicated Resident 71 rarely had the ability to make herself understood and rarely understood others. The MDS indicated that Resident 71 was completely dependent (when the helper does all the work) on facility staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) During a review of Resident 71's History and Physical (H&P) dated 2/10/2026, the H&P indicated Resident 71 did not have the capacity to understand and make decisions. ˆ During a concurrent observation and interview on 4/06/2026 at 8:46 A.M., in Resident 71`s room, in the presence of Certified Nursing Assistant (CNA 2), CNA 2 observed Resident 71's bed had black pipe insulation wrapped on the side rails and stated they had gouges (make a groove, hole or indentation), was worn down and frayed. CNA 2 stated the pipe insulation should have been reported so they could be replaced. CNA 2 stated the residents deserve a clean and safe room. During an interview on 4/09/2026 at 10:26 A.M., with the Assistant Director of Nursing (ADON), the ADON stated the black pipe insulation should not be torn and frayed because it is harder to keep clean and should be in good repair, especially because they are in the resident's room. The ADON stated staff should have reported it to maintenance right away so they could be replaced. During a review of the facility`s policy and procedures (P&P) titled, Homelike Environment,, last reviewed on 3/9/2026, the P&P indicated that Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.clean, sanitary and orderly environment; clean bed and bath linens that are in good condition. c. During a review of Resident 10's admission Record, the admission Record indicated the facility admitted the resident on 2/2/2026 with diagnosis including weakness and hypertension (high-blood pressure). During a review of Resident 10's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 3/10/2026, the MDS indicated the resident had the ability to make self-understood and the ability to understand others. The MDS indicated that Resident 10 required partial/moderate assistance (helper does more than half the effort) from staff for oral hygiene, personal hygiene and substantial/maximal assistance (helper does more than half the effort) for upper and lower body dressing and putting on and taking off footwear.ˆ During a concurrent observation and interview on 4/07/2026 at 8:42 a.m., in Resident 10`s room, Resident 10 was observed in bed with pool noodles (waterlogs colorful foam tubes that have excellent water resistance and to play water games) on the side rails and the frame of the footboard. Resident 10 stated that when she got here there was already a pool noodle on the siderails and footboard. Resident 10 stated that she does not know why she has this pool noodle on her bed. Upon closer inspection, the pool noodles on the footboard were already torn and frayed with part of the pool noodle sticking outward. During a concurrent observation and interview on 4/08/2026 at 11:07 a.m., while in Resident 10`s room along with the Assistant Director of Nursing (ADON), the ADON verified the initial observation that Resident 10`s bed had pool noodles wrapped around the side rails and the foot board. The ADON also confirmed that the pool noodles were torn and frayed. The ADON stated that Resident 10`s room (continued on next page)

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and environment is not homelike and the pool noodles needed to be repaired. The ADON stated that it can potentially affect the resident`s well-being if the environment where they lived is not in good condition.  During a review of the facility`s policy and procedures (P&P) titled, Homelike Environment,, the P&P indicated that Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.clean, sanitary and orderly environment; clean bed and bath linens that are in good condition.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to monitor hours of sleep for a resident that was prescribed trazadone (medication used to treat depression [mood disorder that causes a persistent feeling of sadness and loss of interest] and insomnia [difficulty falling or staying a sleep]) that is also used to help a resident sleep) for one of five residents (Resident 11) investigated for unnecessary medications. This deficient practice had the potential to place the resident at risk of taking an unnecessary medication and experiencing adverse side effects (undesired harmful effect resulting from a medication or other intervention).Findings: During a review of Resident 11's admission Record, the admission Record indicated the facility admitted the resident on 6/19/2024 with diagnoses that included depression. During a review of Resident 11's Minimum Data Set (MDS, a resident assessment tool) dated 1/1/2026, the MDS indicated Resident 11 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident required setup assistance (helper sets up; resident completes the activity) with eating. The MDS indicated Resident 11 has a diagnosis of depression and has taken an anti-depressant medication in the seven-day assessment period. During a review of Resident 11's physician orders, the physician orders indicated the following:1. Trazadone oral tablet 50 milligrams (mg, unit of measurement), give 50 mg by mouth at bedtime for depression manifested by the inability to sleep/rest at night causing stress, dated 12/1/2024.2. Monitor hours of sleep for trazadone use every evening and night shift, dated 11/22/2025. During a review of Resident 11's Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 11/2025, 12/2025, 1/2026, 2/2026, 3/2026 and 4/2026 covering the dates from 11/22/2025 to 4/8/2026, the MAR indicated Resident 11's number of hours of sleep documentation was indicated by a check mark, not by quantitative, measurable numbers. During a concurrent interview and record review on 4/9/2026 at 9:57 a.m., with Registered Nurse 1 (RN 1), reviewed Resident 11's MAR dated 4/2026 and physician orders. RN 1 did not see any documentation of quantity number of hours slept by Resident 11. RN 1 stated there is an order to monitor the hours of sleep from 11/22/2025. RN 1 stated there should be a place for the licensed nurses to put in the hours of sleep Resident 11 had on their shift. RN 1 stated this is important to ensure Resident 11 gets enough sleep and to adjust the medication if needed. During a phone interview on 4/9/2026 at 10:57 a.m., with the facility's Consultant Pharmacist (PHARM 1), PHARM 1 stated if she sees an order to monitor the hours of sleep for a resident, she expects to see a quantitative number for a physician's order to monitor the hours of sleep. PHARM 1 stated she would make this recommendation if she did not see the quantitative hours of sleep documented. PHARM 1 stated this is important to see if the resident is sleeping or not, if the medication is helping or the potential to place a resident at risk for excessive sleeping. During a concurrent interview and record review on 4/9/2026 at 11:24 a.m., with the Assistant Director of Nursing (ADON), reviewed Resident 11's physician order for monitoring hours of sleep. The ADON stated she entered the order in November 2025 and should have clicked a drop-down menu in the electronic health record to select an option requiring the licensed nurses to put a quantitative number. The ADON stated, instead she mistakenly clicked the option, no documentation needed. The ADON stated there should be an area requiring the licensed nurses to input a quantitative number in the eMAR (electronic MAR) but there was not. The ADON stated this is important to determine the effectiveness of the medication. During an interview on 4/9/2026 at 1:29 p.m., with the Director of Nursing (DON), the DON stated the licensed nurses should have been documenting quantitative hours of sleep. The DON stated this is important to see if the medication is effective or if it needs readjustment in dosage or discontinue altogether. During a review of the facility's policy and procedure titled, Psychotropic Medication Use, last reviewed 3/9/2026, the policy indicated the (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following:- Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: anti-depressants.- Psychotropic medication management includes: adequate monitoring for efficacy (the capacity or power to produce a desired effect or intended result) and adverse consequences. During a review of the facility's policy and procedure titled, Administering Medications, last reviewed 3/9/2026, the policy indicated medications are administered in accordance with prescriber orders. The policy indicated the individual administering the medication in the resident's medical record any results achieved and when those results were observed. During a review of the facility's policy and procedure titled, Charting and Documentation, last reviewed 3/9/2026, the policy indicated the following:The following information is to be documented in the resident medical record:a. Objective observations;b. Medications administered;c. Progress toward or changes in the care plan goals and objectives.Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for three of five residents (Resident 85, 98 and 11) investigated under unnecessary medications by failing to:a. Rotate (a method to ensure repeated injections are not administered in the same area) Resident 85's insulin (a medication that regulates sugar in the blood) injections sitesˆon several occasions from 2/4/2026 to 4/5/2026. This deficient practice placed Resident 85 at risk for developing bruises, pain, and/or lipodystrophy (lump or accumulation of fatty tissue under the skin). b. Ensure timely follow-up and implementation of physician ordered referrals to specialty services for Resident 98. These deficient practices had the potential to result in unmet medical needs, delayed diagnosis and treatment, worsening of chronic conditions, and an avoidable decline in Resident 98's physical, mental, and psychosocial well-being. c. Follow the physician's order for drawing laboratory (or labs for short) values for a resident on medications requiring monitoring to ensure there are no adverse effects for Resident 11.This had the potential to result in Resident 11 having adverse effects from either too little or too much medication.Findings:ˆ ˆ a. During a review of Residentˆ85'sˆFace Sheet, theˆFace Sheetˆindicated the facility admitted Residentˆ85ˆon 1/26/2026ˆwith diagnoses that included, but not limited to type 2 diabetes mellitus (DMˆ- a disease that occurs when the glucose, also called blood sugar, is too high)ˆand depressionˆ(a mood disorder that causes a persistent feeling of sadness and loss of interest).ˆ ˆ During a review of Residentˆ85's Minimum Data Set (MDS, a standardized assessment and care screening tool), datedˆ2/1/2026, indicated Residentˆ85ˆhad the capacity toˆusuallyˆmake herself understood andˆsometimesˆunderstand others andˆwas dependent (helper does all the effort) on facilityˆstaff for toileting, dressing,ˆbathingˆand personal hygiene. The MDS indicated Resident 85ˆwas on a high-risk drug class medication-hypoglycemic (a group of drugs used to help reduce the amount of sugar present in the blood).ˆ During a review of Resident 85's Order Summary Report, printed on 4/4/2026 indicated on 2/28/2026ˆto inject Insulinˆlispro Injection Solution 100 units per milliliters (unit/ml, a unit of fluid volume) per sliding scaleˆ(amount depends on the blood sugar reading)ˆsubcutaneously (SQ - in the fatty layer of the skin) before meals and at bedtime.ˆRotate sites.ˆ ˆˆ During a review of Residentˆ85's Medication Administration Record (MAR) fromˆ2/4/2026 to 4/5/2026ˆindicated Insulin Lispro Injection Solutionˆ100 unit/ml was administered as follows:ˆ 2/4/2026 -ˆabdomen – right upper quadrant (RUQ)ˆ 2/5/2026 - abdomen – right upper quadrant (RUQ)ˆ 2/8/2026 - abdomen – left upper quadrant (LUQ)ˆ 2/9/2026 - abdomen – left upper quadrant (LUQ)ˆ 2/10/2026 - abdomen – right upper quadrant (RUQ)ˆ 2/11/2026 - abdomen – right upper quadrant (RUQ)ˆ 2/20/2026 - abdomen – left lower quadrant (LLQ)ˆ 2/21/2026 - abdomen – leftˆlower quadrant (LLQ)ˆ 2/23/2026 - abdomen – right upper quadrant (RUQ)ˆ 2/24/2026 - abdomen – right upper quadrant (RUQ)ˆ 3/22/2026 - abdomen – left lower quadrant (LLQ)ˆ 3/23/2026 - abdomen – left lower quadrant (LLQ)ˆ 3/27/2026 - abdomen – right lower quadrant (RLQ)ˆ 3/29/2026 - abdomen – right lower quadrant (RLQ)ˆ 4/1/2026 - abdomen – right upper quadrant (RUQ)ˆ 4/2/2026 - abdomen – right upper quadrant (RUQ)ˆ 4/4/2026 - abdomen – right upper quadrant (RUQ)ˆ 4/5/2026 - abdomen – right upper quadrant (RUQ)ˆ ˆ During a review of Residentˆ85's DM Care Plan (CP), (What was the date of the Care Plan?) the CPˆindicated to administer medication as ordered.ˆ ˆ During a concurrent interview and record review on 4/9/2025 at 11:27 am with the Assistant Director of Nursing (ADON), the ADON reviewed Resident 85's medication administration record (MAR). The ADON stated there were multiple instances where the injection sites for the insulin were not rotated. The ADON stated the licensed nurses are expected to rotate insulin injections sites each and every time. The ADON stated the sites for insulin administration should be rotated to prevent damage to the resident's skin. The ADON also stated failure to follow the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician's order to rotate the insulin administration site were medication errors. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, last reviewed onˆ3/9/2026,ˆthe P&Pˆindicatedˆto administer medicationˆin accordance withˆthe prescriber's orders.ˆˆ During a review of the undated FDA Label forˆInsulin Lispro provided by the facility, the labelˆindicatedˆto rotate the injection sites to reduce the risk of lipodystrophy.ˆˆˆ b. During a review of Resident 98's Face Sheet, the Face Sheet indicated the facility admitted Resident 98 on 12/20/2022 with diagnoses including multiple sclerosis (MS, a chronic progressive disease involving damage to the nerve cells in the brain and spinal cord), type 2 diabetes mellitus (DM II, body does not use insulin properly, causing sugar to build up in the blood instead of being used for energy), polyneuropathy (many nerves in the body are damaged, causing numbness, tingling, or weakness, usually in the hands and feet), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and hyperlipidemia (condition where there is too much fat in the blood, which can increase the risk of heart disease). During a review of Resident 98's History and Physical (H&P), dated 12/4/2025, the H& P indicated Resident 98 has the capacity to understand and make decisions. During a concurrent interview and record review on 4/6/2026 at 12:00 p.m. with Registered Nurse (RN) 1, RN 1 reviewed two physician orders for specialty services referrals for Resident 98. RN 1 identified a physician order dated April 3, 2026, for referrals to Urology (the medical specialty that manages the urinary system and male reproductive organs) and Neurology (the medical specialty that manages the brain, spinal cord, and nerves). RN 1 stated that after reviewing the progress notes, there was no documentation indicating that staff carried out the physician's order for Resident 98. RN 1 stated that after reviewing the Licensed Notes, there was no nursing documentation showing that staff implemented the physician's referral order. RN 1 stated that completing physician orders for specialty services in a timely and appropriate manner is essential to ensure safe patient care and prevent complications. During a concurrent interview and record review on 4/8/2026 at 9:04 a.m. with Social Services Director (SSD), the SSD stated nursing staff are responsible for contacting specialty providers to schedule appointments. The SSD explained that after nursing schedules the appointment, nursing prints the physician's order and provides it to the SSD so transportation can be arranged. The SSD stated she did not receive notification of the physician's orders for Urology or Neurology for Resident 98. The SSD added that an additional consultation order for Ophthalmology (the medical specialty that evaluates and treats conditions related to vision and eye pain) was written for Resident 98, and she was not informed of this order either. The