STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055163	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montecito Heights Healthcare & Wellness Centre, LP	4585 N. Figueroa St. Los Angeles, CA 90065

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage and distribution practices, by failing to:Ensure food in refrigerators and dry storage were labeled and dated.Ensure food beyond expiration dates was discarded.Ensure potentially hazardous foods were not stored above ready-to-eat foods.Ensure milk that was stored within the temperature danger zone (a range of temperatures, 41-135 degrees Fahrenheit [F], where harmful bacteria can multiply rapidly) was not served to residents.Ensure unlabeled and expired food was not kept in the resident refrigerator. These deficient practices had the potential to result in harmful bacterial growth that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or toxins) in all residents who received food from the facility kitchen.Findings: 1. During an observation of the facility's kitchen on 6/22/26 at 7:58 AM in the reach-in refrigerator, an opened translucent plastic gallon jug of milk, approximately 2/3 full was observed with no open date. During continued observation in the reach-in refrigerator, a 32oz plastic tub of chopped garlic in water, approximately 3/4 full had no open date. During continued observation in the reach-in refrigerator, a small, resealable, translucent plastic food storage bag containing 2 slices of brown bread had no label or date.During an observation of the facility's kitchen on 6/22/26 at 8:08 AM in the walk-in refrigerator, a large, white, plastic tub labeled Onions R/Y/W containing eight onions, had no received or use by date. During continued observation in the walk-in refrigerator, a large, white, plastic tub labeled Coleslaw with a receive date of 6/12/26 and use by date 6/24/26, contained a translucent plastic bag with one bunch of celery inside with no receive or use by date. During continued observation in the walk-in refrigerator a large, grey, plastic tub contained 25 individually sealed, four-ounce plastic cups of orange juice with no label or date on the tub nor use by dates on the individual cups. During a concurrent observation of a sign posted on the walk-in refrigerator door, it reads Everything in the cooler must have: Receive Date, Open Date, Expire Date.During an interview with the Registered Dietitian (RD) on 6/23/26 at 2:00 PM, the RD stated that lack of labeling and dating risked expired food would be served to residents and that could promote foodborne illness. During a document review of the facility's policies and procedures (P&P) titled Food Storage and Handling dated 06/04/24, in the P&P indicated that all items would be correctly labeled and dated for the purpose of properly storing food to avoid foodborne illnesses.During a document review of the 2022 FDA Food Code section 3-501.17(B) indicates that ready-to-eat time/temperature control for safety food shall be clearly marked at the time the container is opened to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded. 2. During an observation of the facility's kitchen on 6/22/26 at 8:14 AM in the walk-in refrigerator, a large cardboard box labeled received 6/11/26, use by 6/18/26 was filled with green zucchini squash which appeared bruised, covered with black spots, and had white and grey-colored fuzzy growth. During continued observation in the walk-in refrigerator, a rack holding a tray labeled Sandwich Bread with a receive date of 6/2/26 and a use by date of 6/16/26 held seven translucent bags of brown loaves of bread.During an observation of the facility's kitchen on 6/22/26 at 8:25 AM in the dry storage area, an unsealed, (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	translucent plastic bag labeled [NAME] Krispy had a use by date of 11/25/25. During continued observation in the dry storage area, an unopened bag of dry rice cereal had a manufacturer printed best by date of 3/23/26. During continued observation in the dry storage area, a translucent plastic jug of paprika was labeled with a use by date of 9/27/25. During continued observation in the dry storage area, a sealed, translucent plastic bag labeled Chow Mein Noodles was dated use by 6/6/26.During an interview with the RD on 6/23/26 at 2:00 PM, the RD stated that expired and moldy foods had to be discarded due to the risk of promoting foodborne illness to residents including potential gastrointestinal issues (referring to the stomach and the intestines) including diarrhea, nausea, vomiting, and potentially leading to hospitalizations among residents at the facility. During a document review of the facility's P&P titled Food Storage and Handling dated 06/04/24, the P&P indicated that fresh vegetables had to be checked and sorted for ripeness, dry goods to rotate stock, all food items to be labeled and dated.3. During an observation of the facility's kitchen on 6/22/26 at 8:01 AM in the reach-in refrigerator, a shallow metal pan, loosely covered and unsealed with a sheet of aluminum foil, filled with raw chicken marinating in spices and a brown-colored liquid, was resting on top of two cardboard boxes, one labeled oven roasted sliced turkey breast and the other labeled fully cooked sliced bacon.During an interview with RD on 6/23/26 at 2:00 PM, the RD stated that placing raw foods on top of ready-to-eat foods was a risk for cross-contamination which promoted the risk of foodborne illness among residents at the facility.During a document review of the facility's P&P titled Food Storage and Handling dated 06/04/24, the P&P indicated that raw poultry should be stored following a top to bottom order hierarchy as follows:[top] ready to eat foodseafoodwhole cuts of beef and porkground meats and fish[bottom] whole and ground poultry During a review of the 2022 FDA Food Code section 3-302.11, the FDA Food Code indicated that food had to be protected from cross contamination by cooked ready-to-eat food. During a review of the 2022 FDA Food Code, Annex 3 section 3-302., the FDA Food Code indicated that separating different types of raw animal foods from one another during storage, preparation, holding and display would prevent cross-contamination from one to the other. The required separation was based on a succession of cooking temperatures based on thermal destruction data and anticipated microbial load. 4. During an observation of the facility's kitchen on 6/22/26 at 7:59 AM, the reach-in refrigerator was observed to have a digital display in the upper left corner of the unit which read 35 F. During continued observation, an analog (non-digital) thermometer placed inside the unit read 60 F. During a concurrent review of a document titled Refrigerator/Reach-in Temperature Log posted on the refrigerator door, the recorded temperature for 6/22/26 was 34 F.During a follow-up visit to kitchen on 6/22/26 at 11:00 AM, Dietary Aide (DA1) was observed standing at a food preparation table adjacent to the reach-in refrigerator filling individual cups of milk in preparation for lunch service, after which DA1 placed the milk back into the reach-in refrigerator. During continued observation, the reach-in refrigerator's external thermometer read 39 F and the internal thermometer read 58 F. During a concurrent interview and observation with the Dietary Supervisor (DS), the DS stated the internal thermometer was broken, that the external digital thermometer measurement was the one kitchen staff documented and abided by, the DS then removed the internal thermometer. Upon request, the DS poured out a cup of milk from an unopened gallon jug, the temperature of the milk was taken and measured at 57.5 F using a probe thermometer (a tool featuring a pointed metal stem that is inserted directly into food to measure its internal temperature).During an observation in the kitchen on 6/22/26 at 11:40 AM, the DS was observed pouring milk from a gallon jug into a food processor to puree potatoes in preparation for lunch service.During an observation in the kitchen on 6/22/26 at 11:45 AM, the Maintenance Supervisor (MS) arrived in the kitchen with another analog thermometer that MS placed inside the reach-in refrigerator. Upon request, the MS also placed the initial internal thermometer which the DS stated was broken and removed. During an observation on 6/22/26 at 12:05 PM, the MS opened the doors of the reach-in refrigerator and confirmed that both internal thermometers read 65 F.During a document review titled Summer Menus dated 6/22/26, milk and pureed potatoes were identified (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	among the list of food items being served for lunch on this date.During an observation in the kitchen on 6/22/26 at 12:10 PM, milk and pureed potatoes were served to residents on meal trays during lunch service.During an interview with the RD on 6/23/26 at 2:00 PM, the RD stated all foods in the refrigerator had to be considered unsafe for resident consumption due to the temperature being within the danger zone, which could promote foodborne illness and risk potential hospitalization among residents at the facility. During a document review of the 2022 FDA Food Code, Annex 3 section 3-601.16 titled Time/Temperature Control for Safety Food, Hot and Cold Holding the FDA food code indicated that bacterial growth and/or toxin production could occur if time/temperature control for safety food remained in the temperature danger zone (41 F-135 F) too long. Up to a point, the rate of growth increased with an increase in temperature within this zone. The Food Code indicated operations requiring heating or cooling of food had to be performed as rapidly as possible to avoid the possibility of bacterial growth.5. During an observation on 06/23/26 at 9:35 AM of the resident refrigerator located in the employee lounge, one clear plastic bag holding a plastic container of tacos, one sealed bag of red liquid, and one sealed bag of green liquid, had no receive date labeled. During continued observation, one white plastic bag containing multiple food items had no receive date labeled, one white plastic bag was dated 6/17/26, one clear resealable bag containing a bunch of red grapes had no receive date labeled, one plastic container of cookies with no date labeled. During continued observation, one unopened pint of milk had no receive date labeled with a manufacturer printed expiration date of 02/18/26, one unopened single-serving cup of strawberry yogurt with no receive date with a manufacturer printed best by date of 05/11/26, one unopened plastic container of meatloaf with no name, room number, or receive date and had a manufacturer printed best by date of 05/31/26. During continued observation, no internal thermometer was inside the refrigerator. During an interview with the Director of Nursing (DON) on 6/23/26 at 2:40 PM, the DON confirmed observation of the undated foods, the bag dated 6/17/26 was on the seventh day of storage, and the expired food products were beyond expiration. The DON stated that expired food in the refrigerator was not safe for consumption due to the risk of promoting foodborne illness among residents at the facility, and that facility policy for monitoring resident food in the refrigerator was not being followed.During a document review of the facility's P&P titled Food [NAME] in by Visitors dated 5/22/2025, the P&P indicated that facility staff were to place food in a container that was clearly labeled with the resident's name and date received. The P&P indicated food was to be discarded after 48 hours if not consumed, and unopened/sealed foods had to be discarded by the manufacturer's printed best by or use by date.