SSD further stated there were other specialty referrals that nursing did not complete, including Dermatology (the medical specialty that treats conditions of the skin, hair, and nails). The SSD stated that timely follow-up on specialty service referrals and appointments ensures residents receive necessary care and reduces the risk of condition decline. During an interview on 4/8/2026 at 10:10 a.m. with the Director of Nursing (DON), the DON stated nursing staff are responsible for carrying out specialty service referrals. The DON explained that nursing coordinates the appointments and then notifies the SSD to arrange transportation for residents. The DON stated that five specialty service referrals, Urology, Neurology, Ophthalmology, Orthopedics, and Dermatology, were ordered by Resident 98's primary care physician. The DON stated nurses are expected to ask Resident 98's primary care physician for the name of the specialist when coordinating appointments. The DON stated that there is no established timeframe for completing specialty appointments and the RN Supervisor provides oversight of specialty service referrals. The (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DON stated Resident 98 coordinates his own appointments. The DON stated they were not aware that Resident 98 had been waiting for updates regarding the specialty service appointments. The DON stated that follow-up on specialty service referrals and appointments helps ensure that residents are scheduled appropriately and receive necessary care without delay. During a review of the facility's policy and procedure (P&P) titled, Referrals, Social Services 12/2008, indicated, .Referrals for medical services must be based on physician evaluation of resident need and a related physician order.Social Services will collaborate with the nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician.Social Services and administration will maintain a listing of referral agencies that may provide assistance or therapy to residents with special problems and/or needs. c. During a review of Resident 11's face sheet (a page with information indicated for a resident such as facility admission date and pertinent diagnoses), the document indicated the resident was admitted to the facility on [DATE] with diagnoses that included hyperlipidemia (HLD, having high cholesterol which could lead to heart problems) and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 11's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 1/01/2026, the MDS indicated Resident 11 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 11 required setup assistance (helper sets up; resident completes the activity) with eating. The MDS indicated Resident 11 had hyperlipidemia. The MDS indicated Resident 11 has taken an antipsychotic medication in the last seven-day assessment period. During a review of Resident 11's Physician's Orders, the documents indicated an order for lipid panel (taking cholesterol), complete metabolic panel (CMP, includes labs to evaluate overall health by measuring chemical balance, metabolism, liver/kidney function, electrolytes, and blood sugar), Hemoglobin A1C (HgA1c, a test that indicates the average level of blood sugar control over the last couple of months, a high number is a sign of poor blood sugar control), and electrocardiogram (EKG, a noninvasive test that records the electrical signals of the heart) every six months, dated 2/19/2026. During a review of Resident 11's Physician's Orders indicated the following:- Atorvastatin Calcium Oral Tablet 20 milligrams (mg, metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth at bedtime for HLD, dated 4/10/2025.- Quetiapine Fumarate Oral Tablet (an antipsychotic medication) 25 mg, give one tablet by mouth in the morning for schizoaffective disorder manifested by yelling out without apparent reason to the point of exhaustion, dated 12/03/2025.- Quetiapine Fumarate Oral Tablet 25 mg, give two tablets by mouth in the evening for schizoaffective disorder manifested by yelling out without apparent reason to the point of exhaustion, dated 12/03/2025. During a concurrent interview and record review with Registered Nurse 1 (RN 1) on 4/09/2026 at 9:57 a.m. RN 1 reviewed Resident 11's physician's order for labs to be drawn on 2/19/2026. RN 1 was unable to find any blood labs that were drawn in 2026 for Resident 11. RN 1 confirmed there was only an EKG conducted after 2/29/2026. RN 1 reviewed the nursing progress notes and found no documentation why the blood labs were not completed. RN 1 stated the blood labs should have been done because Resident 11 is taking a HLD medication and knowing the cholesterol level might be an indication for HLD medication dosage adjustment. RN 1 stated Resident 11 takes an antipsychotic (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication and side effects should be monitored by drawing labs. During an interview with the Director of Nurses (DON) on 4/09/2026 at 1:29 p.m., the DON confirmed no blood labs were drawn after 2/19/2026 for Resident 11. The DON stated she was not sure why the blood labs were not done, but the EKG was done. The DON stated Resident 11 is on Lipitor and an antipsychotic medication and the lipid levels and blood sugar labs are important to prevent adverse effects. During a review of the facility's policy and procedure titled, Psychotropic Medication Use, last reviewed (Please include date) indicated the following:- Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: anti-depressants.- Psychotropic medication management includes adequate monitoring for efficacy (the capacity or power to produce a desired effect or intended result) and adverse consequences.- Psychotropic medication management includes preventing, identifying and responding to adverse consequences. During a review of the Facility's Assessment Tool, last reviewed 3/09/2026, indicated specific care or practices of the facility includes medication management which includes Awareness of any limitations of administering medications and Assessment/management of polypharmacy (the concurrent use of multiple medications by a single patient, most commonly affecting older adults with chronic conditions).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an environment that was free from accident hazards for three of five sampled residents (Resident 6, Resident 7, and Resident 71) investigated under accidents by failing to:1. Ensure Resident 6 who was accessed as needing supervision to smoke, according to the care plan, did not have access to a cigarette lighter.2. Ensure that Resident 7 was free of accident hazards by allowing unsupervised access to a lighter and cigarettes. 3. Ensure over half of the padding was not missing from the right-side rail for a resident with a history of seizures (a sudden surge of abnormal electrical activity in the brain, leading to a range of symptoms like muscle spasms, loss of consciousness).These failures had the potential to result in injuries to Resident 6, Resident 7, and Resident 71.Findings: a. During a review of Resident 6's Face Sheet (the front page of the chart that contains a summary of basic information about the resident), the document indicated the resident was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing). During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6 currently used tobacco. During a review of Resident 10's Smoking and Safety Assessment, dated 2/24/2026, the assessment indicated Resident 6 follows the facility's policy on location and time of smoking. There was no indication of whether Resident 6 required supervision while smoking. During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 3/02/2026, the MDS indicated Resident 6 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact in skills required for daily decision making. The MDS indicated Resident 6 needed setup or clean up assistance (helper sets up or cleans up; resident completes activity) with eating. During a review of Resident 6's Care Plan for Smoking, initiated on 1/12/2023, the care plan indicated Resident 6 was a smoker, and an assessment of Resident 6's capabilities and deficits determined that Resident 6 required supervision while smoking. The care plan included a goal that Resident 6 would be able to smoke according to the facility policy with precautions taken for the resident's safety, as well as the safety of others. The goal also indicated Resident 6 would have no smoke-related incidents in the facility. The care plan further indicated Resident 6 needed supervision while smoking and is to have no access to matches and lighters. During a concurrent observation and interview with Resident 6, in the outside smoking area, on 4/09/2026 at 12:40 p.m., with the Director of Nurses (DON) present, the DON observed Resident 6 smoking without any staff present. Resident 6 stated she keeps her own lighter because the licensed nurses lost it in the past. During an interview with the DON on 4/09/2026 at 1:12 p.m., she stated Resident 6 is non-compliant with the facility's policy and keeps two cigarettes with her. The DON stated Resident 6 gets anxious and yells when she wants a cigarette but does not have one. The DON stated she was not sure who lit Resident 6's cigarette during the earlier observation. The DON stated the smoking care plan should address that behavior so the facility can provide appropriate interventions for the residents' smoking. When asked if Resident 6 requires supervision while smoking, the DON stated that sometimes (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 6 is alert and other times there is a decline in her cognitive area. The DON stated it is important to determine if a resident needs supervision to prevent injuries such as burning themselves. During an interview with Registered Nurse 1 (RN 1) on 4/09/2026 at 2:33 p.m., RN 1 stated Resident 6's smoking care plan should be specific, addressing who keeps the lighter, whether it is the licensed nurses who would keep the smoking items in the medication cart or the resident themself. RN 1 stated this is important for resident safety. During a review of the facility's policy and procedure titled, Smoking Policy – Residents, last reviewed 3/09/2026, the policy indicated the following:- Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes ability to smoke safely with or without supervision.- A resident's ability to smoke safely is re-evaluated quarterly, upon significant change (physical or cognitive) and as determined by the staff.- Any smoking-related privileges, restrictions, and concerns are noted on the care plan, and all personnel caring for the residents shall be alerted to these issues.- Any resident with smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking.- Residents without independent smoking privileges may not have or keep any smoking items, including cigarettes, tobacco, etc., except under direct supervision. b. During a review of Resident 7's admission Record (Face sheet), the record indicated that Resident 7 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), major depression disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), muscle weakness, and difficulty walking. During a review of Resident 7's MDS, dated [DATE], the record indicated that Resident 7 used a walker, has impairment (reduced, weak, or loss of function) to one upper extremity (arm or hand), wears glasses, and has some short-term memory impairment (a problem with the part of memory that temporarily holds information you learned for a few seconds to minutes). During a review of Psychiatric Evaluation from a hospital admission, dated 3/29/26, the record indicated that Resident 7 had increasing paranoia (a mental state with intense, irrational mistrust, suspicion, or delusional beliefs that others are trying to harm, deceive, or persecute you, often without evidence) and had an episode of aggressive behavior (ready or likely to attack or confront), which resulted in this evaluation. The record indicated that Resident 7's mood is depressed, his judgement is impaired, and he is experiencing paranoia and hearing voices. During an observation on 04/06/2026 at 9:02 a.m. in Resident 7's room, Resident 7 had an opened pack of cigarettes in his shirt's outer chest pocket. At 9:15 a.m., Resident 7 wheeled himself, in his wheelchair, outside to the smoking area without alerting any staff members. A staff member near the smoking area noticed Resident 7 and stayed to supervise. Resident 7 was observed already smoking. Resident 7 stated that he lets the nurse know when he wants to smoke and that usually someone supervises him. During an interview on 04/08/2026 at 8:12 a.m. with the Social Services Designee (SSD, a trained staff member who supports residents' psychosocial, emotional, and social needs under the supervision of a licensed social worker), the SSD stated that she stores some smoking materials (cigarettes, lighters, etc.) for the residents, but that some are kept at the nurse station for the nurses to give to residents upon request. The SSD states that when a residents family brings cigarettes into the facility, they are brought to SSD to manage. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/08/2026 at 8:24 a.m. with Resident 7's Family Member 1 (FM 1), FM 1 stated that he does not give cigarettes to any staff members, but Resident 7 keeps them in his room. FM 1 stated that Resident 7 does have a lighter in his room. During an interview on 04/08/2026 at 12:06 p.m. with LVN 1, LVN 1 stated that Resident 7 is not allowed to keep his lighter and that the lighters are kept in the medication cart (mobile, secured workstation used to distribute medication to residents), available on request. LVN 1 stated that she believes the Social Services department stores cigarettes for Resident 7. During an interview on 4/09/2026 at 8:12 a.m. with Resident 7, Resident 7 stated that he is allowed to keep his own lighter and can light his cigarettes himself. When asked to show his lighter, Resident 7 placed his hand in his jacket pocket, paused, then removed his hand without lighter, folded his hands together, and declined to speak further. During an interview on 4/09/2026 at 8:19 a.m. with the DON, the DON stated that the residents' lighters are kept on the medication carts and cigarettes are kept with Social Services. The DON stated that some residents are noncompliant (not following rules) with the smoking policy, as family brings them cigarettes. The DON further clarified that residents are not allowed to keep lighters in their rooms and must get them from the nurse. During an interview on 04/09/2026 at 10:48 a.m. with LVN 7, LVN 7 stated that possible negative outcomes (final result or effect of an action) related to a resident having a lighter in their room include a fire hazard, exposure of other residents to secondhand smoke, and an increased risk of fire in the presence of oxygen (which supports combustion and is commonly used in healthcare settings. During an interview on 04/09/2026 at 1:11 p.m. with the Assistant Director of Nursing (ADON), the ADON states that Resident 7 is non-compliant (not following rules) with the facility's smoking policy. The ADON states that staff periodically (at regular intervals of time) ask him if he has a lighter or cigarettes since he leaves the facility for outings with his son and comes back with them. The ADON stated that he is probably not safe to have a lighter in his room. During a record review of Resident 7's Smoking care plan, last reviewed on 3/20/26, the record's interventions (actions taken to improve a situation or medical condition) indicated that Resident 7 needs no supervision while smoking and has access to matches and lighters. During a record review of Resident 7's Smoker Risk Assessment, dated 3/20/2025, the assessment indicated Resident 7 met the scoring criteria for Requires Supervision Non-independent Smoker. During a record review of Resident 7's Smoking and Safety assessment dated [DATE], the assessment documented that the resident smoked cigarettes and followed facility policy regarding location and time. The assessment did not include a scoring system or documentation to determine whether the resident was safe to smoke independently or required supervision. During a review of the facility's policy and procedure (P&P) titled Smoking Policy- Residents, last reviewed 3/09/2026, the P&P indicated that residents are informed of the smoking policy prior to and upon admission. The P&P indicated that staff consults with the physician and director of nursing services to decide if smoking safety restrictions are needed for a resident. The P&P indicated that a resident's ability to smoke safely is re-evaluated quarterly, when a significant change occurs, and as needed, determined by staff. The P&P indicated that any smoking-related privileges, restrictions, and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	concerns are noted on care plan and that all staff caring for the resident shall be alerted to those issues. The P&P indicated that the facility may place smoking restrictions on a resident at any time if the resident cannot smoke safely with the available levels of support and supervision. The P&P indicated that any resident that requires monitoring while smoking will be supervised by staff, family, visitor, or volunteers at all times when smoking. The P&P indicated that residents without independent smoking privileges may not have or keep any smoking items, including cigarettes, tobacco, etc., except for under direct supervision. The P&P indicated that the facility has the right to confiscate (take away) smoking items found in violation of the smoking policy. The P&P indicated that confiscated items are itemized (listed in personal items record) and returned to the resident or family members later. c. During a review of Resident 71's Face Sheet, the Face Sheetˆindicatedˆtheˆfacility admitted ˆResident 12 onˆ7/10/2016 with diagnosis including seizures and dementia (a progressive state of decline in mental abilities). During a review of Resident 71's History and Physical (H&P), dated 2/10/2026, the H&P indicated Resident 71 did not have the capacity to understand and make decisions. During a reviewˆofˆResident 71's MDS, dated [DATE], the MDS indicated Resident 71 rarely had the ability to make herself understood and rarely understood others. The MDS indicated that Resident 71ˆwas completely dependent (when the helper does all the work) on facility staff for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) During a concurrent observation and interview on 4/06/2026 at 8:22 a.m., in Residentˆ71`sˆroom with Minimum Data Set Coordinator (MDS), the MDSˆobservedˆResidentˆ71's bed with black pipe insulation wrapped on the side rails and stated there was a large piece missing on the right side and the rest were worn down and frayed. The MDS stated the pipe insulation should have been reported and replaced right away for safety, cleanliness and so it would look nice. During an interview on 4/09/2026 at 10:26 a.m., with the Assistant Director of Nursing (ADON), the ADON stated the black pipe insulation should not be torn and frayed because it is harder to keep clean and should be in good repair, especially because the resident has a history of seizures. The ADON stated staff should have reported it to maintenance right away so they could be replaced. During a review of the facility`s P&P titled, Homelike Environment,, last reviewed on 3/9/2026, the P&P indicated that Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.clean, sanitary and orderly environment; clean bed and bath linens that are in good condition.ˆ

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Controlled Drug Record (CDR, accountability record of medications that are considered to have a strong potential for abuse) coincided with the Medication Administration Records (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for one of one sampled residents (Resident 35). This deficient practice had the potential to result in medication error and/or drug diversion (illegal distribution or abuse of prescription drug).Findings: During a review of Resident 35's admission Record, the admission Record indicated the facility admitted the resident on 10/16/2025 with diagnoses that included low back pain. During a review of Resident 35's Minimum Data Set (MDS, a resident assessment tool) dated 1/22/2026, the MDS indicated Resident 35 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. The MDS indicated Resident 35 was independent with eating and oral hygiene. During a review of Resident 35's physician orders, the physician orders indicated an order for Tramadol tablet 50 milligrams (mg, unit of measurement) as needed every six hours for severe pain (7-10/10 on numeric pain scale with 0 being no pain and 10 being severe excruciating pain), dated 2/28/2026. During a review of Resident 35's Care Plan for Pain, initiated 2/7/2026, the care plan indicated a goal that the resident will have less/reduced episodes of pain or discomfort through appropriate interventions through the next assessment. The care plan indicated an intervention to administer pain medication as ordered. During a review of Resident 35's Pain assessment dated [DATE], the Pain Assessment indicated Resident 35 had pain frequently in the last five days. During a review of Resident 35's CDR for Tramadol, the CDR indicated Tramadol was removed from the blister pack (or called bubble pack, a card that packages doses of medication within small, clear, plastic bubbles [or blisters] thatare punched out to administer to a resident) on the following dates while the MAR dated 4/2026 indicated the following administration times:- 4/1/2026 6 a.m. CDR signed, 4/1/2026 7:14 p.m. MAR signed. - 4/1/2026 6 p.m. CDR signed, 4/1/2026 7:58 p.m. MAR signed. - 4/2/2026 6 p.m. CDR signed, 4/2/2026 8:06 p.m. MAR signed. - 4/3/2026 6 p.m. CDR signed, 4/2/2026 8:17 p.m. MAR signed. - 4/4/2026 12 a.m. CDR signed, 4/4/2026 1:25 a.m. MAR signed. - 4/4/2026 6 a.m. CDR signed, 4/4/2026 6:52 a.m. MAR signed. - 4/4/2026 6 p.m. CDR signed, 4/4/2026 7:35 p.m. MAR signed. - 4/5/2026 12 a.m. CDR signed, 4/5/2026 1:14 a.m. MAR signed. - 4/6/2026 6 p.m. CDR signed, 4/4/2026 8:12 p.m. MAR signed. During an interview on 4/7/2026 at 7:33 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated when removing an as needed controlled medications for a resident, licensed nurses document on the CDR and MAR after giving the resident the medication. During a concurrent interview and record review on 4/7/2026 at 2:07 p.m., with the Director of Nursing (DON), reviewed Resident 35's Tramadol Audit Report. The DON confirmed that licensed nurses documented Tramadol as given on the above dates. The DON stated the MAR needs to be signed immediately after administration of medications. The DON reviewed the policy titled, Controlled Substances, last reviewed 3/09/2026 which indicated the following:The nurse administering the medication is responsible for recording:(1) Name of the resident receiving the medication(2) Name, strength and dose of the medication(3) Time of administration(4) Method of administration(5) Quantity of the medication remaining; and(6) Signature of nurse administering medicationThe DON acknowledged that the policy did not indicate which documents are to be signed or the steps in documenting controlled substance removal. The DON stated the process is that when a controlled drug is removed from the bubble pack, the licensed nurse is to sign the controlled drug record, give the medication to the resident, and then sign the MAR. The DON stated the reason for doing this is to ensure there is accountability of controlled medications. During a concurrent interview and record review on 4/7/2026 at 3:50 p.m., with LVN 5, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reviewed Resident 35's CDR for Tramadol and MAR dated 4/2026. LVN 5 confirmed she administered Resident 35's Tramadol on the following days:- 4/1/2026 6 p.m. CDR signed, 4/1/2026 7:58 p.m. MAR signed- 4/2/2026 6 p.m. CDR signed, 4/2/2026 8:06 p.m. MAR signed- 4/3/2026 6 p.m. CDR signed, 4/2/2026 8:17 p.m. MAR signed- 4/4/2026 6 p.m. CDR signed, 4/4/2026 8:12 p.m. MAR signedLVN 5 stated she should have signed the MAR immediately after administering the medication and not wait. LVN 5 stated this is important to prevent double dosing (giving a medication before it is next due) the medication and ensures accountability of records.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to label and store drugs and biologicals in accordance with accepted professional principles for two of four (West Station Medication Cart and Middle Station Medication Cart 1) affecting Residents 17 and 21) for failing to ensure: 1.Resident 17's artificial tears (drops to provide lubrication to the eyes) were labeled with first name and last name. 2. Resident 21's glaucoma (a group of eye diseases that damage the optic nerve, causing gradual, irreversible vision loss) eye drops were labeled with an open date. These deficient practices had the potential for residentsˆto receive medication that had become ineffective due to using the medication after the expiration date, as well as the risk of administration to the wrong resident when medications were labeled only with a room number and last name instead of the resident's full name.Findings: 1. During a review of Resident 17's Face Sheet (the front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included hypertension (high blood pressure). During a review of Resident 17's Minimum Data Set (MDS, a resident assessment tool), dated 2/16/2026, the MDS indicated Resident 17 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. Resident 17's MDS indicated the resident required substantial/maximal assistance (helper does more than half the effort) with personal hygiene. During a review of Resident 17's Physician's Orders, dated 8/31/2025, the orders indicated an order for artificial tears ophthalmic solution 1%, instill one drop in both eyes three times a day for chronic dry eye syndrome (a long-term condition where the eyes do not produce enough quality tears). During a review of Resident 17's Care Plan for Eye Dryness, initiated 4/13/2023, the care plan indicated a goal: reduce risk of redness, irritation or infection daily. The care plan indicated an intervention to administer eye medication/drops as ordered/indicated. 2. During a review of Resident 21's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included glaucoma. During a review of Resident 21's MDS, dated [DATE], the MDS indicated Resident 21 was severely impaired in cognition with skills required for daily decision making. Resident 21's MDS indicated the resident required substantial/maximal assistance with personal hygiene. During a review of Resident 21's Physician's Orders, dated 1/20/2026, the orders indicated the following: Brimonidine Tartrate ophthalmic solution 0.2%, instill one drop in both eyes two times a day for glaucoma. Latanoprost ophthalmic solution 0.005%, instill one drop in both eyes at bedtime for glaucoma. During a review of Resident 21's Care Plan for Impaired Visual Functioning, initiated 2/15/2026, the care plan indicated a goal, will minimize the risk of injury related to visual impairment daily through the next assessment. The care plan indicated an intervention to provide and maintain good eye care and hygiene. During a concurrent medication cart observation and interview with Licensed Vocational Nurse 4 (LVN 1) on 4/07/2026 at 8:47 a.m., LVN 4 opened the Medication Cart Middle Station 2. Observed a bottle of Artificial Tears, labeled with a room number and last name for Resident 17. LVN 4 stated the process for labeling eye drops is to label the box with a first name and last name. LVN 4 stated this is important to avoid confusion and for the right resident to receive the right medication. During a concurrent medication cart observation and interview with Registered Nurse 1 (RN 1) on 4/07/2026 at 7:33 a.m., RN 1 opened the Medication Cart Middle Station 1. RN 1 observed Resident 21's brimonidine and latanoprost eye drops without an open date on the box or bottle. RN 1 stated there should be an open date on medications to ensure the licensed nurses know when to discard the medications. RN 1 stated the eye drops are effective for only a certain time. RN 1 stated this is important to ensure the medication is effective in treating Resident 21's glaucoma. During a concurrent interview and record (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review with the Director of Nursing (DON) on 4/08/2026 at 4:59 p.m., the DON reviewed the facility's policy and procedure titled Labeling of Medication Containers, last reviewed 3/09/2026. The DON stated eye drops that do not come labeled from the pharmacy such as house supply (medications that include over the counter medications but still require a doctor's order) should be labeled with a first name and last name. The DON stated labeling for individual resident medications, according to the policy, indicated the resident's name. The DON stated this referred to a resident's first and last name. The DON stated this is important to ensure the five rights (fundamental safety principles used by nurses to prevent errors, including:ˆright patient, right drug, right dose, right route, and right time) with the right patient receiving the right medication. The DON stated multi-dose containers, such as eye drops, should have an open date recorded on the container. The DON stated this is important to ensure the medication is effective in treating the resident's condition. During a review of the facility's policy and procedure titled, Labeling of Medication Containers, last reviewed 3/09/2026, the policy indicated labels for individual resident medications include all necessary information, such as the resident's name. During a review of the facility's policy and procedure, titled, Administering Medications, last reviewed 3/09/2026, the policy indicated the expiration/beyond use date on the medication label is checked prior to administering. The policy indicated when opening a multi-dose container, the date opened is recorded on the container. During a review of the Latanoprost Manufacturer Guidelines, revised 6/2022, the guidelines indicated once a bottle is opened for use, it may be stored at room temperature up to 25ˆ (77ˆ) (Centigrade and Fahrenheit, units of measurement for temperature) for six weeks. ˆˆ

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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 serve food in accordance with professional standards for food service safety by failing to:1. Ensure food items on the tray line (a system of food serving in which a tray is moved along an assembly line to ensure a resident receives their prescribed diet) were at the proper temperatures when [NAME] 2 failed to take the temperature of the Asian salad.2. Follow safe food handling procedures by leaving the resident's breakfast at the beside until she woke up four hours later for one of one resident (Resident 20) during an initial pool observation. These failures had the potential to result in the possibility of harmful bacterial growth and cross contamination leading to foodborne illness.Findings: a. During a kitchen tray line observation on 4/08/2026 at approximately 12:15 p.m., [NAME] 1was observed checking the temperatures of the food. [NAME] 1 and the kitchen aides were about to start to serve the food and place it on the residents' plates. The Asian salad had already placed on the residents' trays. When asked about the temperature of the Asian salad, the Dietary Supervisor (DS) stated [NAME] 2 is to take the Asian salad food temperature. The DS took the Asian salad food temperature and recorded on the Food Temperature Log. During an interview with [NAME] 2 on 4/08/2026 at 1:05 p.m., [NAME] 2 stated he was the evening cook, and he was supposed to take the Asian salad temperature. [NAME] 2 stated he normally takes the salad temperatures, but he was completing many tasks and forgot to take the temperature. [NAME] 2 stated this is important to follow the requirement of keeping cold food at 40 ˆ (degrees Fahrenheit, a unit of measure for food) or below because that is the requirement. [NAME] 2 stated if the food is above 40 ˆ, the residents may not enjoy the food. During an interview with the DS on 4/09/2026 at 2:06 p.m., the DS stated the process for taking food temperatures is to take the temperature as soon as they are placed on the steam table. The DS stated the cook conducting the tray line is to take the steam table temperatures, the dietary aides take the temperature of the drinks, and the evening cook (Cook 2) takes the temperature of the soup and salad and records the temperatures on the Food Temperature Log. The DS stated this is important so that the food will not fall into the danger zone (the temperature range of 41ˆ to 140 ˆ where bacteria grow most rapidly; food should not be in this range, to prevent foodborne illness). During a review of the facility's policy and procedure titled, Daily Food Temperature Control, last reviewed 3/09/2026, the policy indicated the following: Temperature of all hot and cold food shall be taken prior to every meal service and recorded on the Temperature Log. The cook and/or dietary aide shall take the temperature of the food prior to meal service. All cold foods shall be held for service at temperatures 40 ˆ or below. b. During a review of Resident 20's Face Sheet, the Face Sheet indicated the facility admitted Resident 20 on 5/31/2024 with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs). During a review of Resident 20's History and Physical (H&P), dated 6/30/2025, the H&P indicated Resident 20 had the capacity to understand and make decisions. During a review of Resident 20's Minimum Data Set (MDS, a standardized assessment and care (continued on next page)