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review the facility failed to submit the Payroll Based Journal (PBJ - a mandatory reporting system for healthcare facilities to submit direct care staffing information that is collected and can be audited) for the first quarter (every three months) from 10/1/2025 to 12/31/2025 to the Centers of Medicare and Medicaid (CMS, the federal agency that provides health coverage).This failure compromised the accuracy of the facility's staffing levels and had the potential to affect the facility not to be adequately staffed and/or have the necessary staff to provide care to meet the needs of the residents (in general).Findings: During a review of the CMS PBJ Staffing Data Report dated 6/16/2026, the PBJ report indicated the facility did not submit staffing data for quarter 1 from 10/1/2025 to 12/31/2025. During an interview on 6/24/2026 at 1:23 PM with the facility's Corporate Payroll Consultant (CPC), the CPC stated they (the facility's corporate payroll staff) did not discover until March 2026 that the PBJ for quarter the facility's corporate payroll staff) used a third party vendor (TPV - any independent business, person, or contractor hired to provide goods or services to another company) to submit the PBJ to CMS and thought they (the facility's corporate payroll staff) were submitting the data for quarter 1 to the TPV. The CPC stated the PBJ data for quarter 1 from 10/1/2025 to 12/31/2025 had not been submitted. The CPC stated he (CPC) did not check the Certification and Survey Provider Enhanced Reporting (CASPER) Report (CMS's National Reporting Database that allows healthcare facilities such as nursing homes to access, review and analyze data) because he (CPC) did not know he could check the CASPER Report. During an interview on 6/24/2026 at 1:45 PM with the facility's Administrator (ADM), the ADM stated he (ADM) was aware the facility did not submit the quarter 1 PBJ to CMS after he had spoken with the facility's CPC. Per the facility's Administrator, the facility did not have any policy and procedure for PBJ submission.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain infection control practices by failing to:1. Ensure nephrostomy tubing (a thin catheter that drains urine from the kidney into a bag) was found on the floor for one of one sampled resident (Resident 25).2. Implement an effective water management program to reduce the risk of Legionella (a [NAME] of bacteria naturally found in fresh water) and other waterborne pathogens by failing to maintain documentation of routine cold-water monitoring for the facility's water distribution system. This failure had the potential to contaminate and worsen Resident 25's existing Urinary Tract Infection (UTI- an infection in the bladder/urinary tract) and the potential to result in inadequate monitoring of the facility's water system, increasing the risk for the growth and transmission of Legionella and other opportunistic waterborne pathogens, placing residents, staff, and visitors at risk for healthcare-associated infections, including Legionnaires' Disease (a severe, potentially life-threatening form of pneumonia caused by Legionella bacteria). Findings: 1. During a review of Resident 25's admission Record, the admission Record indicated that Resident 25 was originally admitted on [DATE] and readmitted on [DATE] with a diagnosis of UTI, chronic kidney disease (damaged kidneys that prevents blood filtration), and malignant neoplasm of the cervix uteri (a type of cancer that causes healthy cells in the cervix to become abnormal). During a review of Resident 25's Minimum Data Set (MDS- a resident assessment tool) dated 4/30/2026, the MDS indicated that Resident 25 is cognitively intact (ability to think coherently and make decisions independently) and uses a walker to ambulate (walk). The MDS indicated that Resident 25 requires supervision for eating, oral hygiene, and upper body dressing, and moderate assistance with toileting, showering, and lower body dressing. During an observation on 6/22/2026 at 10:08 a.m. in Resident 25's room, Resident 25's nephrostomy tubing was noted to be touching the floor and the nephrostomy drainage bag was hooked to the walker. Resident 25 stated she hooks the nephrostomy bag on the walker for convenience when ambulating. During an interview on 6/24/2026 at 7:44 a.m. with Licensed Vocational Charge Nurse (LVN 5), LVN 5 stated that the nephrostomy tubing was touching the floor but should not have been. LVN 5 stated certified nursing assistants (CNA's), and LVN's are responsible for ensuring the tubing is not on the floor to prevent infections, such as UTIs. During an interview on 6/24/2026 at 10:10 a.m. with LVN 3, LVN 3 stated urinary tubing should not be touching the floor and should be hanging below the bladder to prevent infections. LVN 3 stated residents (in general) need to be educated about the risks of infection. LVN 3 stated if it is the resident's preference to have the nephrostomy tube on the walker, staff must document and create a care plan. During an interview on 6/25/2026 at 12:03 p.m. with the Director of Nursing (DON), the DON stated the nephrostomy tubing should not be in contact on the floor. The DON stated the nephrostomy should be clipped to the resident's gown or bed to prevent infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 25's care plan dated 5/19/2026, the care plan indicated that Resident 25 will maintain safe and effective drainage while preventing infection. During a review of the facility's policy and procedure (P&P) titled, Nephrostomy Tube Management, dated 1/30/2026, the P&P listed infection prevention techniques to prevent contamination of the nephrostomy and stated to monitor for signs and symptoms of infection. During an interview on 6/24/2026 at 12:30 p.m. with Maintenance Supervisor (MS), MS stated the facility routinely monitors and documents hot water temperatures throughout the building. MS stated there was no log maintained for cold water temperature monitoring and he does not check the cold temperature of the building. During a review of the facility's Water Temperature Logbook Documentation for the date of 6/8/2026, 6/13/2026, and 6/19/2026, the Water Temperature Logbook documented routine monitoring of hot water temperatures at the North Station, South Station, and designated shower rooms. The Water temperature logbook did not contain documentation cold water temperature monitoring. During a review of the facility's undated Risk Management Plan for Waterborne Pathogen Control, the Water Management Plan identified the facility's cold water distribution system as a potential area for the growth and transmission of Legionella and other opportunistic waterborne pathogens. The plan indicated routine cold water temperature monitoring was required as a control measure to verify that water temperatures remained within the facility's established control limits. During a review of the facility's Water Infection Control Risk Assessment (WICRA), dated 01/06/2026, the WICRA identified multiple water system components requiring monitoring, including cold water storage tanks, hot water storage tanks, water heaters, water filters, faucets, showerheads, the municipal water supply, and other building water system components as part of the facility's Legionella prevention program. During a review of the facility's Risk Management Plan for Waterborne Pathogen Control, the policy indicated that operational monitoring is performed through the TELS (is a platform that specialized building management software built specifically for senior living and healthcare facilities) Preventive Maintenance Program and facility logs to verify implementation of the Water Management Program and maintain documentation of water management activities.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain equipment in safe operating condition when the reach-in refrigerator (an upright, standalone, commercial cooling unit designed to keep perishable ingredients cold) in the kitchen had an internal temperature within the temperature danger zone (a range of temperatures, 41-135 degrees Fahrenheit [F], where harmful bacteria can multiply rapidly). This deficient practice had the potential to result in harmful bacterial growth that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or toxins) in 68 of 70 residents who received food from the kitchen. Findings:During an observation of the facility's kitchen on 6/22/26 at 7:59 AM, the reach-in refrigerator had a digital display in the upper left corner of the unit which read 35 F. During continued observation, an analog (non-digital) thermometer placed inside the unit read 60 F. During a concurrent review of a document titled Refrigerator/Reach-in Temperature Log posted on the refrigerator door, the recorded temperature for 6/22/26 was 34 F.During a follow-up visit to kitchen on 6/22/26 at 11:00 AM, Dietary Aide (DA1) was observed standing at a food preparation table adjacent to the reach-in refrigerator filling individual cups of milk in preparation for lunch service, after which DA 1 placed the milk back into the reach-in refrigerator. During continued observation, the reach-in refrigerator's external thermometer read 39 F and the internal thermometer read 58 F. During a concurrent interview and observation with the Dietary Supervisor (DS), the DS stated the internal thermometer was broken and that the external digital thermometer measurement was the temperature reading kitchen staff documented and abided by. The DS then removed the internal thermometer. Upon request, the DS poured out a cup of milk from an unopened gallon jug which was measured at 57.5 F using a probe thermometer (a tool featuring a pointed metal stem that is inserted directly into food to measure its internal temperature).During an observation in the kitchen on 6/22/26 at 11:40 AM, the DS was observed pouring milk from a gallon jug into a food processor to puree potatoes in preparation for lunch service.During an observation in the kitchen on 6/22/26 at 11:45 AM, the observable contents of the reach-in refrigerator were as follows:Seven, 1-gallon plastic jugs of reduced fat milkOne black plastic tub of raw chicken thighsOne black plastic tub of two sealed rolls of ground beefOne metal pan of raw chicken thighs marinating in spices and liquidsOne black plastic tub of containing two foiled-wrapped turkey roastsOne box holding multiple cartons of liquid whole eggsOne box of pasteurized shelled eggsOne plastic container of mayonnaiseOne plastic container of grape jellyOne plastic container of sliced deli meatsOne opened container of sour creamOne opened container of low-fat cottage cheeseOne opened container of peach chunks in juiceOne opened container of soy sauceOne opened container of chopped garlic in water During an interview with the Maintenance Supervisor (MS) in the kitchen on 6/22/26 at 11:45 AM, the MS stated that there had been no known issues or maintenance requests for the reach-in refrigerator. The MS stated that every three months the reach-in cooling units in the kitchen had the coils cleaned, however there was no log, schedule, or record of the maintenance being performed. The MS placed another analog thermometer inside the reach-in refrigerator. Upon request, the MS also placed the initial internal thermometer which the DS said was broken and removed. During an observation on 6/22/26 at 12:05 PM, the MS opened the doors of the reach-in refrigerator and confirmed that both internal thermometers read 65 F.During an observation in the kitchen on 6/22/26 at 12:10 PM, milk was observed served to residents on meal trays during lunch service.During a document review titled Summer Menus dated 6/22/26, milk was identified among the list of food items being served. During a document review of the manufacturer's manual titled Owner's Manual undated the manual indicated that the most important thing to do was to ensure reliable service for the refrigerator, and that the refrigerator condenser coil which allowed the unit to operate efficiently was cleaned regularly.During a document review of the 2022 FDA Food Code, Annex 3 section 3-601.16 titled Time/Temperature Control for Safety Food, Hot and Cold Holding the FDA food code, the food code indicated that (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	bacterial growth and/or toxin production could occur if time/temperature control for safety food remains in the temperature danger zone (41 F-135 F) too long. Up to a point, the rate of growth increased with an increase in temperature within this zone. Beyond the upper limit of the optimal temperature range for a particular organism, the rate of growth decreases. Operations requiring heating or cooling of food had to be performed as rapidly as possible to avoid the possibility of bacterial growth.During a document review of the 2022 FDA Food Code, Annex 3 section 4-501.11 titled Good Repair and Proper Adjustment, the code indicated proper maintenance of equipment to manufacturer specifications helped ensure that the equipment would continue to operate as designed. The code indicated failure to properly maintain equipment could lead to violations of the associated requirements of the Code that place the health of the consumer at risk.