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Magnolia Gardens Convalescent Hospital	17922 San Fernando Mission Rd Granada Hills, CA 91344

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	screening tool), dated 6/30/2025, the MDS indicated Resident 20 understood others and usually was understood by others. The MDS indicated Resident 20 required setup/clean-up assistance (helper sets up/cleans up; resident completes the activity), and partial assistance (helper does less than half the effort) with oral and personal hygiene. During a concurrent initial pool observation and interview on 4/06/2026 at 8:08 a.m. in Resident 20's room, Resident 1 was asleep in bed. Next to Resident 20, on her bedside table was her breakfast tray; it had not been eaten yet. Resident 20 woke up briefly and stated not to touch her food tray, that she eats it after she wakes up. Resident 20 stated she wakes up and eats around 11:00-11:30 a.m. daily. During a review of Resident 20's Care Plan initiated on 3/26/2025, titled Resident Non-compliance manifested by: patient likes to sleep in late, therefore meal trays left on table until she wakes up per resident request, the CP did not include alternative interventions for leaving the food tray at the bedside. During an observation on 4/06/2026 at 10:27 A.M. in Resident 20's room, the meal tray was still next to the resident – untouched. During a concurrent observation and interview on 4/06/2026 at 11:48 a.m. in Resident 20's room, Resident 20 was up in her wheelchair and was eating the same plate of food from breakfast left at her bedside. 75% of the meal was consumed. Resident 20 stated she did not ask for the food to be replaced or warmed up. Resident 20 stated, again, that she likes to sleep in and did not want her meal or food warmed up or replaced. During a concurrent observation and interview on 4/06/2026 at 11:55 a.m. in Resident 20's room with Certified Nursing Assistant (CNA 1), CNA 1 pointed to Resident 20's breakfast meal tray and stated the resident did not want staff to remove it so they leave it for her to eat later. CNA 1 stated the breakfast tray was never removed out of the room, swapped or heated up. CNA 1 stated she was assigned to Resident 20 that day and stated there was a chance of food poisoning if the food is left out the way it was, but that they leave it so the residents would not complain or become upset. During an interview on 4/06/2026 at 1:22 p.m. with the Dietary Supervisor (DS), the DS stated it is the facility's policy that once a tray of food is delivered, it cannot stay out safely for more than two hours. The DS stated Resident 20's tray should have been removed sooner. During a concurrent interview and record review on 4/09/2025 at 1:37 p.m. with the Assistant Director of Nursing (ADON), the ADON reviewed the Meal Service policy and stated all food delivered to rooms must be removed two hours after delivery to avoid potential contamination and food born illness. The ADON stated the food tray should have been removed by staff after two hours and not left for over four hours at the bedside. During a review of the facility's Policy and Procedure, (P&P) titled Meal Service last reviewed 3/09/2026, the P&P indicated meal trays delivered to resident rooms must be removed within 2 hours of delivery to ensure food safety. If a resident is unavailable or chooses to eat later, the tray will still be removed within this timeframe, and an alternate meal or reheated tray will be provided upon request.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to establish and implement a clear policy for controlled drug administration (refers to the process of safely managing medications that are regulated by the government due to their potential for misuse or dependency - often called controlled substances) when its policy did not indicate the required timeframes for documenting controlled substances, including when to sign the Controlled Drug Record (CDR - document used in healthcare settings to track and account for medications that are regulated due to their potential for misuse) and when to sign/complete the Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident). Three of three licensed nurses (Licensed Vocational Nurse 1 [LVN 1], Licensed Vocational Nurse 3 [LVN 3], Licensed Vocational Nurse 5 [LVN 5]) were unable to identify the proper chronological steps for removing and administering controlled medications during a review of 19 sampled residents.This deficient practice had the potential to result in medication errors, including incorrect dosing, missed or delayed administration, and an increased risk of drug diversion (the illegal distribution or misuse of prescription drug). Findings:During a review of Resident 35's Face Sheet (a document containing resident information such as facility admission date and pertinent diagnoses), the Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included low back pain.During a review of Resident 35's Minimum Data Set (MDS - a resident assessment tool), dated 1/22/2026, the MDS indicated Resident 35 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact, with the ability to make daily decisions, and was independent with eating and oral hygiene.During a review of Resident 35's Physician's Orders dated 2/28/2026, the Physician Orders indicated an order for Tramadol (a medication used to manage severe pain) 50 milligrams (mg - metric unit of measurement, used for medication dosage and/or amount) tablet to be administered every six hours as needed for severe pain (seven to 10 out of 10 on a numeric pain scale, with zero [0] indicating no pain and 10 indicating severe pain).During a review of Resident 35's CDR from 4/1/2026 to 4/7/2026, the CDR indicated that Tramadol was removed from the blister pack (known as bubble pack, a type of protective, unit-dose packaging where medications are sealed in individual pockets [blisters]) on the following dates and times, however, a comparison with the April 2026 MAR Audit Record indicated discrepancies in the documented administration times as follows: 4/01/2026 6 a.m.; MAR documented 4/01/2026 7:14 p.m. 4/01/2026 6 p.m.; MAR documented 4/01/2026 7:58 p.m. 4/02/2026 6 p.m.; MAR documented 4/02/2026 8:06 p.m. 4/03/2026 6 p.m.; MAR documented 4/02/2026 8:17 p.m. 4/04/2026 12 a.m.; MAR documented 4/04/2026 1:25 a.m. 4/04/2026 6 a.m.; MAR documented 4/04/2026 6:52 a.m. 4/04/2026 6 p.m.; MAR documented 4/04/2026 7:35 p.m. 4/05/2026 12 a.m.; MAR documented 4/05/2026 1:14 a.m. 4/06/2026 6 p.m.; MAR documented 4/04/2026 8:12 p.m.During a medication cart observation and concurrent record review on 4/7/2026, at 7:33 a.m., with LVN 1, the contents of Medication Cart [NAME] were observed and Resident 35's CDR for Tramadol was reviewed. Resident 35's CDR for Tramadol indicated the medication (Tramadol) was signed and documented as administered every six hours each day from 4/1/2026 to 4/7/2026 at 12 a.m., 6 a.m., 12 p.m., and 6 p.m. Resident 35's MAR Audit Record on the computer with LVN 1 indicated multiple entries that were not documented within 30 minutes of administration. None of the entries were signed by LVN 1, however she (LVN 1) stated that when administering an as needed controlled medication, she (LVN 1) documents on both the CDR and MAR after giving the medication to the resident. During a follow-up interview on 4/7/2026, at 1:29 p.m., with LVN 1, LVN 1 stated that when administering controlled medications, she (LVN 1) removes the controlled pain medication from the drawer, places it in a small (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cup, asks the resident to rate their pain, and if the resident agrees to take the medication, she (LVN 1) returns to the medication cart to sign the CDR and the resident's MAR.During an interview on 4/7/2026 at 1:35 p.m., with LVN 3, LVN 3 stated that the process for administering controlled medications to a resident is to remove the medication, administer it to the resident, and then sign the MAR and the CDR. LVN 3 further stated that both the MAR and CDR are signed after the medication has been given. During an interview on 4/07/2026 at 1:46 p.m., with Registered Nurse 1 (RN 1), RN 1 stated that the process for administering controlled medications is to prepare the medication, administer it to the resident, and then document by signing both the MAR and the CDR simultaneously after the medication has been given. During a follow-up interview and concurrent record review on 4/07/2026 at 2 p.m., with RN 1, the facility's policy and procedure (P&P) titled, Controlled Substances, last reviewed on 3/9/2026 was reviewed. The facility policy indicated the following: Upon Administration: a. The nurse administering the medication is responsible for recording:(1) Name of the resident receiving the medication;(2) Name, strength and dose of the medication;(3) Time of administration;(4) Method of administration;(5) Quantity of the medication remaining; and(6) Signature of nurse administering medication.The P&P further indicated that monitoring controlled medications to prevent loss, diversion or accident exposure are periodically reviewed and updated by the director of nursing services and the consultant pharmacist. RN 1 stated that the Controlled Substances policy is not clear regarding the chronological steps for administering controlled medications. RN 1 further stated that policies should clearly outline each step in a manner that is easy for licensed nurses to understand. RN 1 stated that this clarity is important to prevent medication errors and ensure resident safety.During a concurrent interview and record review on 4/8/2026 at 2:30 p.m., with the Director of Nurses (DON) and Administrator (ADM), Resident 35's MAR Audit Record for the month of 4/2026 was reviewed. The DON stated that LVN 5 should have documented the Tramadol administrations sooner than was done on the identified dates. The DON further stated the process for administering controlled medications as follows: adhere to the five rights of medication administration, remove the medication from the medication cart, sign the CDR, lock the medication cart, explain the purpose of the medication to the resident, administer the medication, and then immediately sign and document in the electronic MAR. The DON stated this process is necessary to ensure accountability for controlled medications. The DON also reviewed the P&P titled, Controlled Substances, last reviewed on 3/09/2026 and stated that the policy does not specify the correct order of steps for administering controlled medications. The ADM stated that it is important to have a clear and detailed policy to ensure controlled medications are documented accurately and consistently.During a concurrent interview and record review on 4/7/2026 at 3:50 p.m., with LVN 5, Resident 35's CDR from 4/1/2026 to 4/7/2026 and MAR Audit Record for the month of 4/2026 were reviewed. LVN 5 confirmed she (LVN 5) administered Tramadol on the following dates: 4/01/2026 at 6 p.m. CDR signed, 4/01/2026 at 7:58 p.m. MAR signed 4/02/2026 at 6 p.m. CDR signed, 4/02/2026 at 8:06 p.m. MAR signed 4/03/2026 at 6 p.m. CDR signed, 4/02/2026 at 8:17 p.m. MAR signed 4/04/2026 at 6 p.m. CDR signed, 4/04/2026 at 8:12 p.m. MAR signedLVN 5 stated she should have signed the MAR immediately after administering the medication and not delayed documentation. LVN 5 further stated that timely documentation is important to prevent potential medication errors, including double dosing (administration of a medication before it is next due), and to ensure accurate accountability of medication records.During a review of the document titled, Facility Assessment, last reviewed on 3/9/2026, the Facility Assessment indicated in section 3.5 policies and procedures are evaluated to ensure those meet current professional standards of practice. The Facility Assessment indicated existing policies and procedures will be reviewed annually to ensure compliance with the state and federal regulations.During a review of the facility's P&P titled, Quality Assurance and Performance Improvement (QAPI) Program - Governance and Leadership, last reviewed on 3/9/2026, the P&P indicated that the responsibility of the QAPI committee (interdisciplinary [group of medical disciplines with the purpose of helping a resident achieve their medical goals] team such as administrator, DON, (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Pharmacy, etc. who meet to improve safety and quality in the nursing home) are to identify, evaluate, monitor, and improve facility systems and processes that support the delivery of care and services.

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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. Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity in a manner that promotes maintenance or enhancement of his or her quality of life by failing to ensure a staff member was at eye level while providing feeding assistance for one of three residents (Resident 75) investigated under the dignity care area. This deficient practice had the potential to result in a decrease in the residents' psychosocial well-being and loss of dignity.Findings: During a review of Resident 75's admission Record, the admission Record indicated the facility admitted the resident on 2/25/2021 and readmitted the resident on 10/24/2025 with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and dementia (a progressive state of decline in mental abilities). During a review of Resident 75's History and Physical (H&P) dated 2/23/2026, the H&P indicated Resident 75 did not have the capacity to understand and make decisions. During a review of Resident 75's Minimum Data Set (MDS, a resident assessment tool) dated 4/7/2026, the MDS indicated Resident 75 could make herself understood but only sometimes understood others and was dependent (helper does all the effort) on facility staff with toileting, bathing, and dressing. During an observation on 4/6/2026 at 12:12 p.m., in the Dining Room, Resident 75 was observed sitting up in her wheelchair at a table and the Activities Director (AD) was standing over the resident and above eye level while assisting Resident 75 with eating. During an interview on 4/6/2026 at 12:14 p.m., with the AD, the AD stated that she should be sitting on a chair and at eye level while assisting Resident 75 while eating. The AD stated it was important to sit and interact with the resident while assisting with eating for respect, to maintain their dignity. During an interview on 4/9/2026 at 11:15 a.m., with the Assistant Director of Nursing (ADON), the ADON stated when assisting residents with eating, the best practice is for staff to sit at eye level to maintain respect and dignity and for safety purposes. During a review of the facility's policy and procedure (P&P) titled, Dignity, last reviewed 3/9/2026, the P&P indicated when assisting with care, residents must be provided with a dignified dining experience.

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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 observation, interview, and record review, the facility failed to promote the resident's right to be informed of and participate in their treatment for two of four (Resident 7 and Resident 63) sampled residents by failing to inform the resident and provide the name of medications and their indications (reason for the use of the medication) prior to administration of the medications. This deficient practice violated Resident 7 and Resident 63`s rights to make decisions regarding their medication regimen and afford the residents the opportunity to refuse any or all the medications due for administration. Findings: a. During a review of Resident 7's admission Record, the admission Record indicated the facility originally admitted the resident on 12/06/2018 and readmitted on [DATE] with diagnosis including muscle weakness and anxiety disorder (a mental health condition involving excessive, uncontrollable fear or worry that interferes with daily life, lasting for months rather than being temporary). During a review of Resident 7's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 3/14/2026, the MDS indicated the resident had the ability to make self-understood and the ability to understand others. The MDS indicated that Resident 7 was independent (resident completes the activity by themselves with no assistance from the helper) with eating, oral hygiene, toileting hygiene, upper body dressing, lower body dressing putting on/taking off footwear and personal hygiene. During an observation on 4/08/2026 at 8:01 a.m., Licensed Vocational Nurse 1 (LVN 1) was observed while preparing and administering medications to Resident 7. LVN 1 poured the medications into the medication cup then proceeded to the resident`s bedside and administered the medications without informing the resident of the medication name, its indication for use and without giving the resident the opportunity to consent or refuse the medications.  During a review of Resident 7`s Order Summary Report (OSR) as of 4/08/2026, the OSR indicated the following medications orders that were administered by LVN 1: 1. Artificial Tears Ophthalmic Solution (lubricating eye drops designed to soothe dry, irritated eyes by mimicking natural tears and protecting the ocular surface), 1 drop in both eyes two times a day for dry eyes.\ 2. Aspirin (used to reduce pain, fever, and inflammation) 81 milligram (mg), give 1 tablet by mouth in the morning for cardiovascular accident (occurs when blood flow to the brain is blocked or a blood vessel bursts, causing brain cell death due to lack of oxygen) prophylaxis (action taken to prevent disease, especially by specified means or against a specified disease). 3. Cetirizine (used to treat cold or allergy symptom) HCL Oral Tablet 10 mg, give 1 tablet by mouth in the morning for itching. 4. Citalopram (a prescription antidepressant) Hydrobromide Oral Capsule 30 mg, give 1 capsule by mouth one time a day for depression. 5. Cyclosporine (usedˆto treat organ rejection post-transplant) Emulsion 0.05%, instill 1 drop in both eyes two times a day for dry eyes. 6. Docusate Sodium Oral Capsule 100 mg, give 1 capsule by mouth two times a day for bowel management. 7. Furosemide (ˆgiven to help treat fluid retention (edema) and swelling) Oral Tablet 20 mg, give 1 tablet by mouth in the morning for Diuretic (ˆtreat high blood pressure, heart failure, and edema by encouraging the kidneys to vessels) hold for Systolic Blood Pressure (SBP- measures the maximum pressure in your arteries when the heart contracts, with a normal reading below 120 mmHg) less than 110 mmHg (unit of measure). 8. Gabapentin (a prescription medication primarily used to treat nerve pain) Capsule 300 mg, give 1 tablet by mouth three times a day for Polyneuropathy (disease affecting peripheral nerves). 9. Multivitamin (dietary supplements containing a blend of vitamins and minerals designed to fill (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nutritional gaps, supporting immune, bone, and energy health) Tablet, give 1 tablet by mouth in the morning for supplement. 10. Seroquel (dietary supplements containing a blend of vitamins and minerals designed to fill nutritional gaps, supporting immune, bone, and energy health) Oral Tablet 100 mg, give 200 mg by mouth in the morning for schizophrenia (dietary supplements containing a blend of vitamins and minerals designed to fill nutritional gaps, supporting immune, bone, and energy health). During an interview on 04/08/2026 at 8:10 a.m., immediately after the medication pass observation, LVN 1 was interviewed regarding resident rights as far as their medication regimen. It is 1 stated that every resident must be informed of what medications they are taking, and it is important for them to be given an opportunity to refuse any or all the medications. LVN 1 stated that it is a violation of the resident rights if they are not informed of the medication they are about to take. LVN 1 stated that she did not inform Resident 7 about the medications and their indication for use which constitutes a violation of Resident 7`s rights.  During a review of the facility`s Policy and Procedure (P&P) titled Resident Rights, last revised on 02/2021, the P&P indicated that Employees shall treat all residents with kindness, respect, and dignity.be informed of, and participate in, his or her care planning and treatment. b. During a review of Resident 63's Face sheet, the Face Sheet indicated the facility admitted the resident on 6/27/2023 with diagnoses including epilepsy (brain sends abnormal electrical signals, causing changes in the body like shaking, staring, or losing awareness), hyperlipidemia (too much fat in the blood causing build up in blood vessels and make it harder for blood to flow), hypertension (HTN, high blood pressure, and delusional disorders (mental health condition where a person has strong beliefs that are not true, even when there is clear proof they are wrong). During a review of Resident 63's [NAME] Data Set (MDS, a resident assessment tool)ˆdatedˆ3/20/2026, theˆMDSˆindicated Resident 63 has the ability to understand others with clear comprehensionˆcan never/rarelyˆunderstand and make decisions.ˆ During a concurrent observation, interview and record review on 4/6/2026 at 9:25 a.m. with Licensed Vocational Nurse (LVN) 6, Resident 63's physician's orders (written medical orders for healthcare professionals regarding specific medical treatments, medications, and instructions for patients), were reviewed. The physician's orders indicated the following: a. Order date on 1/28/2026, Amlodipine Besylate (treat high blood pressure and chest pain) 5milligram (mg, unit of measurement), give one tablet by mouth one time a day for HTN. Hold for systolic blood pressure (SBP, top number in a blood pressure reading) less than (<) 110. Start date 1/29/2026 and no stop date. b. Order date on 1/28/2026, Aspirin (used to reduce pain, fever, and inflammation) 81mg, give one tablet by mouth one time per day for cardiovascular accident (CVA, another name for stroke). Start date 1/29/2026 and no stop date. c. Order date on 12/13/2025, Cyanocobalamin (form of Vitamin B12 to treat deficiency of Vitamin B12) Tablet 1000micrograms (mcg, unit of measurement), give one tablet by mouth one time a day for supplement. Start date 12/13/2025 and no stop date. d. Order date on 12/13/2025, Docusate Sodium (stool softener for constipation) Tablet 10mg, give one tablet by mouth one time a day for stool softener (Hold for loose bowel movements). Start date (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/13/2025 and no stop date. e. Order date on 12/13/2025, Lisinopril (treat high blood pressure, heart failure and kidney protection) Oral Tablet 20mg, give one tablet by mouth one time per day for HTN. Hold for SBP for <110. Start date 12/13/2025 and no stop date. f. Order date on 1/5/2026, Risperidone (treat schizophrenia [mental illness that is characterized by disturbances in thought]) Oral Tablet 0.5mg, give one tablet by mouth one time a day for delusion disorder, auditory hallucinations (person hears sounds or voices that are not really there), thinking the neighbors can see through the walls and are coming to get her. Start date 1/6/2026 and no stop date. g. Order date on 12/15/2025, Valproic Acid (anti-seizure and mood stabilizer) Oral Solution 250mg/5 millimeters (ml, unit of measurement), give 3.75ml three times per day for seizure. Start date 12/15/2025 and no stop date. LVN 6 administered the medications to Resident 63 without reviewing and verifying each medication. Resident 63 stated she was uninformed of each medication. LVN 6 stated she did not review and verify each medication as she is too busy. LVN 6 stated reviewing and verifying each medication deters medication errors, prevent adverse medication effects, and resident rights to defer medications. During an interview on 4/8/2026 at 10:10 a.m. with the Director of Nursing (DON), the DON stated LVNs administer medications in the facility, and are expected to do the following prior to administering medication(s): a. Identify resident with a photo from EMR, then confer with second licensed personnel. b. Medication administration; verify right resident, right medication, right time, right dosage, right route. c. LVN prepares medication(s), review and name of each medication and side effects, administer medication(s). The DON stated LVN 6 did not review and verify each medication with Resident 63. All residents have rights and LVNS are to review and verify each medication prior to administration. Medication verification and review is essential for safeguarding patient safety and minimizing the risk of medication errors. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, 2/2021, indicated, . be informed about his or her rights and responsibilities.be notified of his or her medical condition and of any changes in his or her condition.be informed of, participate in, his or her care planning or treatment .

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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 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. Based on observation, interview, and record review, the facility failed to ensure that discharge documentation included all the required elements, including the reason for transfer/discharge, effective date, and receiving location for one of three residents reviewed for closed records (Resident 102). This deficient practice resulted in incomplete documentation of discharge information, which could impair coordination of care and continuity of services for Resident 102. Findings: During a review of Resident 102's Face Sheet, the Face Sheet indicated the facility admitted Resident 8 on 12/06/2025 with diagnoses including hypertension (HTN, high blood pressure), asthma (condition where the airways in the lungs become swollen and narrow, making it hard to breathe), dislocation of left hip, hypotension (low blood pressure), and hypothyroidism (condition where the thyroid gland [a small gland in the neck] does not make enough hormones and causes the body to slow down). The Face Sheet indicated Resident 102 was discharged from the facility on 2/3/2026. During a review of Resident 102's History and Physical (H&P), dated 12/8/2025, the H&P indicated Resident 102 has the capacity to understand and make decisions. During a review of Resident 102's Minimum Data Set (MDS-a resident assessment tool) dated 1/25/2026, the MDS indicated Resident 102's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated Resident 102 required partial/moderate assistance (helper does less than half the effort) with showering/bathing, lower bathing dressing, and putting on/taking off footwear. During an interview on 4/8/2026 at 8:47 a.m. with the Social Services Director (SSD), the SSD stated she assists with resident discharges by ordering and arranging delivery durable medical equipment (DME, medical equipment that people use at home to help them stay healthy or move around slowly), and coordinating placements in lower level of care, including assisted living, board and care, senior living and independent living settings. The SSD stated she documents all communication, decisions, and placement activities in the electronic medical record (EMR). The SSD stated that EMR documentation should include contact discussions, confirmation of placement, and the date and time of each entry. The SSD stated she did not document the confirmation of placement for Resident 102. The SSD stated that the lack of documentation results in no evidence that placement occurred for Resident 102 and creates risks such as incorrect placement, an incomplete transfer/discharge report, and nursing staff being unaware of the confirmed location of discharge. The SSD stated that the Registered Nurse (RN) Supervisor or another licensed nurse completes the transfer/discharge report, and that nursing staff should have contacted her if additional information was needed to complete the report. During a concurrent interview and record review on 4/8/2026 at 9:24 a.m. with the Registered Nurse 1 (RN 1), reviewed Resident 102's Discharge Summary Report, Post Discharge plan of Care, and Transfer/Discharge Report. RN 1 stated all three documents contained missing elements. RN 1 stated the Discharge Summary Report lacked prognosis, the Interdisciplinary Team (IDT) representative, and the location of the board and care. RN 1 stated the Post Discharge Plan of Care did not include the location of the board and care, Resident 102's address, mental and social status, medical equipment and supplies, safety precautions and instructions, or the responsible party's name. RN 1 stated the Transfer/Discharge Report did not include the address of the board and care. RN 1 stated the nurse who completed the discharge forms should have contacted the Social Services Director (SSD) to obtain the missing information. During a concurrent interview and record review on 4/8/2026 at 10:10 a.m. with the Director of Nursing (DON), the DON stated the discharge process begins with the SSD, who coordinates placement, durable medical equipment (DME), and follow-up on the resident's condition after placement. The DON stated the SSD is required to document in progress notes and that emails are part of the extended chart. The DON stated the SSD did not document in the progress notes and that emails were not included in Resident 102's extended chart. The DON stated nursing staff are responsible for initiating and completing three discharge forms: the Discharge Summary (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Report, the Notice of Proposed Transfer and Discharge, and the Post Discharge Plan of Care. The DON stated after reviewing the forms, the Discharge Summary Report lacked the IDT representative and the address of the board and care. The DON stated the Post Discharge Plan of Care was missing the coordination of care, the address of the board and care, Resident 102's address, mental and social status, DME, safety precautions and instructions, and the responsible party. The DON stated the Transfer/Discharge Report did not include the board and care location. The DON stated nursing staff should have contacted the SSD to obtain the name and location of the board and care, and nursing staff are aware they must complete all required elements of the three discharge forms when discharging a resident. The DON stated failing to accurately complete the discharge forms creates a risk as the resident's destination is unclear and the receiving facility may be unable to provide continuity of care. During a review of the facility's policy and procedure (P&P) titled, Discharging the Resident, dated 12/2026, indicated, .The following information should be recorded in the resident's medical record: 1. The date and time the discharge was made. 2. The name and title of the individual(s) who assisted in the discharge.6. The signature and title of the person recording the data. During a review of the facility's policy and procedure (P&P) titled, Discharge Summary and Plan, dated 12/2026, indicated, .The post-discharge plan will be developed by the care planning/interdisciplinary team with the assistance of the resident and his or her family and will include: a. where the individual plans to reside; b. arrangements that have been made for follow-up care and services.A copy of the following will be provided to the resident and receiving facility and a copy will be filed in the resident's medical record:.b. The post-discharge plan; and c. The discharge summary.