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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 ensure informed consent (a form signed by resident after providers fully explain a proposed treatment, its risks, benefits, and alternatives) was signed before ordering psychotropic (also referred to as psychoactive drugs, a medication that affects brain activities associated with mental processes and behavior) and antidepressant drug (medication to treat depression [persistent sadness, low mood, loss of interest]) and there was a stop date on as needed medication for psychotropic drug administration for one of five sampled residents (Resident 87). This failure had potential for Resident 87 unable to know the side effects of psychotropic medication prior to administering medication.Findings:During a review of Resident 87's admission Record (Face Sheet), admission Record indicated, the facility initially admitted Resident 87 on 1/22/2026, and then readmitted Resident 87 on 6/18/2026 with medical diagnoses that included fracture part of neck of left femur (broken bone of left hip), dementia with behavioral disturbances (a progressive state of decline in mental abilities with aggression, agitation, wandering, and psychosis [behavior and thoughts are detached from reality]), depressive episodes (persistent low mood, loss of interest in activities, and deep feelings of hopelessness).During a review of Resident 87's History and Physical (H & P, a foundational medical document that records a patient's current illness, past medical history, and a physical examination) dated 6/19/2026, the H & P indicated Resident 87 was confused and did not have decision making capacity (unable to comprehend concepts and memorize information).During a concurrent interview and record review on 6/25/2026 at 1:36 p.m. with Registered Nurse (RN) 1, Order Summary Report for Resident 87, dated 6/25/2026, and Psychotherapeutic Drug Informed Consent form dated 6/21/2026 were reviewed. RN 1 stated quetiapine (generic name for Seroquel an antipsychotic medication to treat psychosis) 25 milligram (mg, unit of measurement) tablet, give half (0.5) a tablet (dose is 12.5 mg) by mouth every 24 hours as needed (PRN as needed) for psychosis manifested by recurrent outbursts of anger for no reason at all, ordered on 6/19/2026 with no stop date. RN 1 stated trazadone 50 mg 1 tablet by mouth as needed for insomnia (inability to fall or stay asleep) manifested by inability to sleep at bedtime, start date 6/18/2026, also had no stop date. RN 1 stated PRN psychotropic medications should be ordered for 14 days only and should have the stop date after 14 days to reevaluate the need for continuation and to see if the medication was effective or not effective. The Pharmacist comes to review residents' medication regimen once a month, however, Resident 87 was somewhat newly admitted , so medication regimen was not reviewed yet for Resident 87.During a continued interview and record review on 6/25/2026 at 1:36 p.m. with RN 1, RN 1 stated that the consent was signed by Resident 87's representative on 6/21/2026 and signed by the physician on 6/23/2026. RN 1 stated the consent should have been signed prior to placing the order for psychotherapeutic drug in the electronic system and sending the order to the pharmacy. RN 1 stated the consent is necessary because the psychotherapeutic drugs are considered high risk medications that have a Black Box Warning (safety warning to alerts patients and healthcare providers about serious, life-threatening, or permanently disabling side effects) and considered a chemical restraint (any drug used for discipline or that makes it more convenient for staff to care for a resident, and not required to treat medical symptoms).During a concurrent interview and record review on 6/25/2026 at 3:06 p.m. with Director of Nursing (DON), the Psychotherapeutic Drug Informed Consent form, dated 6/21/2026 was reviewed. DON stated the consent for psychotropic drugs should have been obtained before placing the order for the drugs because of high-risk nature of such drugs. DON stated the staff cannot administer the psychotropic drugs to the residents before the consent is obtained from the resident or resident's representative.During a review of the facility's policy and procedure (P & P), titled Behavior/Psychoactive Medication Management dated 1/30/2026, the P & P indicated Facility must obtain a resident's written informed consent for treatment using psychoactive drugs and consent (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	renewal every 6 (six) months. Any psychoactive medication ordered on an as necessary (prn) basis, must be ordered not to exceed 14 days. Antipsychotic and antidepressant medications are not to be administered on a prn basis.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set {(MDS), a resident assessment tool}, was accurately completed as follows:The facility did not accurately assess anticoagulant use (medications that prevent or slow the blood's ability to clot) for one of three sampled residents (Resident 6).The facility failed to accurately assess and document the type and location of the dialysis access site (an invasive procedure in which blood is filtered through a machine to remove waste and excess fluid as a replacement for kidney function) for one of one sampled residents (Resident 7).This failure had the potential to lead to inaccurate care planning for the dialysis access site and to cause physical and psychosocial harm to Resident 7.This failure had the potential to result in the lack of an appropriate care plan for anticoagulant therapy for Resident 6. Findings: During a review of Resident 6's admission Record, the admission Record indicated the facility admitted the resident on 3/27/2024 with diagnoses that included type 2 diabetes (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), hyperlipidemia (high levels of cholesterol in the blood), dysphagia (difficulty swallowing), muscle weakness, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (partial weakness or reduced control on one entire side of the body), and benign prostatic hyperplasia (enlargement of the prostate gland). During a review of Resident 6's Medication Administration Record (MAR) dated 5/1/2026 – 5/31/2026, the MAR indicated the resident received Eliquis (a type of anticoagulant medication) 2.5 Milligrams (mg, a metric unit of mass or weight) by mouth on 5/16/2026 for Deep Vein Thrombosis (DVT, a blood clot that forms in the deep veins of the legs or pelvis) prophylaxis (preventative measure taken to stop DVTs from forming). During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool) dated 5/21/2026, the MDS indicated Resident 6 was cognitively intact (had the ability to think, understand, and reason). The MDS indicated Resident 6 required setup or clean up assistance (helper sets up or cleans up) with eating and oral hygiene. The MDS indicated Resident 6 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene and upper body dressing. The MDS indicated Resident 6 required substantial/maximal assistance (helper does more than half the effort) with personal hygiene. The MDS indicated Resident 6 was dependent on help (helper does all the effort) with showering/bathing himself, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 6 was not taking anticoagulant medication. During a concurrent interview and record review on 6/24/2026 at 11:22 AM with Minimum Data Set Nurse 1 (MDSN 1), Resident 6's MDS dated [DATE] was reviewed. MDSN 1 stated Resident 6's MDS dated [DATE] indicated the resident was not taking anticoagulant medication. MDSN 1 stated that the look back period for coding anticoagulants on the MDS was seven days. MDSN 1 stated that if an anticoagulant was given to Resident 6 during the seven days before 5/21/2026, then anticoagulants should have been coded on the resident's MDS. MDSN 1 stated the MDS should be accurate. MDSN 1 stated that if anticoagulants were not coded on Resident 6's MDS dated [DATE], there was a potential for the care plan for anticoagulants not to be triggered. During a concurrent interview and record review on 6/24/2026 at 12:20 PM with the Director of (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing (DON), Resident 6's MDS dated [DATE] was reviewed. The DON stated Resident 6's MDS dated [DATE] indicated the resident was not taking an anticoagulant. The DON stated that if an anticoagulant was given to Resident 6 within the look back period of seven days, then anticoagulants should have been coded on the residents MDS dated [DATE]. The DON stated that the MDS should be coded accurately. The DON stated that if anticoagulants were not triggered on Resident 6's MDS there was a potential for the care plan for anticoagulants not to be triggered. During a review of the Center's for Medicare and Medicaid Services (CMS) User's Manual titled Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1 Dated 10/2025, the User Manual indicated Steps for Assessment: Review the resident's medical record for documentation that any of these medications were received by the resident and for the indication of their use during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).Coding Instructions: Code all high-risk drug class medications according to their pharmacological classification, not how they are being used. Column 1: Check if the resident is taking any medications by pharmacological classification during the 7-day observation period (or since admission/entry or reentry if less than 7 days). Column 2: If Column 1 is checked, check if there is an indication noted for all medications in the drug class.N0415E1. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). N0415F1. Anticoagulant: Check if there is an indication noted for all anticoagulant medications by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days). Anticoagulants such as Target Specific Oral Anticoagulants (TSOACs), which may or may not require laboratory monitoring, should be coded in N0415E, Anticoagulant.Code a medication even if it was given only once during the look-back period. During a review of the facility's Policy and Procedure (P&P) titled RAI Process reviewed 4/24/2026, the P&P indicated Purpose: To provide resident-assessments that accurately depict and identify resident-specific issues and objectives as required, while meeting state and federal guidelines and data submission requirements. The facility will utilize the Resident Assessment Instrument (RAI) process as the basis for the accurate assessment of each resident's functional capacity and health status, as outlined in the CMS RAI MDS 3.0 Manual. The facility uses CMS's RAI Version 3.0 Manual as a reference tool. 2. During a review of Resident 7's Face Sheet (admission record), dated 6/24/2026, the Face Sheet indicated the facility initially admitted Resident 7 on 3/28/2026 and then readmitted Resident 7 on 5/6/2026 with medical diagnoses that included pleural effusion (collection of fluid around lungs), acute respiratory failure with hypoxia (sudden difficulty breathing and oxygen exchange due to damage in lungs), and end stage renal disease (irreversible loss kidney function), renal hemodialysis dependence (HD, a long term treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed). During a review of Minimum Data Set (MDS, resident assessment tool) dated 6/8/2026, the MDS indicated the Resident 7's cognitive patterns were intact (able to comprehend complex concepts, memory intact, and verbalize own needs). The MDS indicated that Resident 7's functional abilities (abilities to perform activities of daily living, such as eating, dressing, walking, toileting) required moderate assistance (helper does less than half the effort) with dressing, showering, and transferring, maximal assistance (helper does more than half of efforts) with toileting. During a concurrent interview and record review on 6/24/2026 at 9:23 a.m. with Registered Nurse (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(RN) 1 and Licensed Vocational Nurse (LVN) 