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately (in a correct or exact manner) complete a smoking and safety assessment (a tool used to measure and interpret information) for one of two sampled residents (Resident 7) reviewed under the Smoking care area. This failure resulted in missing information on the assessment used to determine whether Resident 7 could safely smoke independently or required assistance and supervision. Findings:During a review of Resident 7's Face Sheet, the Face Sheet indicated the facility admitted Resident 7 to the facility on [DATE] with diagnoses (illness or problem) including schizophrenia (a mental illness that is characterized by disturbances in thought), major depression disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), muscle weakness, and difficulty walking. During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated Resident 7 used a walker and has impairment (reduced, weak, or loss of function) to one upper extremity (arm or hand), wore glasses, and has some short-term memory impairment (a problem with the part of memory that temporarily holds information you learned for a few seconds to minutes). During a review of Resident 7's Care Plan Report, the Care Plan (CP) Report indicated a focus dated 3/20/2025, identifying the resident is a smoker who requires supervision during smoking. The CP Report indicated a goal that Resident 7 will be able to smoke according to facility policy and with precautions taken for resident's safety, as well as the safety of others, and the resident will not have smoke-related incidents in the facility through the next assessment. The CP report indicated interventions that included Resident 7 did not require supervision while smoking and has access to matches and lighters.ighters. During a concurrent (done at the same time) interview and record review with the Assistant Director of Nursing (ADON) on 04/09/2026 at 9:41 AM, the ADON reviewed Resident 20's MDS dated [DATE] and stated that Resident 7 has upper extremity impairment to one limb and uses a walker. The ADON reviewed the Smoking and Safety assessment, dated 4/2/2026, and stated that the assessment is incomplete and inaccurate due to missing documentation on assessment items that apply to Resident 7 including limited range of motion (the full, normal distance and direction a joint can move), and issues with balance. The ADON further stated the care plan section of the assessment is blank. The ADON reviewed the Smoker Risk Assessment, completed by the ADON on 3/20/2025 (this form was retired and is no longer available for documenting new assessments. It was replaced by the Smoking and Safety assessment). The ADON stated that the scoring result on the Smoker Risk Assessment, indicated that the resident requires supervision while smoking. The ADON stated that the current smoking assessment does not meet the requirements for a smoking evaluation per the facility's policy. The ADON verbally agreed that the new form Smoking and Safety does not have a clear scoring or indication that a resident may be independent or needs supervision while smoking. During a concurrent interview and record review on 4/9/2026 at 9:41 a.m., with the ADON, the facility's policy and procedure (P&P) titled Smoking Policy- Residents, last reviewed 3/9/2026 was reviewed. The P&P indicated that Resident smoking status is evaluated upon admission. If a resident is a smoker, an evaluation includes current level of tobacco consumption, method of tobacco consumption, desire to quit smoking, and ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation). The ADON stated that the current smoking assessment does not meet the requirements for a smoking evaluation per the facility's policy. The ADON verbally agreed that the new form Smoking and Safety does not have a clear scoring or indication that a resident may be independent or needs supervision while smoking.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive, person-centered care plan (a document designed to facilitate communication among members of the care team that summarizes a resident's health conditions, specific care needs, and current treatments) for one of 19 residents investigated under Care Planning. Specifically, the facility failed to include and address the following in the care plan: a. Vascular Dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, often following a stroke or chronic vessel damage) diagnosis, which requires individualized interventions to address safety, cognition, and supervision needs.b. Eliquis (Apixaban- a prescription oral anticoagulant (blood thinner) that lowers the risk of stroke in people) carrying a Black Box Warning (the highest safety-related warnings that medications can have assigned by the Food and Drug Administration) which require monitoring, safety precautions, and appropriate care planning interventions.These deficient practices had the potential to result in inadequate care coordination, lack of appropriate interventions, and increased risk for adverse outcomes for Resident 23.Findings: During review of Resident 23's admission Record (AR), the admission Record indicated that the facility originally admitted the resident on 3/11/2024 and readmitted on [DATE] with diagnoses that included vascular dementia and long- term use of anticoagulant. During a review of Resident 23's Minimum Data Set (MDS - a resident assessment tool), dated 2/07/2026, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired and the resident required partial/moderate assistance (helper does less than half the effort) with oral hygiene, personal hygiene and substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, lower body dressing, and putting on/taking off footwear. During a concurrent interview and record review on 4/08/2026 at 9:51 a.m., with the Assistant Director of Nursing (ADON) Resident 23`s Care Plans were reviewed. The review indicated that there was no care plan developed for the resident`s medical diagnosis of vascular dementia. The ADON stated that there should be a care plan to focus on the diagnosis of dementia and set a goal for minimizing or resolving the resident`s behavior problem through the implementation of interventions. The ADON stated that without a care plan the resident`s need may not be meet and staff won`t be able to address and manage the resident`s behavior consistently since a care plan serves as a communication tool among the care team. The ADON added that basically they will not be able to provide a person-centered approach to the resident`s behavior problem which could lead to poor management of his dementia diagnosis. Also, the ADON reviewed Resident 23`s order for Eliquis Oral Tablet 2.5 mg (Apixaban) dated 4/14/2025, one tablet by mouth two times a day for atrial fibrillation (a common heart rhythm disorder characterized by rapid, erratic electrical signals causing the upper chambers (atria) to quiver instead of beating effectively). The ADON stated that Eliquis carries a black box warning which should be care planned. The ADON stated that the Care Plan for the use of Eliquis (Apixaban) initiated on 11/01/2025 with a target date of 5/19/2026 did not include interventions such as a warning including premature discontinuation of any oral anticoagulant can increase the risk of thrombotic (medical conditions where blood clots (thrombi) form inside blood vessels, partially or completely blocking the flow of blood) events. The ADON stated it is important that any medication that has a black box warning requires a care plan, to ensure that any serious adverse effects of the medications are known (outlined) so that interventions can be developed to monitor the residents and prevent these adverse effects which can be serious and life-threatening. During a review of the facility`s policy and procedure (PP) titled Care Plans, Comprehensive Person-Centered, last reviewed on 3/9/2026, the policy indicated that Care Plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the relationship between the resident`s problem areas and their causes, and relevant clinical decision making, when possible, the interventions address the underlying source (s) of the problem area (s), not just symptoms or triggers.During a review of the facility`s policy and procedure (PP) titled Black Box Warning, last reviewed on 3/9/2026, the policy indicated that a black box warning on a medication denotes that there is a serious or life-threatening potential side effect associated with that medication.

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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:1. Update and revise a resident`s care plan (CP- a document outlining a detailed, individualized approach to care tailored to a resident's specific needs) to reflect that breakfast should not be left at the bedside until the resident awakens, for one of four sampled residents (Resident 20) reviewed under the Nutrition care area.This deficient practice had the potential to place Resident 20 at risk, as the resident consistently wakes approximately four hours after breakfast is served. Leaving food at the bedside for this duration could promote harmful bacterial growth, increasing the risk of foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals).2. Update and revise a resident's CP to reflect interventions (actions taken to improve a situation or medical condition) for safe smoking practices for one of four sampled residents (Resident 7) reviewed under the Accidents care area.This deficient practice resulted in Resident 7 having incorrect smoking interventions on his care plan, which had the potential to place Resident 7 at risk for injury during smoking.Findings: 1.During a review of Resident 20's Face Sheet, the Face Sheet indicated the facility admitted Resident 20 on 5/31/2024 with diagnoses including chronic obstructive pulmonary disease (COPD- a chronic lung disease that causes difficulty breathing) and peripheral vascular disease (PVD – a progressive narrowing of blood flow to the arms and legs). During a review of Resident 20's History and Physical (H&P – a medical document completed by a healthcare provider that includes a comprehensive overview of the resident's health status and is used to guide diagnosis, treatment, and care planning), dated 6/30/2025, the H&P indicated Resident 20 had the capacity to understand and make decisions. During a review of Resident 20's Minimum Data Set (MDS – a resident assessment tool), dated 6/30/2025, the MDS indicated Resident 20 was able to understand others and was usually understood by others. The MDS further indicated Resident 20 required setup/clean-up assistance (helper sets up/cleans up; resident completes the activity), and partial assistance (helper does less than half the effort) with oral and personal hygiene. During a concurrent initial pool observation and interview on 4/6/2026 at 8:08 a.m., in Resident 20's room, Resident 1 was asleep in bed. A breakfast tray was observed on the bedside table next to Resident 20 and had not been eaten. Resident 20 woke up briefly and stated not to touch her food tray, as she prefers to eat after waking. Resident 20 stated she (Resident 20) typically wakes up and eats around 11:00 a.m. to 11:30 a.m. daily. During a review of Resident 20's CP titled, Resident Non-compliance manifested by: patient likes to sleep in late, therefore meal trays left on table until she wakes up per resident request, initiated on 3/26/2025. The CP did not include alternative interventions to leaving the food tray at the bedside. During an observation on 4/6/2026 at 10:27 a.m., in Resident 20's room, the breakfast tray remained next to Resident 20 and was still untouched. During a concurrent observation and interview on 4/6/2026, at 11:48 a.m., with Resident 20, in Resident 20's room, Resident 20 was observed sitting in a wheelchair and eating from the same breakfast tray that had been left at the bedside. Approximately 75% of the meal had been consumed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 20 stated she did not request the meal to be replaced or reheated. Resident 20 stated that she prefers to sleep in and does not want her meal to be reheated or replaced. During a concurrent observation and interview on 4/6/2026, at 11:55 a.m., in Resident 20's room, with Certified Nursing Assistant (CNA 1), CNA 1 stated that staff leave the meal tray at the bedside per the resident's request. CNA 1 stated the tray was not removed, replaced, or reheated. CNA 1 stated there is a risk of foodborne illness when food is left out but that they leave it so the resident would not complain or get upset. During an interview on 4/6/2026 at 1:22 p.m. with the Dietary Supervisor (DS), the DS stated that facility policy requires meal trays not be left out for more than two (2) hours after delivery for safety. The DS further stated that Resident 20's tray should have been removed sooner. During a concurrent interview and record review on 4/9/2025 at 1:37 p.m., with the Assistant Director of Nursing (ADON), Resident 20's Non-compliance CP, initiated on 3/26/2025 was reviewed. The ADON stated the CP should have been updated with specific interventions such as leaving in the kitchen refrigerator and reheating the food when Resident 20 wakes up be to prevent potential contamination and foodborne illness. The ADON further stated the meal tray should have been removed by staff after two hours and not left at the bedside for over four hours. During a review of the facility's Policy and Procedure, (P&P) titled Meal Service last reviewed on 3/9/2026, the P&P indicated meal trays delivered to resident rooms must be removed within 2 hours of delivery to ensure food safety. If a resident is unavailable or chooses to eat later, the tray will still be removed within this timeframe, and an alternate meal or reheated tray will be provided upon request. During a review of the facility's P&P titled Care Plans, Comprehensive Person-Centered last reviewed on 3/9/2026, the P&P indicated the facility must develop a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet each resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The P&P further indicated assessments of residents are ongoing and care plans are revised as information about the residents. 2. During a record review of Resident 7's Face Sheet, the Face sheet indicated the facility admitted Resident 7 to the facility on [DATE] with diagnoses (illness or problem) including schizophrenia (a mental illness that is characterized by disturbances in thought), major depression disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), muscle weakness, and difficulty walking. During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated Resident 7 used a walker and has impairment (reduced, weak, or loss of function) to one upper extremity (arm or hand), wore glasses, and has some short-term memory impairment (a problem with the part of memory that temporarily holds information you learned for a few seconds to minutes). During a review of Resident 7's Care Plan Report, the Care Plan (CP) Report indicated a focus dated 3/20/2025, identifying the resident is a smoker who requires supervision during smoking. The CP Report indicated a goal that Resident 7 will be able to smoke according to facility policy and with precautions taken for resident's safety, as well as the safety of others, and the resident will not have smoke-related incidents in the facility through the next assessment. The CP report indicated (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions that included Resident 7 did not require supervision while smoking and has access to matches and lighters. During a concurrent interview and record review on 04/09/2026 at 9:41 a.m. with the Assistant Director of Nursing (ADON), Resident 7's care plan dated 3/20/25, was reviewed. The care plan indicated that while the focus of the care plan is requires supervision while smoking, the interventions indicated are needs no supervision while smoking and has access to matches and lighters. The ADON stated that the focus and interventions of the care plan are in conflict and care plan was not revised to reflect accurate interventions. During a review of the facility's policy and procedure titled Care Plans, Comprehensive Person-Centered, last reviewed on 3/9/2026, the P&P indicated that a comprehensive and person-centered care plan is developed for each resident. The P&P also indicated that care plans are updated upon a significant change in a resident's condition, when a desired outcome is not met, upon readmission to the facility, and at least quarterly.