6 reviewed the dialysis access site documentation in Resident 7's medical record as follows: admission assessment skin check, dated 5/6/2026, indicated - Left chest Permacath (surgically inserted tunneled central venous catheter, a long-term vascular access device used for dialysis) present. Pre-Dialysis Evaluation V 2, dated 6/12/2026, indicated arteriovenous (AV shunt or fistula, a direct connection between an artery and a vein used for dialysis) access site on Right chest, Resident has no AV shunt. Dialysis Unit to Complete, dated 6/15/2026, indicated – Central Venous Catheter (CVC a long, flexible tube inserted into a large vein in the chest, neck, arm, or groin and advanced toward the heart) illegible. Pre-Dialysis Evaluation V 2, dated 6/17/2026, Section for Dialysis center to Complete, indicated – Tunneled Dialysis Catheter (TDC, a soft, flexible tube placed under the skin to provide immediate vascular access for dialysis) Left. Pre-Dialysis Evaluation V 2, dated 6/17/2026, indicated AV shunt access site on Left Arm, Resident 7 has AV shunt and bruit (an audible, whooshing or blowing sound heard through a stethoscope) and thrill (a low-frequency vibration felt by touch) present. Nursing Advanced – Skin assessment, dated 6/19/2026 indicated Left Chest wall Permacath. e-Interact Transfer form V5 (an electronic assessment tool used to communicate critical clinical and demographic information when a resident is transferred to an acute care hospital), dated 6/21/26, Devices treatments, and Risk Alerts indicated – Port – Permacath on Right Chest wall. Order Summary Report, dated 6/24/2026, indicated Observe Permacath site on Left chest for redness, vascular access, tenderness, bleeding and drainage every shift starting on 3/29/2026. During an interview on 6/24/2026 at 9:23 a.m. with LVN 6 and RN 1, LVN 6 stated nurses should check the resident's dialysis access site for bleeding, infection, and the presence of the emergency kit next to resident's bed. and that bruit and thrill assessments apply only to AV shunts, not Permacaths. LVN 6 stated Resident 7's dialysis access documentation was inaccurate. LVN 6 stated it is important to record accurate assessment of the dialysis access for the patient's safety, for proper assessment and care plan. RN 1 added that AV shunts and Permacaths require different assessments and precautions and explained that the dialysis center provides the facility with a Preˆ and Postˆ Dialysis Evaluation form that includes weights, vital signs (blood pressure, pulse, temperature), access site status, and medications given during the treatment. During a concurrent interview and record review on 06/24/2026 at 10:54 a.m. with the Treatment Nurse (TN), the Nursing Advance Skin Check forms for Resident 7 dated 5/6/2026 and 6/12/2026 were reviewed and indicated the presence of a Permacath on the left chest. TN stated she conducts weekly and asˆneeded skin assessments and stated that Resident 7 never had an AV shunt. TN stated that if an AV shunt had been present, it would have been observed during her assessments. During a review of facility's policy and procedure (P & P) titled Medical Records Manual – General - MR04 Completion & Correction dated 3/25/2026, the P & P indicated Only those who are credentialed and/or have the authority to do so may document in the medical record of a Resident. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Any person(s) making observations or rendering direct services to the resident will document in the medical record. Entries will be recorded in a timely manner and will be complete, legible, and accurate.

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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. Based on observation, interview, and record review, the facility failed to ensure safe and accurate medication management practices for two of four sampled residents (Resident 42 and Resident 71) by failing to:-Ensure accurate medication administration documentation of the lidocaine patch (topical analgesics that provide temporary, localized pain relief by numbing nerve signals in the treated area) for Resident 42.- Ensure narcotic accountability record (count sheet) matched the electronic medication administration record (eMAR), for Resident 71.These failures had the potential for medication error, misuse, and/or drug diversion (involving the transfer of a legally-prescribed controlled substance from the individual for whom it was prescribed to another person).Findings:a. During a review of Resident 42's admission Record, the admission Record indicated the facility admitted Resident 42 on 4/10/2026 with diagnoses including, but not limited to: chronic kidney disease, diabetes mellitus 2 (a medical condition characterized by the body's inability to regulate blood sugar levels) with diabetic polyneuropathy (a medical condition involving simultaneous malfunction of multiple peripheral nerves throughout the body, which typically causes weakness, numbness, and burning pain), and muscle weakness. During an observation and interview on 6/23/2026 at 10:04 AM with Licensed Vocational Nurse 1 (LVN 1), LVN1 removed a lidocaine patch that was on Resident 42's right shoulder and then placed a new lidocaine patch on. Per surveyor's request, LVN 1 checked the old patch had handwritten date 6/22/2026. During a concurrent interview, LVN 1 reviewed the pharmacy label on Resident 42's lidocaine box and stated the instruction was 12 hours on and 12 hours off; LVN 1 stated the night shift nurse (unidentified) should have removed it the night before. During a review of Resident 42's medication order dated 6/5/2026 at 9:40 AM, the order indicated to apply Lidoderm patch (lidocaine patch) to right shoulder topically one time a day for pain management and remove per schedule. During a review of Resident 42's eMAR for June 2026, the eMAR indicated Resident 42's lidocaine patch had a scheduled time to apply [at] 9 AM and Remove [at] 8:59 PM. However, on 6/22/2026, eMAR the documentation on eMAR indicated not administered and see progress notes. During an interview on 6/23/2026 at 10:14 AM, Registered Nurse 1 (RN 1) concurrently reviewed the administration notes for Resident 42 and stated the note on 6/22/2026 at 9:54 AM which indicated resident was out on appointment. RN 1 stated there was another note on 6/22/2026 at 9:01 PM indicated no patch previously applied. During an interview on 6/23/2026 at 10:20 AM with RN 1, RN1 stated this could be considered a medication error if the order was not followed. During an interview on 6/23/2026 at 12:54 PM with the Director of Nursing (DON), the DON stated she (DON) had confirmed with Resident 42's doctor (unidentified) that a nurse (unidentified) had communicated with the doctor on 6/22/2026. The DON stated the doctor provided instruction for the lidocaine patch to be applied later in the day when Resident 42 returned to the facility. The DON stated the nurse (unidentified) failed to document the aforementioned instruction in the progress notes. b. During a review of Resident 71's admission Record, the admission Record indicated the facility admitted Resident 71 on 3/12/2026 with diagnoses including, but not limited to, fracture of right femur (broken thigh bone). During an interview on 6/23/2026 at 1:21 PM with LVN 2, LVN2 reviewed Resident 71's tramadol (an narcotic to treat pain) 50 milligrams (mg, an unit to measure dosage) accountability record. LVN 2 stated the aforementioned tramadol accountability record indicated the last removal was on 6/22/2026 at 12:22 AM for 1 tablet. However, when LVN 2 reviewed Resident 71's eMAR for June 2026, there was no administration record. A concurrent review of Resident 71's eMAR for May 2026 indicated the last dose administered was on 5/30/2026. During an interview on 6/23/2026 at 4:14 PM with the DON, the DON stated nurses (in general) not documenting the administration of narcotics had the potential of resident getting additional dose unnecessarily, misuse, and/or drug diversion. During a review of the facility's policy and procedures, Controlled Substances (dated May 2022), the policy indicated When a controlled substance is (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered, the licensed nurse administering the medication immediately enters the information on the accountability record and the medication administra

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, interview, and record review, the facility failed to provide 24 of 68 residents (unidentified) with a Carbohydrate-Controlled (CCHO) diet order (a therapeutic diet intended to limit or balance the amount of carbohydrates consumed) when kitchen staff (Cook 1) provided twice the amount of potatoes as indicated This failure had the potential to negatively affect 24 of 68 residents' (unidentified) nutritional status by altering the intended carbohydrate content of the meal, which may impact nutrient balance, blood sugar control, and overall therapeutic effectiveness.Findings:During an observation of lunch tray line service in the kitchen on 6/22/2026 at 12:30 PM, [NAME] 1 used a scoop utensil with a grey-colored handle to plate potatoes for a meal tray which indicated a CCHO diet order. During continued observation, [NAME] 1 proceeded to use the same utensil scoop for both CCHO diet orders Regular diet orders (diets with no therapeutic indication). During a concurrent interview with Registered Dietitian (RD), the RD stated that [NAME] 1 should be using a smaller scoop utensil, identified by a blue-colored handle, to adhere to CCHO diet order specifications. The RD confirmed the difference in portion size nullifies (void) the therapeutic effect a CCHO diet order was intended to have.During a review of the facility's document titled Summer Menus dated 6/22/2026, the document indicated Diced Fried Potatoes to be portioned using a number 8 scoop (1/2 cup or 4 ounces [oz] total volume) for Regular diet orders and using a number 16 scoop (1/4 cup or 2 oz total volume) for CCHO diet orders.During a review of the facility's policy titled Therapeutic Diets dated 6/4/2014, the policy indicated the DS and RD will observe meal preparation and serving to ensure that food portions served are equal to the written portion sizes.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to follow the menu when kitchen staff used a cornstarch slurry (a mixture of cornstarch and a liquid used to thicken soups, gravies, and stir-fry sauces) instead of gravy as indicated in the recipe for 5 of 68 meal trays requiring gravy. This failure had the potential to alter nutrition and increase meal dissatisfaction for 5 of 68 residents.Findings:During an observation of lunch tray line service in the kitchen on 6/22/26 at 12:22 PM, [NAME] 1 used a scoop utensil to pour an opaque, white-colored liquid with gel-like consistency, on top of chopped Salisbury Steak. During a concurrent interview with [NAME] 1, [NAME] 1 confirmed that the cornstarch slurry was being used as a gravy for Minced-and-Moist, Level 5 (MM5) texture modified diets (a diet in accordance with the International Dysphagia Diet Standardization Initiative [IDDSI] standardized framework for residents with swallowing difficulties).During an interview with Regional Dietary Supervisor (DS2) in the kitchen on 6/23/26 at 10:15 AM, DS2 observed the cornstarch slurry being used in place of gravy and stated that the cornstarch-slurry was not an appropriate substitution and that gravy should have been used to adhere to the recipe. DS2 stated the practice of using the cornstarch-slurry instead of gravy altered nutrition of the meals provided and that resident expectations and meal satisfaction were negatively impacted. During a document review of the facility's recipe titled Salisbury Steak with Onions, the recipe indicated that Minced-and-Moist, Level 5 diets had to be moistened with gravy to achieve the appropriate thickness.During a document review of the facility's policy and procedures titled Therapeutic Diets dated 06/04/14, the policy ad procedures indicated that therapeutic diets are to be planned and prepared in consultation with the Dietitian.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to prepare food in accordance with the International Dysphagia Diet Standardization Initiative (IDDSI: standardized framework (0-7 levels) that uses consistent terminology, colors, and testing methods to define texture-modified foods and thickened liquids for people with swallowing difficulties [dysphagia]), Level Five minced and moist foods - (All foods prepared for this diet must be soft, moist with all excess fluid drained, and minced to size no larger than 4mm fits through the gaps of fork prongs) meal requiring level five minced and moist foods. This failure had the potential to result in decreased meal intake related to inconsistent and large sized food, meal dissatisfaction, and increased risk for choking and aspiration (inhalation of food or liquids into the lungs) for residents receiving food from the kitchen.Findings:During an observation of lunch tray line (assembly line style meal preparation) service in the kitchen on 6/22/26 at 12:20 PM, [NAME] 1 was observed using a scoop utensil designated for Small-and-Bite-Sized, Level 6 (SB6, defined as soft, tender pieces of food measuring no greater than 15 x 15 millimeters [mm]) to plate chopped Salisbury Steak from a pan on the steam table for a tray which called for MM5 texture (defined as soft, moist pieces of food measuring no greater than 4 x 15 mm). During continued observation, [NAME] 1 proceeded to use the edge of the scoop utensil to mash some of the SB6 meat. During a concurrent interview with [NAME] 1, when inquired [NAME] 1 confirmed that the SB6 texture was used to create MM5 stating I mashed it and put gravy because it is soft. During an interview with Regional Dietary Supervisor (DS2) in the kitchen on 6/23/26 at 10:15 AM, upon review of an MM5 tray prepared for lunch on 6/22/26 DS2 stated that the meat was too large and posed a risk of choking to residents. DS2 stated that preparing MM5 texture during plating was not an appropriate practice and that texture-modified food should have been prepared in advance. During a document review of the facility's recipe titled Salisbury Steak with Onions, the recipe indicated that IDDSI #5/Minced and Moist had to be prepared by placing the desired number of servings into a food processor and minced until food is 4 x 15mm. During a document review of the facility's policy and procedures titled Therapeutic Diets dated 06/04/14, the policy and procedures indicated that therapeutic diets were to be planned and prepared in consultation with the Dietitian.

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NAME OF PROVIDER OR SUPPLIER: Montecito Heights Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE: 4585 N. Figueroa St. Los Angeles, CA 90065	

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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 promote and maintain residents' quality of life by not conducting and documenting a change of condition (COC) assessment for two of two sampled residents (Residents 90 and 89) who were roommates and experiencing an interpersonal conflict.This^deficient practice^had the potential to cause emotional distress and affect the^residents'^self-esteem and cause a loss of dignity and decline in psychosocial wellbeing.^^ During a review of Resident 90's admission Record (AR), the AR indicated the facility admitted Resident 90 on^6/18/2026,^with a diagnoses including congestive heart failure (a chronic condition where the heart muscle is too weak or stiff to pump blood), anemia (body lacks enough healthy red blood cells or hemoglobin to carry adequate oxygen to your tissues), and Diabetes Mellitus (DM-chronic condition where your body cannot properly process sugar from the food you eat). During a review of Resident 90's History and Physical (H&P), dated^6/19/2026,^the H&P^indicated^Resident 90^can understand and make own medical decisions.^^ During a review of Resident 89's admission Record (AR), the AR indicated the facility admitted Resident 89 on^6/13/2026,^with a diagnoses including osteomyelitis of left ankle and foot (serious bacterial or fungal infection of the bone in the left ankle and foot), DM and foot ulcer (open sore or wound on the foot that refuses to heal or keeps returning). During a review of Resident 89's H&P dated^6/14/2026,^the H&P^indicated^Resident 89^can understand and make own medical decisions.^^ During an^interview on 6/22/26 at^10:40^a.m.^with^Resident 89^stated^Resident 90 provokes him and keeps the cell phone and TV volume too loud on 6/21/26 and Resident 90 could not sleep. During an^interview on 6/22/26 at^10:50^a.m.^with^Director of Nursing (DON), the DON stated Social Services Director (SSD) plan to change his room. The DON was aware of the verbal disagreement between Resident 89 and 90. Neither resident wanted to move rooms last night. During a review of social services progress notes dated 6/21/26, no documented progress notes about disagreement for Resident 89 or Resident 90. During an^interview on 6/24/26 at^8:58^a.m.^with^DON, the DON stated she is aware of patient disagreement that occurred on 6/21/2026. DON stated there was no progress notes or care plan for incompatibility for Resident 89 and Resident 90. DON stated staff did not include Resident 89's notes change of condition in for disagreement causing inconvenience and sleep disruption. The DON stated documentation is vital for awareness and timely intervention the nurse assigned that night should have documented it. If residents are incompatible, staff needs to offer a room change right then and there or immediately and document refusals. Facility staff must intervene during noise disagreements, as arguments disrupt the facility. Both residents were not offered a room change that night. During a review of the facility's^policy and procedure (P&P) titled, Resident Rights - Quality of Life, dated 03/2017, the P&P^indicated, to ensure that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care; each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in person-centered manner, as well as those that support the resident in attaining or maintaining his/her practicable well-being. ^

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure an Interdisciplinary Team (IDT- a group of healthcare professionals from different disciplines who work together to assess, plan and coordinate care) meeting for Resident 25 about noncompliance with keeping her nephrostomy tube (a thin catheter that drains urine from the kidney into a bag) off the floor was conducted for one out of one sampled resident.This failure had the potential for Resident 25's Urinary Tract Infection (UTI- an infection in the bladder/urinary tract) to worsen.Findings:During a review of Resident 25's admission Record, the admission Record indicated that Resident 25 was originally admitted on [DATE] and readmitted on [DATE] with a diagnosis of UTI, chronic kidney disease (damaged kidneys that prevents blood filtration), and malignant neoplasm of the cervix uteri (a type of cancer that causes healthy cells in the cervix to become abnormal).During a review of Resident 25's Minimum Data Set (MDS- a resident assessment tool) dated 4/30/2026, the MDS indicated that Resident 25 is cognitively intact (ability to think coherently and make decisions independently) and uses a walker to ambulate (walk). The MDS indicated that Resident 25 requires supervision for eating, oral hygiene, and upper body dressing, and moderate assistance with toileting, showering, and lower body dressing.During an observation on 6/22/2026 at 10:08 a.m. in Resident 25's room, Resident 25's nephrostomy tube was touching the floor and the nephrostomy bag was hooked to the resident's walker. Resident 25 stated she placed the nephrostomy bag on the walker for convenience when ambulating to the restroom.During an interview on 6/24/2026 at 10:10 a.m. with LVN 3, LVN 3 stated that if a resident's preference is to have their nephrostomy bag on their walker, an IDT meeting must be conducted and documented to ensure resident safety and consistent care among staff.During an interview on 6/25/2026 at 8:45 a.m. with the Treatment Nurse (TN1), TN 1 stated that if a resident is noncompliant with a treatment plan, an IDT meeting needs to be held as soon as possible. TN 1 stated IDT meetings are necessary to prevent a decline in care for residents.During an interview on 6/25/2026 at 9:20 a.m. with the Registered Nurse Supervisor (RN 1), RN 1 stated that IDT meetings should be conducted and documented for residents with noncompliance.During an interview on 6/25/2026 at 12:03 p.m. with the Director of Nursing (DON), the DON stated there could have been an IDT meeting for Resident 25 for noncompliance. The DON stated IDTs (in general) are important for discussing concerns, initiating interventions, and educating the resident and/or family members.During a review of the facility's policy and procedures (P&P) titled, Interdisciplinary Team Skilled Review dated 9/5/2017, the P&P stated that within 72 hours of admission to the facility, the IDT will gather information, and collect data to determine resident expectations, and goals using observation and assessment.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on observation, interview and record review, the facility failed to develop a dementia (a progressive state of decline in mental abilities) care plan (a personalized document outlining a person's health conditions, care services, and treatment goals) within 48 hours of admission for one of the five sampled residents (Resident 87).This failure had potential to cause delay in care or nursing services for Resident 87. Findings:During a review of Resident 87's admission Record, dated 6/25/2026, the admission Record indicated, the facility initially admitted Resident 87 on 1/22/2026, and then readmitted Resident 87 on 6/18/2026 with medical diagnoses that included fracture part of neck of left femur (broken bone of left hip), dementia with behavioral disturbances (a progressive state of decline in mental abilities with aggression, agitation, wandering, and psychosis [behavior and thoughts are detached from reality]), depressive episodes (persistent low mood, loss of interest in activities, and deep feelings of hopelessness).During a review of Resident 87's History and Physical (H & P) dated 6/19/2026, H & P indicated Resident 87 was confused and did not have decision making capacity (unable to comprehend concepts and memorize information).During a concurrent observation and interview on 6/22/2026 at 10:44 a.m. in Resident 87's room, Resident 87 was sitting in bed, could not state current place, date nor time. Resident 87 stated she sees the calendar but cannot read. Resident 87 stated did not know what call light was and how to use it.During a concurrent interview and record review on 6/25/2026 at 2:11 p.m. with Registered Nurse (RN) 1, Resident 87's Care Pan Report, dated 6/25/2026 was reviewed. RN 1 stated there was no care plan for dementia created within 48 hours of Resident 87's admission or after. RN 1 stated an initial care plan is typically based on medication and diagnosis for each resident and covers basic care needs of the resident. RN 1 stated care plan should have been initiated upon admission of Resident 87 to provide proper care.During review of the facility's policies and procedures (P & P) titled Person-Centered Care Planning, dated 5/22/2025, the P & P indicated the baseline care plan must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission. It should address resident-specific health and safety concerns to prevent decline or injury, and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living, as necessary. The Baseline Care Plan will be developed and implemented, using the necessary combination of problem specific care plans to promote continuity of care and communication among facility staff, increase resident safety and safeguard against adverse events, within 48 hours of the resident's admission.