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident with visual impairment was provided with assistive devices to help one of one sampled resident communicate his needs to the care team (Resident 93) investigated under the care area Vision and Hearing. This deficient practice had the potential to result in frustration and unmet needs if the resident is unable to express his care needs.Findings:During a review of Resident 93's admission Record, the admission Record indicated the facility originally admitted the resident on 1/9/2015 and readmitted on [DATE] with diagnosis including dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and blepharitis (a common, chronic inflammation of the eyelids, often caused by bacterial overgrowth, clogged oil glands, or skin conditions like rosacea, leading to red, itchy, flaky, and crusty eyelids). During a review of Resident 93's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 1/06/2026, the MDS indicated the resident had the ability to make self-understood and the ability to usually understand others. The MDS indicated that Resident 93 required substantial/maximal assistance (helper does more than half the effort) for eating, oral hygiene, upper body dressing, personal hygiene and dependent (helper does all the effort) on staff for toileting hygiene, shower, lower body dressing and putting on/taking off footwear.During a concurrent observation and interview on 04/06/2026 at 1:10 p.m., with Registered Nurse 1 (RN 1), in Resident 93`s room, Resident 93 was in bed awake but did not reply when spoken to. RN 1 looked around the resident`s room, and asked permission from the resident if she could look at his bedside table (plastic table) for a communication board. There was no communication board found. RN 1 stated that the resident has a communication deficit and would be able to use a communication board to help him express his needs and facilitate communication. RN 1 stated that it would be frustrating for the resident if he is unable to be understood by the staff and the staff also won't be able to provide the right intervention due to the resident`s impaired vision and communication deficit.During a review of the facility`s policy and procedure (PP) titled Visually Impaired Resident, Care of, last reviewed on 3/9/2026, the PP indicated that Residents with visual impairment will be assisted with activities of daily living as appropriate.assistive devices to maintain vision include glasses, contact lenses, magnifying lens and any other device used by the resident to assist with visual impairment.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure a resident's low air loss mattress (LALM - designed to distribute a patient's body weight over a broad surface area and help prevent skin breakdown) was set to the resident's weight per physician`s order for one (Resident 54) of two sampled residents investigated for pressure ulcer/injury (a skin and soft tissue injury that occurs when skin is under pressure).This deficient practice placed the resident at risk of discomfort and development of new pressure ulcers.Findings:During a review of Resident 54's admission Record, the admission Record indicated the facility admitted the resident on 3/24/2026 with diagnoses including depression (a common, serious mood disorder characterized by persistent sadness, loss of interest in activities, and low energy) and sepsis (a life-threatening complication of an infection).During a review of Resident 54's History and Physical (H&P) dated 3/25/2026, the H&P indicated that the resident is alert and oriented x 2 (indicates a patient is awake and aware of their identity [person] and surroundings [place] but disoriented to time [date/year] or situation) with fluctuating capacity (is the varying ability of an individual to make specific decisions over time, often due to conditions like dementia, brain injury, or mental illness. A person may have capacity at one moment but lack it later, requiring assessments to be timed for when the individual is most lucid).During a concurrent interview and record review on 4/08/2026 at 2:32 p.m., with the Assistant Director of Nursing (ADON), Resident 54`s physician orders were reviewed. The physician`s orders included an order for a Low Air Loss Mattress (LALM) for wound care management with setting according to weight at 92 pounds (lbs.). The ADON stated that the order for low air loss mattress is part of the wound management and the LALM should be set according to the doctor`s order which is to set at 92 lbs. During a concurrent observation and interview on 4/08/2026 at 2:42 p.m., with the ADON, in Resident 54`s room, Resident 54's LALM mattress setting was set at 120 lbs. The ADON stated that the setting is not accurate according to the physician's order which indicated to set at 92 lbs. The ADON stated that the higher the setting, the firmer the mattress is and this higher setting could potentially lead to skin impairment for Resident 54.During a review of the facility`s policy and procedure titled Pressure-Reducing Mattress, last reviewed on 3/9/2026, the policy indicated an objective that the facility will provide mattresses that will prevent and/or minimize pressure on the skin.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to provide appropriate continence care and interventions for one of five sampled patients (Resident 98). This deficient practice had the potential to result in a decline from continence to incontinence, increased skin breakdown and pressure injuries, compromised dignity and quality of life and an increase in urinary tract infections.Findings:During a review of Resident 98's Face Sheet, the Face Sheet indicated the facility admitted Resident 98 on 12/20/2022 with diagnoses including multiple sclerosis (MS, a chronic progressive disease involving damage to the nerve cells in the brain and spinal cord), type 2 diabetes mellitus (DM II, body does not use insulin properly, causing sugar to build up in the blood instead of being used for energy), polyneuropathy (many nerves in the body are damaged, causing numbness, tingling, or weakness, usually in the hands and feet), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and hyperlipidemia (condition where there is too much fat in the blood, which can increase the risk of heart disease). During a review of Resident 98's History and Physical (H&P), dated 12/4/2025, the H & P indicated Resident 98 has the capacity to understand and make decisions. During a concurrent interview and record review on 4/6/2026 at 12:00 p.m. with Registered Nurse (RN) 1, RN 1 reviewed a physician order for PureWick (an innovative system that is intended for non-invasive urine output) dated 1/2/2026 for Resident 98. RN 1 stated the facility did not enter the physician's order into the electronic medical record (EMR). RN 1 stated there was no documentation in the Nursing Notes from the RN Supervisor or nursing staff indicating the PureWick order was carried out, and no documentation indicating the physician was informed that the order was not implemented. RN 1 stated that carrying out physician orders ensures safe, effective, and legally compliant patient care.During an interview on 4/8/2026 at 10:10 a.m. with the Director of Nursing (DON), the DON stated she did not carry out the physician's order for the PureWick device for Resident 98. The DON stated Resident 98 would need to be able to use the PureWick independently. The DON stated the device was not appropriate for Resident 98 because he was unable to use the device. The DON stated the Certified Nurse Assistants (CNAs) already spent too much time providing care for Resident 98. The DON stated Resident 98 was bedbound, required maximum assistance with Activities of Daily Living (ADLs), and was unable to use his left arm. The DON stated Resident 98 currently used a hand held urinal, but the urine overflowed onto his abdomen and thigh. The DON stated there were no other urinal options available for Resident 98.During a review of the facility's policy and procedure (P&P) titled, Urinary Continence and Incontinence- Assessment and Management, 8/2022, the policy indicated, .Physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections.As part of the initial and ongoing assessments, the nursing staff and physician will screen for information related to urinary continence.Relevant information related to urinary continence includes:.b. previous treatment/management attempts and response to interventions.c. pertinent diagnoses, including congestive heart failure, stroke, diabetes mellitus, obesity, neurological disorders (Parkinson's disease, multiple sclerosis).e. functional and/or cognitive capabilities or limitations that could affect continence, including.impaired mobility, decreased manual dexterity, decreased upper and lower extremity muscle strength, impaired vision, and pain with movement f. additional information such as the type and frequency of physical assistance necessary for the resident to access the toilet, commode, or urinal, and the scope of prompting needed to encourage urination.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure the enteral feeding (a feeding tube that provides liquid nutrition directly into the stomach) was properly labeled for medication and solution and failed to administer timely prescribed enteral feeding for one of five sample residents (Resident 8).This deficient practice had the potential to result in administering the wrong formula or contaminated fluid, placing patients at risk for gastrointestinal infection (inflammation or irritation of the digestive tract), fluid imbalance (body has either too much or too little fluid for proper function) or aspiration (accidental inhalation of food, liquids, or saliva into the lungs) for Resident 8.Findings:During a review of Resident 8's Face Sheet, the Face Sheet indicated the facility admitted Resident 8 on 3/11/2025 with diagnoses including cerebral palsy (condition that affects how a person moves, balances, and controls their muscles), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional high), schizophrenia (a mental illness that is characterized by disturbances in thought), hypotension (low blood pressure), and hypothyroidism (condition where the thyroid gland [a small gland in the neck] does not make enough hormones and causes the body to slow down). During a review of Resident 8's History and Physical (H&P), dated 3/12/2026, the H & P indicated Resident 8 is alert, but was not oriented and had significant cognitive impairment and lacked capacity to make independent medical decisions (Medical decision-making is deferred to the designated healthcare and does not have the capacity to understand and make decisions).a. During a concurrent interview and record review on 4/7/2026 at 9:25 a.m. with RN 1, RN 1 stated the physician's order dated 2/18/2026 indicated to administer Enteral Feed Order Glucerna 1.2, at 65 cubic centimeter (cc, unit of measurement) per hour for 20 hours via feeding pump (medical machine that slowly and safely pushes liquid food or fluids into the body through a tube) to provide 1300cc and 1560 kilocalorie (kcal, unit of measurement) per day. The physician's order indicated staff to turn off the enteral feeding at 8:00 a.m. and turn-on at 12:00 p.m. or until desired dose is finished. RN 1 reviewed the Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) and stated the feeding started at 4:13 p.m., not at 12:00 p.m., as ordered. RN 1 stated the label must include the date and time of feeding, the name, amount, and type of feeding, the rate of feeding, and the initials of the licensed staff who prepared the feeding. RN 1 stated an incorrect label can result in administering the wrong feeding or incorrect rate or amount, which places the resident at risk for fluid imbalance.During an observation and interview on 4/7/2026 at 10:00 a.m. with LVN 3 and LVN 4, LVN 3 stated she was assigned to Resident 8 on 4/6/2026 and did not start the enteral feeding at 12:00 p.m. as ordered. LVN 3 and LVN 4 reviewed the enteral feeding label and stated the date should read 4/6/2026, not 4/7/2026. Both LVN's stated LVN 3's initials were missing, the amount of enteral feeding was not documented, and the end time was not written on the label. LVN 3 and LVN 4 stated an inaccurate label places Resident 8 at risk for fluid overload, high blood pressure, and breathing problems. LVN 3 and LVN 4 stated accurate labeling ensures the correct resident receives the correct formula safely and on time.During a concurrent interview and record review on 4/8/2026 at 11:30 a.m. with the Director of Nursing (DON), the DON stated the licensed nurses should adhere to the facility's policy, Enteral Tube Feeding via Continuous Pump when a physician writes an order for enteral feeding. The DON stated licensed nurses are not required to document the start and end times for enteral feeding on a medication label. The DON stated licensed staff received training on how to complete a medication label, which includes documenting the resident's name, the rate per hour, the time the bottle is changed (not the time the enteral feeding begins), and the initials of the licensed staff. The DON stated documentation on the medication label prevents serious errors, such as aspiration, by ensuring the rate is documented and by confirming accountability through staff initials. The DON stated the if any required element is (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	missing, the enteral feeding may be unsafe to use.During a review of the facility's policy and procedure (P&P) titled, Enteral Tube Feeding via Continuous Pump, 3/2023, indicated, .On the formula label document initials, date and time the formula was hung/administered, and initial that the label was checked against the order . During a review of the facility's policy and procedure (P&P) titled, Continuous Infusion of Medications and Solutions, 3/2023, indicated, .Label medication/solution container and administration set with: 1. Date and time 2. Nurse's initials . b. During a concurrent observation and interview on 4/7/2026 at 9:17 a.m. with Registered Nurse (RN) 1 in Resident 8's room, RN 1 assessed Resident 8's gastrostomy tube (g-tube, soft tube that goes directly into the stomach through the belly to give food, liquids, and medicine to someone who cannot eat or swallow safely). The g-tube site had a dry four-by-four gauze (soft, this piece of cloth to cover and protect wounds) in place, and the site showed no signs of infection (no foul odor, no warm-to-touch skin, and no drainage of blood). Resident 8 was not receiving enteral feedings via the g-tube. During a concurrent interview and record review on 4/7/2026 at 9:25 a.m. with RN 1, RN 1 stated the physician's order, dated 2/18/2026, indicated to administer Enteral Feed Order (Glucerna 1.2), at 65 cubic centimeter (cc, unit of measurement) per hour for 20 hours via feeding pump (medical machine that slowly and safely pushes liquid food or fluids into the body through a tube) to provide 1300cc /1560 kilocalorie (kcal, unit of measurement) per day. The physician's order indicated to turn off the enteral feeding at 8:00 a.m. and turn on at 12:00 p.m. or until desired dose is finished. RN 1 reviewed the Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) and stated the feeding started at 4:13 p.m., not at 12:00 p.m., as ordered. RN 1 stated starting g-tube enteral feedings on time per the physician's order is important to ensure Resident 8 receives adequate calories to prevent weight loss and to avoid overfeeding or underfeeding. During an observation and interview on 4/7/2026 at 10:00 a.m. with LVN 3 and LVN 4, LVN 3 stated she was assigned to Resident 8 and did not start the enteral feeding at 12:00 p.m. as ordered. LVN 4 stated he was aware the enteral feeding did not start at 12:00 p.m. LVN 4 stated he paused the enteral feeding at 9:30 a.m. with 500cc remaining. LVN 3 and LVN 4 stated that starting enteral feedings on time, per the physician's order, is important to ensure Resident 8 receives the required daily calories, maintains her weight, prevents muscle loss, and supports her healing.During a concurrent interview and record review on 4/8/2026 at 11:30 a.m. with the Director of Nursing (DON), the DON stated the licensed nurses should adhere to the facility's policy, Enteral Tube Feeding via Continuous Pump when a physician writes an order for enteral feeding. The DON stated the licensed nurses are not required to document start, end, and pause for enteral feeding. The DON stated licensed nurses should document when an enteral feeding is delayed in addition notifying physician and family representative, during shift huddle. The DON stated licensed nurses should adhere to the physician's order for Resident 8 to ensure the resident receives calories, otherwise Resident 8 can experience weight and muscle loss, and may experience fluid overload which can lead to cardiac issues.During a review of the facility's policy and procedure (P&P) titled, Enteral Tube Feeding via Continuous Pump, 3/2023, indicated, The person performing this procedure should record the following information in the resident's medical record: 1. The date and time the procedure was performed.3. Amount and type of enteral feeding. 