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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. Based on observation, interview, and record review, the facilityˆfailed to initiate an anticoagulant (blood thinner- a medication or substance that prevents or slows down the clotting of blood) care plan for one of one sampled resident (Resident 82). This failure had the potential to negatively impact the resident's quality of life, as well as the quality of care and services received. During a review of Resident 82's admission Record (AR), the AR indicated the facility admitted the resident onˆ6/15/2026,ˆwith diagnoses including chronic obstructive pulmonary disease (a group of long term lung diseases that cause damaged airways and trapped air, making it difficult to breathe), pneumonia (an infection of the lungs that causes the tiny air sacs to become inflamed and fill with fluid), and sepsis (infection-fighting processes turn on the body, causing the organs to work poorly). During a review of Resident 82's History and Physical (H&P), datedˆ6/16/2026,ˆthe H&PˆindicatedˆResident 82ˆhas limited decision-making capacity. During a review of Resident 82's order, dated 6/15/2026, the order indicated Dabigatran Etexilate Mesylate (a prescription anticoagulant (blood thinner))oral capsule 110 milligram (mg-unit of measurement), give 1 capsule by mouth two times a day for A-fib (Atrial fibrillation - irregular heartbeat). During a record review of Care Plan Report, datedˆ06/ 2026, no care plan found for risk of bleeding for anticoagulant medication.ˆˆ During a concurrent interview and record review on 6/25/2026 at 12:05 p.m. with Director of Nursing (DON), Resident 82'sˆCare Plan Report, dated 6/2026 was reviewed. TheˆCare Plan Reportˆindicatedˆthe facility admitted the patient on 6/15/2026. Staff started the anticoagulant care plan on 6/24/2026. DON stated on admission nursing department initiates care plan. Nursing is responsible for initiating, implementing, and revising care plan. DON stated policy requires initiation of care plan within 48 hours. Dabigatran Etexilate Mesylate increases bleeding risk. Care plans identify needs and guide interventions, requiring patient-specific monitoring and education. During a review of the facility'sˆpolicy and procedure (P&P) titled, Person-Centered Care Planning, dated 5/22/2025, the P&PˆindicatedˆComprehensive care plans are developed within 48 hours of the resident's admission.

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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. Based on interview and record review the facility failed to update and revise the care plan (a plan of care that summarizes a resident's health conditions, current treatments, and specific care and services facility staff [in general] need to provide a resident to promote healing and prevent a worsening of a condition) for Trazadone (a type of medication used to treat depression, a serious mood disorder that causes a persistent feeling of sadness, emptiness, and a loss of interest in activities) for one out of five sampled residents (Resident 11).This failure had potential for Resident 11 to receive care that was not in alignment with the resident's physician orders and needs.Findings:During a review of Resident 11's admission Record, the admission Record indicated the facility re-admitted the resident on 4/12/2026 with diagnoses that included insomnia (trouble falling asleep or staying asleep), unspecified psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with reality), and Post-Traumatic Stress Disorder (PTSD, a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event).During a review of Resident 11's Minimum Data Set (MDS, a resident assessment tool) dated 5/9/2026, the MDS indicated the resident was cognitively intact (had the ability to think, understand, and reason). The MDS indicated Resident 11 required set up or clean up assistance (helper sets up or cleans up) with eating and oral hygiene. The MDS indicated Resident 11 required partial/moderate assistance (helper does less than half the effort) with showering/bathing herself, upper body dressing, and personal hygiene. The MDS indicated Resident 11 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene and lower body dressing. The MDS indicated Resident 11 was dependent (helper does all the effort) on help with putting on/taking off footwear. The MDS indicated Resident 11 was taking antidepressant medication (medication used to depression).During a review of Resident 11's Order Summary Report dated 6/1/2026, the Order Summary Report indicated the resident had a physician order for Trazadone (a type of antidepressant medication) 37.5 milligrams (mg, a metric unit of mass or weight) by mouth at bedtime for depression manifested by the inability to sleep.During a review of Resident 11's Medication Administration Record (MAR) dated 6/1/2026 to 6/23/2026, the MAR indicated the resident received 23 doses of Trazadone 37.5 mg.During a review of Resident 11's Care Plan Report dated 6/24/2026, the Care Plan Report indicated the resident was using Trazadone related to depression. The Care Plan Report indicated a goal for Resident 11 to be free from discomfort or adverse reactions (a harmful, unintended result caused by taking medication) related to antidepressant therapy through the review date. The Care Plan Report indicated interventions to administer Trazadone 50 mg to Resident 11 as ordered by the physician, to monitor/document/report as needed any adverse reactions to the therapy of Trazodone 50 mg, and to educate Resident 11/family/caregivers about the risks, benefits, side effects and/or toxic symptoms of Trazadone 50 mg.During a concurrent interview and record review on 6/24/2026 at 9:49 AM with Licensed Vocational Nurse 1 (LVN 1), Resident 11's physician order for Trazadone dated 6/1/2026 and Care Plan Report dated 6/24/2026 were reviewed. LVN 1 stated Resident 11 had been receiving Trazodone 37.5 mg as ordered by the resident's physician. LVN 1 stated Resident 11's Care Plan Report indicated the resident was receiving Trazodone 50 mg. LVN 1 stated Trazodone 50 mg was a previous physician order. LVN 1 stated Resident 11's Care Plan Report had not been updated to reflect the resident's current physician order for Trazodone 37.5 mg. LVN 1 stated Resident 11's Care Plan Report should have been updated to indicate the resident was receiving 37.5 mg. LVN 1 stated the Care Plan Report was supposed to be updated whenever there were changes to Resident 11's physician orders or care. LVN 1 stated that if the Care Plan Report was not updated the Care Plan Report was not accurate or specific to Resident 11. LVN 1 stated that if Resident 11's Care Plan Report did not reflect the resident's current plan of care, there was potential for the nursing staff (in (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	general) to not monitor the resident for the appropriate behaviors or symptoms of the medication. LVN 1 stated there was potential for Resident 11 to not receive the care the resident needs.During a concurrent interview and record review on 6/24/2026 at 12:45 PM with the Director of Nursing (DON), Resident 11's physician order for Trazodone dated 6/1/2026 and Care Plan Report dated 6/24/2026 were reviewed. The DON stated Resident 11 had a physician order for Trazodone 37.5 mg. The DON stated Resident 11's Care Plan Report indicated the resident was receiving 50 mg of Trazodone. The DON stated Resident 11's Care Plan Report was not updated and revised to indicate the resident's new orders for 37.5 mg of Trazodone. The DON stated Resident 11's Care Plan Report should have been updated when the resident's physician order for Trazodone was changed. The DON stated the Care Plan Report was supposed to be updated and revised whenever there was a change to Resident 11's plan of care or physician orders. The DON stated there was potential for the nursing staff (in general) to not be aware of Resident 11's updated physician orders for Trazodone which could lead to the resident receiving care that was not in alignment with the resident's needs.During a review of the facility's Policy and Procedure (P&P) titled Person-Centered Care Planning reviewed 4/24/2026, the P&P indicated The facility must develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights, that includes measurable objectives, and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental, and psychosocial well-being.Comprehensive care plans must be reviewed and revised by the interdisciplinary team after each assessment, include both the comprehensive and quarterly review assessments.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document a follow-up assessment after a change of condition (COC- a significant alteration in a resident's health status requiring physician notification) for one out of one sample resident (Resident 83).This failure had the potential for Resident 83 to continue experiencing nausea without appropriate monitoring and interventions.During a review of Resident 83's admission Record, the admission Record indicated that Resident 83 was admitted on [DATE] with a diagnosis of acute respiratory failure with hypoxia (a condition where the lungs cannot supply enough oxygen to the bloodstream), pneumonia (an infection/inflammation in the lungs), and immunodeficiency (when the immune system's ability to fight off infectious diseases is weakened).During a review of Resident 83's Minimum Data Set (MDS- a resident assessment tool), dated 6/19/2026, the MDS indicated that Resident 83 is cognitively intact (ability to think coherently and make decisions independently) and uses a walker to ambulate (walk). The MDS indicated that Resident 83 requires set-up assistance for eating, supervision for oral hygiene, and upper body dressing, and moderate assistance for toileting, showering, and lower body dressing.During a review of Resident 83's COC record, dated 6/22/2026 at 2:32 p.m., the COC record indicated that Resident 83 was experiencing nausea in the morning. The COC record indicated that the physician ordered a KUB (an x-ray of the kidneys, ureter, and bladder) for continued monitoring and antiemetics (anti-nausea) medications for Resident 83.During a review of Resident 83's Assessment Record, the Assessment Record indicated that there were no follow-up assessment notes documented on 6/23/2026 or 6/25/2026 after the change of condition was identified.During an interview on 6/25/2026 at 8:45 a.m. with the Treatment Nurse (TN 1), the TN 1 stated when a nurse identifies a change of condition with a resident, the Physician is notified, orders are implemented, and a COC is documented. The TN 1 stated generally the resident's status should be monitored and documented in the COC every shift. TN1 stated if there is no monitoring, the resident's health status can decline.During an interview on 6/25/2026 at 9:43 a.m. with the Registered Nurse Supervisor (RN 1), the RN 1 stated when a resident's baseline changes, a COC is needed. RN 1 stated that typically a resident is monitored for approximately 72 hours after a COC has occurred, and an assessment must be documented in the resident's electronic record. The RN 1 stated if monitoring is not documented, the resident's condition can worsen.During an interview on 6/25/2026 at 12:03 p.m. with the Director of Nursing (DON), the DON stated that a resident (in general) should be monitored for 72 hours following a change of condition, but monitoring can be more frequent depending on the resident's condition and the physician's orders. The DON acknowledged that there was no documentation indicating that Resident 83 was being monitored after the COC. The DON stated an assessment should have been documented and the COC policy was not followed.During a review of the facility's policy and procedure (P&P), titled Change of Condition, dated 8/25/2022, the P&P indicated that a licensed nurse should document for at least 72 hours every shift after a resident experiences a change of condition.