4. The average fluid intake per day. 5. The name and title of the individual(s) who performed the procedure.Report complications.promptly to the supervisor and the attending physician.Report other information in accordance with facility policy and professional standards of practice. During a review of the facility's policy and procedure (P&P) titled, Continuous Infusion of Medications and Solutions, 3/2023, indicated, .Verify physician order .Documentation in the medical record includes, but is not limited to: 1. Date and time.3. Medication/Solution, 4. Rate of Infusion.6. Complications and interventions.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 31), who required hemodialysis (HD or dialysis, a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) treatment, received care in accordance with standards of practice by failing to: Update a resident's care plan for hemodialysis to address a resident's repeatedly elevated blood creatinine (a waste product from muscle metabolism, filtered from the blood by the kidneys, normal reference range is 0.73 to 1.30 milligrams per deciliter [mg/dL, a unit of measure for kidney function]) blood laboratory (labs) level. Ensure there was information exchanged between the facility and the hemodialysis center when the Resident 31's creatinine was elevated. This deficient practice had the potential for Resident 31 to have unidentified complications after dialysis treatment such as fatigue, swelling (edema) in legs/feet, and confusion. Findings: During a review of Resident 31's Face Sheet (a page with information indicated for a resident such as facility admission date and pertinent diagnoses), the Face Sheet indicated the facility admitted the resident to the facility on 3/29/2014 and re-admitted on [DATE] diagnoses that included end stage renal disease (ESRD, irreversible kidney failure). During a review of Resident 31's Minimum Data Set (MDS, a resident assessment tool), dated 1/14/2026, the MDS indicated Resident 31 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. The MDS indicated Resident 31 required setup assistance (helper sets up; resident completes the activity) with eating. The MDS indicated Resident 31 receives hemodialysis. During a review of Resident 31's Physician's Orders, dated 3/04/2026, the orders indicated an order for dialysis treatments Monday, Wednesday, Friday chair time (the time the resident is to be getting dialysis treatment): 9 a.m. During a review of Resident 31's Care Plan for Weight Variance, initiated 6/28/2026, the care plan indicated Resident 31 has a potential for weight variance expected due to fluid retention secondary to ESRD/HD. The care plan indicated a goal that Resident 31 will not have unrecognized signs and symptoms of fluid overload (a condition where excessive water and sodium accumulate in the body often causing rapid weight gain, edema, and shortness of breath due to fluid in the lungs) or dehydration (occurs when the body loses more fluids than it takes in). The care plan indicated the intervention copy of monthly labs from dialysis center. During a review of Resident 31's Care Plan for Chronic Anemia (a chronic condition where the body does not have enough healthy red blood cells), initiated 6/28/2023, indicated Resident 31 is at risk for chronic anemia. One of the goals is that Resident 31 will have a hemoglobin greater than or equal to (ˆ) 11 milligrams per 100 deciliters (ml/dL, a unit of measure for hemoglobin, reference range 13.7 mg/dL to 17.5 mg/dL). The care plan indicated interventions including communicating with the dialysis center as indicated and notify physician and responsible party of change in condition (COC, a change from a resident's normal functioning). During a review of the facility's Laboratory Values, dated 2/19/2026, the Laboratory Values indicated a creatinine level of 4.70 mg/dL. During a review of the dialysis center's Laboratory Values, the Laboratory Values indicated the following: 3/2/2026 creatinine = 7.39 mg/dL 4/1/2026 creatinine = 7.29 mg/dL During a concurrent interview and record review with Registered Nurse 1 (RN 1) on 4/9/2026 at 8:51 a.m., Registered Nurse 1 (RN 1) reviewed Resident 31's labs which indicated the facility labs in which the creatinine was elevated at 4.70 mg/dL on 2/19/2026. When asked what Resident 31's current creatinine level was, RN 1 searched and was unable to find current kidney function laboratory values. RN 1 stated the dialysis center takes labs in addition to the facility's lab draws. RN 1 called the dialysis center to obtain Resident 31's labs taken after 2/19/2026. RN 1 stated the licensed nurses should have called the dialysis center to obtain labs taken regarding kidney function after 2/19/2026 to see if Resident 31's creatinine level taken 2/19/2026 was decreased. RN 1 stated the licensed nurses should have had a conversation with or made a recommendation to Resident 31's physician for (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions due to an elevated creatinine. RN 1 stated Resident 31's care plan for dialysis should have a resident-centered goal range for Resident 31's creatinine and what interventions to conduct when the creatinine is outside that range. RN 1 stated Resident 31's physician should have been notified of Resident 31's elevated creatinine but the dialysis center did not communicate those labs to the facility. As a result, the facility's licensed nurses were unaware of Resident 31's elevated creatinine. During an interview with the Director of Nurses (DON) on 4/09/2026 at 1:29 p.m., the DON stated Resident 31's care plan should have a goal to maintain blood laboratory values in the appropriate range specific Resident 31 because his goals may be different than someone with normal renal function. The DON stated if the blood labs do not fall within that resident-specific range, the resident may need additional dialysis if the doctor decides it is needed. The DON stated that having a specific goal for Resident 31's creatinine is important to maintain his well-being and provide appropriate care for that resident. During a review of the facility's policy and procedure titled, End-Stage Renal Disease, Care of a Resident with, last reviewed 3/09/2026, indicated the following: Agreements between this facility and the contracted end stage renal disease (ESRD) facility include all aspects of how the resident's care will be managed, including but not limited to: a. How the care plan will be developed and implemented; b. How transportation will be arranged; c. How information will be exchanged between the facilities; d. The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care. During a review of the facility's policy and procedure tilted, Care Plans, Comprehensive Person-Centered, last reviewed 3/09/2026, indicated the following: The comprehensive, person-centered care plan: a. Includes measurable objectives and timeframes; b. Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c. Includes the resident's stated goals upon admission and desired outcomes; d. Builds on the resident's strengths; and e. Reflects currently recognized standards of practice for problem areas and conditions.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review the facility failed to ensure residents were free from significant medication errors by failing to rotate (a method to ensure repeated injections are not administered in the same area) insulin (a medication that helps regulate blood sugar levels) injections sites on multiple occasions between 2/4/2026 and 4/5/2026 for one of five sampled residents (Residents 85) investigated under the care area of unnecessary medications.This failure had the potential to result in bruising, pain, and/or lipodystrophy (a buildup or abnormal distribution of fatty tissue under skin) for Resident 85. Findings:During a review of Resident 85's Face Sheet, the Face Sheet indicated the facility admitted Resident 85 on 1/26/2026 with diagnoses that included but not limited to type 2 diabetes mellitus (DM - a chronic medical condition where the body cannot use insulin properly and eventually fails to produce enough insulin, leading to high blood sugar levels) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 85's Minimum Data Set (MDS- a resident assessment tool), dated 2/1/2026, the MDS indicated Resident 85 had the capacity to usually make herself understood and sometimes understand others. The MDS further indicated Resident 85 was dependent (helper does all the effort) on facility staff for toileting, dressing, bathing and personal hygiene. The MDS indicated Resident 85 was receiving a high-risk medication class, hypoglycemic agents (medications used to help lower blood sugar levels).During a review of Resident 85's Order Summary Report, printed on 4/4/2026, the Order Summary Report indicated an order dated 2/28/2026 for:- Insulin Lispro Injection Solution (a rapid acting insulin used to treat DM by controlling high blood sugar) 100 units per milliliters (unit/ml - a unit of liquid volume) inject per sliding scale (dose based on the blood sugar reading) subcutaneously (SQ - into the fatty layer under the skin) before meals and at bedtime. Rotate sites.During a review of Resident 85's Medication Administration Record (MAR - a legal document used in healthcare settings to track, record, and verify all medications given to a resident) from 2/4/2026 through 4/5/2026, the MAR indicated Insulin Lispro was administered as follows without consistent rotation of injection sites. 2/4/2026 - abdomen - right upper quadrant (RUQ) 2/5/2026 - abdomen - RUQ 2/8/2026 - abdomen - left upper quadrant (LUQ) 2/9/2026 - abdomen - LUQ 2/10/2026 - abdomen - RUQ 2/11/2026 - abdomen - RUQ 2/20/2026 - abdomen - left lower quadrant (LLQ) 2/21/2026 - abdomen - LLQ 2/23/2026 - abdomen - RUQ 2/24/2026 - abdomen - RUQ 3/22/2026 - abdomen - LLQ 3/23/2026 - abdomen - LLQ 3/27/2026 - abdomen - right lower quadrant (RLQ) 3/29/2026 - abdomen - RLQ 4/1/2026 - abdomen - RUQ 4/2/2026 - abdomen - RUQ 4/4/2026 - abdomen - RUQ 4/5/2026 - abdomen - RUQDuring a review of Resident 85's DM Care Plan (CP), the CP indicated an intervention for medication administration as ordered.During a concurrent interview and record review on 4/9/2025, at 11:27 a.m., with the Assistant Director of Nursing (ADON), Resident 85's MAR from 2/4/2026 through 4/5/2026 was reviewed. The ADON stated there were multiple instances in which insulin injection sites were not rotated. The ADON stated insulin administration sites should be rotated to prevent damage to the resident's skin tissue. The ADON further stated that failure to follow the physician's order to rotate insulin injection sites constituted medication errors.During a review of the facility's policy and procedure (P&P) titled, Administering Medications, last reviewed on 3/9/2026, the P&P indicated to administer medication in accordance with prescriber's orders.During a review of the facility provided Food and Drug Administration Label (FDA Label - primary tool for communicating drug information) for Insulin Lispro, undated, the FDA Label indicated to rotate injection sites to reduce the risk of lipodystrophy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055142	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Gardens Convalescent Hospital	17922 San Fernando Mission Rd Granada Hills, CA 91344

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide at least 80 square (sq.) feet (ft) per resident for 26 of 40 multiple resident rooms (room [ROOM NUMBER], 103, 105, 106,107,108,109, 110,111, 112,114, 115, 116,117,118,119, 120,123, 126,133,136,137,138, 139,140,141) This deficient practice had the potential to result in inadequate space to provide safe nursing care and privacy for the residents. Findings: During the recertification survey from 4/06/2026 to 4/09/2026 the residents residing in the rooms with an application for room variance were observed with sufficient amount of space for residents to move freely inside the rooms. There was adequate room for the operation and use of wheelchairs, walkers, or canes. The room variance did not affect the care and services provided by nursing staff for the residents. The Administrator submitted an application for the Room Variance Waiver, dated 4/06/2026, for 26 residents' rooms. The room waiver request indicated the following: Room No. Room Sq. Ft Bed Capacity Sq. Ft per Resident 101 156 2 78 103 156 2 78 105 156 2 78 106 156 2 78 107 156 2 78 108 156 2 78 109 316 4 79 110 156 2 78 111 156 2 78 112 156 2 78 114 156 2 78 115 288 4 72 116 156 2 78 117 156 2 78 118 156 2 78 119 157 2 78.5 120 312 4 78 123 311 4 77.75 126 226 3 75.33 133 313 4 78.25 136 313 4 78.25 137 313 4 78.25 138 313 4 78.25 139 313 4 78.25 140 155 2 77.5 141 158 2 79 The minimum requirement for a 2-bed room should be at least 160 sq. ft. The minimum requirement for 4 -bed room should be at least 360 sq. ft. During a review of the room waiver letter dated 4/06/2026, the letter indicated, The rooms are in accordance with the special needs of the resident and would not have an adverse effect on the resident health and safety or impede the ability of any resident in the rooms to attain his or her highest practicable well-being. Each room has adequate space for each patient with his/her own closet space, over bed table and nightstand. Cubicle curtains are hung at each bedside, giving each patient privacy when pulled closed. The rooms are also equipped with a call light for each patient. There is adequate space for moving around in the rooms for both ambulatory and non-ambulatory patients and adequate space for wheelchair accessibility and medication carts to provide care. During a resident council group interview on 4/07/2026 at 10:40 a.m. residents stated they do not have any problem physically getting around their room. The residents stated their nurses were able to provide them with good care and privacy. During multiple room observations conducted in Rooms 101, 103, 105, 110, 112, 115, 117, 119 and 141 from 4/06/2026 to 4/07/2026, between the hours of 7:30 a.m. - 9 a.m., it was observed the that nursing staff had adequate space to provide care to the residents, and that each resident was provided privacy curtains for privacy; and the rooms had two modes of egress, one with direct access to the corridors and another leading to the outside of the building. During a review of the facility's policy and procedure titled, Bedrooms, last reviewed 3/09/2026, the policy and procedure indicated: All residents are provided with clean, comfortable and safe bedrooms that meet federal and state requirements . Bedrooms measure at least measure at least 80 square feet of space per resident in double resident bedrooms, and at least 100 square feet of space in a single resident room.