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure monthly weights was being done and recorded to monitor and assess nutrition and hydration during continued poor meal intake (an ongoing, prolonged inability to consume enough food or beverages to meet the body's physiological energy and nutritional needs) for one of one sampled resident (Resident 17). This deficient practice had the potential to result in inadequate nutritional intake, continued weight loss, dehydration, worsening malnutrition, and functional decline. Findings: During a review of Resident 17's admission Record (Face Sheet), the resident was admitted to the facility on [DATE]. The resident with diagnoses including chronic obstructive pulmonary disease (COPD - a chronic lung disease characterized by airflow limitation with worsening respiratory symptoms), iron deficiency anemia secondary to chronic blood loss (a condition in which the body has insufficient healthy red blood cells due to chronic blood loss), chronic diastolic congestive heart failure (a condition in which the heart has difficulty relaxing and filling properly), chronic kidney disease Stage 3 (moderate loss of kidney function), respiratory failure with hypoxia (a condition in which the lungs cannot adequately oxygenate the blood), unspecified protein-calorie malnutrition (a condition caused by inadequate intake of calories and protein), essential hypertension (persistently elevated blood pressure), unstageable pressure ulcer of the sacral region (a pressure injury whose depth cannot be determined because it is covered with slough or eschar), depression (serious mood disorder that causes persistent feelings of sadness, hopelessness, and a loss of interest in activities you once enjoyed.) During a review of Resident 17's Minimum Data Set (MDS - a resident assessment tool), the assessment indicated the resident was cognitively intact, with a Brief Interview for Mental Status (BIMS) score of 13 and was able to communicate her needs and participate in decisions regarding her care, including meal preferences. The MDS indicated Resident 17 required setup and clean-up assistance while eating. During a review of Resident 17 weight records, documentation reflected a weight of 158.0 pounds (a unit of weight) in 2/2026 and 164.0 pounds (a unit of weight) in 4/2026. No monthly weight documentation was available for the month of 1/2026, 3/2026, 5/2026, or 6/2026. During a record review of Resident 17's Change of Condition = COC refers to any significant alteration in a person's health that deviates from their established baseline). No documentation about meal refusal of meal percentage less than 50%. 5/29/2026 - 13:16, 22:28 (2 meals), 0-25% 5/30/2026 - 12:00, 19:46 (2 meals), 0-25% 6/01/2026 - 13:27 (1 meal), 0-25% 6/03/2026 - 13:09, 18:47 (2 meals), 0-25% 6/04/2026 - 12:57, 20:13 (2 meals), 0-25% 6/05/2026 - 22:50 (1 meal), 0-25% 6/05/2026 - 19:46 (1 meal), 0-25% 6/08/2026 - 14:47, 19:31 (2 meals), 0-25% 6/09/2026 - 08:00 (1 meal), 0-25% 6/11/2026 - 20:23 (1 meal), 0-25% 6/12/2026 - 20:19 (1 meal), 0-25% 6/15/2026 - 12:46, 19:37 (2 meals), 0-25% 6/18/2026 - 10:22, 12:00, 20:00 (3 meals), 0-25% 6/21/2026 - 19:50 (1 meal), 0-25% 6/24/2026 - 19:43 (1 meal), 0-25% During an interview on 6/22/2026 at 7:56 a.m. with Resident 17, Resident 17 stated she is receiving repetitive food selections and stated that she often chose not to eat the meals provided because the food doesn't taste good and doesn't look good either. During an interview on 6/24/2026 at 12:12 p.m. with Resident 17, Resident 17 stated she refused her lunch meal and requested staff remove the tray because the food was disgusting. Resident 17 stated could not identify what had been served and reported consuming only her dessert and an Ensure (a protein nutritional supplement). During a review of Resident 17's Care Plan Report dated 2/04/2026 titled Care Plan Report Focus the unplanned/unexpected weight loss related to food preferences, the care plan indicated Resident 17 had reflected a 22-pound (a standard unit of weight) (12.4%) weight loss over a three-month period. During an interview on 06/24/2026 at 2:17 p.m., CNA 2 (Certified Nursing Assistant 2), CNA 2 stated Resident 17 refused her lunch meal. During an interview on 06/25/2026 at 9:35 a.m., the Rehabilitation Nursing Assistant (RNA), the RNA stated Resident 17 weights are maintained in a weight-loss log and obtained monthly. The RNA stated that significant weight is (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported to the Director of Nursing (DON). During an interview on6/25/2026 at 10:30 a.m., with the Registered Dietitian (RD), RD stated all newly admitted or readmitted residents are being weighed weekly times four then monthly thereafter. RD stated that they need to monitor weight because to assess nutritional needs. RD stated no resident is not being weighed monthly. During an interview on 6/25/2026 at 10:30 a.m. the DON, the DON stated that all residents admitted and readmitted will have weights X 4 then if there is any identified unplanned weight loss or poor meal intake are expected to have their nutritional status monitored through meal intake documentation, routine weight monitoring, nursing assessments, and Registered Dietitian (RD) follow-up. The DON stated that when a resident consistently refuses meals or demonstrates inadequate oral intake, nursing staff are expected to do a COC, notify the physician and registered dietitian, assess contributing factors, implement appropriate interventions based on the resident's needs and preferences, and document assessments and interventions. During a review of the facility policy titled DD01 Evaluation of Weight and Nutritional Status (Effective 02/20/2025), the policy indicated the facility is responsible for assessing residents' nutritional needs, identifying residents at nutritional risk, monitoring oral intake, weight changes, and fluid intake, implementing and revising interventions based on resident needs and preferences, and notifying the physician and registered dietitian when significant weight loss or nutritional concerns are identified. The policy further required residents at risk of weight loss to receive weekly weight monitoring until stable, followed by ongoing monthly monitoring.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) reviewed for respiratory care, received the necessary respiratory ˆcare and services by failing to: -Ensure Resident 1's oxygen nasal cannula (a simple, lightweight plastic tube used to give a person extra oxygen) did not rest on the floor while Resident 1 used the oxygen nasal cannula on 6/22/2026 at 10:29 AM This failure had the potential for Resident 1 to experience an increased risk for respiratory infections (illnesses that affect the parts of your body involved in breathing). Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 2/17/2026 and readmitted Resident 1 on 5/19/2026 with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), other specified sepsis (a life threatening blood infection), muscle weakness, reduced mobility, dementia (a progressive state of decline in mental abilities), and dependence on supplemental oxygen (a medical treatment that provides extra oxygen to people who have trouble breathing naturally). During a review of Resident 1's History and Physical (H&P) dated 5/19/2026, the H&P indicated Resident 1 had the capacity (ability) to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 5/26/2026, the MDS indicated Resident 1 usually could make himself (Resident 1) understood and usually had the ability to understand others. The MDS indicated Resident 1 was dependent (helper does all the effort) for oral hygiene (ability to clean teeth), toileting, shower/bathing, upper/lower body dressing, and rolling left and right.ˆ The MDS indicated Resident 1 had a diagnosis of pneumonia (an infection/inflammation in the lungs) and septicemia (blood poisoning when bacteria, viruses, or fungi get into your bloodstream and multiply). During a review of Resident 1's Order Summary Report dated 6/24/2026, the Order Summary Report indicated Resident 1 had physician orders to change humidifier (a plastic bottle filled with distilled water that attaches to an oxygen machine that moistens the oxygen preventing the nose, throat, and airways from drying out, cracking, or getting irritated during oxygen therapy) and change O2 (oxygen) tubing as needed. During a review of Resident 1's Order Summary Report dated 6/24/2026, the Order Summary Report indicated Resident 1 had physician orders for oxygen at 2 L/min (liters per minute - where a machine pushes 2 liters of concentrated oxygen into your airways every 60 seconds) via NC (nasal cannula). During a concurrent observation and interview on 6/22/2026 at 10:29 AM with Licensed Vocational Nurse 2 (LVN 2) in Resident 1's room, Resident 1's oxygen nasal cannula was observed on the floor while Resident 1 received oxygen through the nasal cannula.ˆ LVN 2 stated Resident 1's oxygen nasal cannula tubing resting on the floor could cause the oxygen nasal cannula tubing to get kinked (twisted, curled, or bent sharply out of shape) or contaminated (unsafe, dirty, or ruined).ˆ LVN 2 stated she (LVN 2) would replace Resident 1's oxygen nasal cannula tubing and would put a label and date on the new tubing. During an interview on 6/22/2026 at 2:07 PM with the Registered Nurse Supervisor (RN 1), RN 1 stated any nurse (in general) who found the oxygen tubing on the floor should replace the tubing for infection control (the habits and rules used to stop germs from spreading).ˆ During an interview on 6/22/2026 at 2:15 PM with the Director of Nursing (DON), the DON stated if Resident 1's oxygen tubing was found on the floor, the oxygen tubing should have been changed for infection control. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program Description, last reviewed 4/24/2026, the P&P indicated The Infection Prevention and Control Program is a set of comprehensive processes that address the prevention, identification, reporting, investigation and control of infections.

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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. Based on observation, interview, and record review, the facility failed to ensure one ofˆoneˆsampled resident (Residentˆ33) reviewed for hemodialysisˆ(HD, treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed) received care and services consistent with professional standards of practice by failing to:ˆ ˆ1. Ensure Resident 1's weight was accurately assessed and documented after dialysis on 6/17/2026.ˆ 2. Ensure Resident 33'sˆpermcath dialysis catheter (a soft, flexible plastic tube inserted into a large vein, usually in the neck) was accurately assessed and documented on 6/17/2026, 6/22/2026, and 6/23/2026.ˆˆ Theseˆfailuresˆhad the potentialˆfor inaccurate information to have been used to calculate Resident 33's dialysis, leading to improper dialysisˆcare treatment orders, infection, serious injury and/or harm. Findings: ˆDuring a review of Resident 33's admission Record, the admission Record indicated the facilityˆoriginally admitted Resident 33 on 4/22/2021 and readmitted Resident 33 on 6/3/2026 with diagnoses that includedˆtype 2ˆDiabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hemiplegia and hemiparesis following cerebral infraction affecting left non-dominant side (the person experienced a death of brain tissue (stroke) which caused weakness and paralysis throughout their entire left sideˆof their body),ˆESRD (End Stage Renal Disease-irreversible kidney failure, and dependence on dialysis).ˆˆ ˆ During a review of Resident 33'sˆMinimum Data Set (MDS - a resident assessment tool) datedˆ6/10/2026, the MDS indicated Resident 33 could usually make himself (Resident 33) understood andˆusually had the ability to understand others.ˆˆThe MDS indicatedˆResident 33 was receiving hemodialysis.ˆˆ ˆˆ During a review of Resident 33's History and Physical (H&P) datedˆ6/21/2026, the H&Pˆindicatedˆ Resident 33 did not have the capacity (ability) to make his (Resident 33) own medical decisions.ˆˆˆˆ ˆ During a review of Resident 33's Order Summary Reportˆdated 6/24/2026, the Order Summary Reportˆindicatedˆ Resident 33 had physician orders forˆHD (hemodialysis)ˆon Mondays, Wednesdays, and Fridays.ˆ ˆ During a review of Resident 33's Order Summary Report dated 6/24/2026, the Order Summary ReportˆindicatedˆtoˆobserveˆResident 33'sˆpermcathˆsite onˆtheˆright upper chest for redness,ˆtenderness, bleeding, and drainage (leakage) every shift.ˆˆ ˆˆ During aˆreview of Resident 33'sˆuntitledˆweightˆrecordˆdatedˆ6/17/2026 at 12:36ˆPM,ˆtheˆweight recordˆindicatedˆResident 33'sˆpost (after) dialysisˆweight wasˆ153.4ˆpounds (lbs.).ˆˆThe weight recordˆindicatedˆResident 33's weight was crossed off on 6/24/2026 at 8:41 AM by the Director of Nursing (DON) and documented as Incorrect Documentation.ˆˆ ˆ During an interview onˆ6/24/2026ˆat 8:06 AM with Resident 33's Dialysis Registered Nurse (DRN,ˆfrom the outside dialysis clinic), the DRN stated the dialysis clinic weighed Resident 33 after dialysisˆon 6/17/2026.ˆˆThe DRN stated Resident 33 weighedˆ178.2 lbs.ˆafter dialysisˆon 6/17/2026.ˆˆ ˆ During an interview on 6/24/2026 at 8:40 AM with Registered Nurse 1 (RN 1),ˆLicensed Vocational Nurseˆ6 (LVN 6), and the DON, RN 1 statedˆshe (RN 1) needed to check with the DON to see if the facility needed to check Resident 33's weight post dialysis.ˆˆThe DONˆstatedˆthe facility needed to check Resident 33's weight after dialysis.ˆˆThe DONˆstatedˆsheˆ(DON)ˆcrossed off Resident 33's weight on 6/17/2026ˆafter she (DON) spoke with the facility's Registered Dietician (RD).ˆRN 1 and LVN 6ˆstatedˆthe facility did not check Resident 33's weight post dialysis on 6/17/2026.ˆˆThe DONˆstatedˆthe facility should have checked Resident 33's weight post dialysis on 6/17/2026.ˆˆLVN 6 stated Resident 33's weight should have been checked in case there was a big weight difference before and after dialysis.ˆˆLVN 6 stated if there was a weight discrepancyˆ(difference or mismatch)ˆshe (LVN 6) would report the weight discrepancy to the Registered Nurse Supervisor.ˆˆRN 1ˆstatedˆthe facility would need to check to see if Resident 33 had fluid retentionˆ(when your body traps extra water)ˆand the facility would need to reweigh Resident 33.ˆˆ ˆ During a concurrent interview and record review onˆ6/24/2026 at 8:40 AMˆwith RN 1 and LVN 6, Resident 33'sˆ NSG Skilled Evaluation, dated 6/17/2026,ˆ6/22/2026, and 6/23/2026 wereˆreviewed.ˆˆRN 1 and LVN 6ˆstatedˆthe facility (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented Resident 33 had aˆpermacathˆand indicatedˆtheˆpermacathˆhad a bruitˆ(whooshing or humming sound) and thrillˆ(a constant, gentle buzzing or vibrating sensation felt just underˆthe skin)ˆonˆtheˆNSG Skilled Evaluation on 6/17/2026, 6/22/2026, and 6/23/2026.ˆˆRN 1ˆand LVN 6ˆstatedˆthe NSG Skilled Evaluations dated 6/17/2026, 6/22/2026, and 6/23/2026 were notˆaccurate.ˆˆRN 1 and LVN 6ˆstatedˆaˆpermacathˆ(in general)ˆwould not have a bruit or thrill.ˆˆRN 1 and LVN 6 stated Resident 33's NSG Skilled Nursing Evaluations needed to beˆaccurateˆbecause Resident 33's care plan could be affected.ˆˆ ˆˆ During aˆconcurrentˆinterviewˆand record reviewˆon 6/24/2026 at 9:37 AMˆwith the DON,ˆthe facility's NSG Skilled Evaluation was reviewed.ˆˆThe DON opened the NSG Skilled Evaluation on Resident 33 electronic medical record (EMRˆ-ˆdigital version of a patient's paper medical chart) to test the NSG Skilled Evaluation.ˆˆThe DON clicked the choice for dialysisˆandˆstatedˆa new questionˆopened asking yes or noˆregardingˆa bruit/thrill for Resident 33.ˆˆThe DONˆstatedˆstaffˆ(licensed nurses in general)ˆshould have skipped answering yes or no to the question if Resident 33 had a bruit/thrill.ˆˆThe DONˆstatedˆthe staffˆ(licensed nurses in general)ˆshould have documented at the bottom of the form that Resident 33 had aˆpermacath.ˆˆˆ ˆˆ During a review of the facility'sˆpolicyˆand procedure (P&P), titledˆ MR04 Completion & Correctionˆ(Medical Records Manual-General), dated 3/25/2026, the P&Pˆindicatedˆthe facility would complete and correct medical records to provide the highest quality and accuracy in documentation.ˆˆThe P&P the facility would ensure medical records were complete andˆaccurate.ˆˆˆ ˆˆ During a review of the facility's P&P, titled P-NP37 Dialysis Managementˆ(Nursing Manual-General), lastˆreviewedˆ4/24/2026, the P&P indicatedˆthe facility wouldˆonly check for a bruit/thrill if a resident (in general) had an AV fistulaˆ(a surgical connection made between an artery and a vein, usually inˆtheˆarmˆforˆreliable access to your bloodstream so a dialysis machine can effectively clean your blood when your kidneys are no longer able to do the job).ˆˆThe P&Pˆindicatedˆfor a central venous catheter (permacath), the facility would onlyˆmonitorˆfor redness,ˆtenderness, bleeding, and drainage.ˆ

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to obtain a Valproic Acid (a medication that is used to stabilize mood) level as recommended by the facility's consultant pharmacist (a healthcare professional who provides specialized expertise to healthcare facilities, typically focusing on ensuring the safe and effective use of medications) during the Monthly Medication Regimen Review (MRR, when a consultant pharmacist reviews and analyzes a resident's medication list, ensuring that the medications are appropriate, effective, and safe) for one of five sampled residents (Resident 61).This failure had the potential for Resident 61 to develop toxic levels (when an excessive amount of a medication accumulates in the bloodstream, leading to adverse, poisonous, or potentially life-threatening effects) of Valproic Acid and experience adverse effects (undesired and harmful effects that occur because of medication, treatment, or a procedure) from the medication.Findings:During a review of Resident 61's admission Record, the admission Record indicated the facility admitted the resident on 10/13/2025 with diagnoses that included auditory hallucinations (the sensory perceptions of hearing noises without an external stimulus), Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia (difficulty swallowing), hypertension (high blood pressure), and hypothyroidism (a condition when the thyroid gland does not make and release enough thyroid hormone into the bloodstream).During a review of Resident 61's Consultant Pharmacist's Medication Regimen Review dated 3/31/2026, the Consultant Pharmacist's Medication Regimen Review indicated the resident was on Valproic Acid for behavior control. The Consultant Pharmacist's Medication Regimen Review indicated an order was to be obtained from Resident 6's physician for a Valproic Acid Level on the next available lab day. The Consultant Pharmacist's Medication Regimen Review indicated that because Resident 6 was on Valproic Acid for mood disorder (a condition that affects your emotional state, causing persistent and severe emotional disturbances), the resident needed monitoring for Valproic Acid toxicity.During a review of Resident 61's Minimum Data Set (MDS, a resident assessment tool) dated 4/16/2026, the MDS indicated the resident had moderate cognitive impairment (a condition in which people have more memory or thinking problems than other people their age). The MDS indicated Resident 61 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating and oral hygiene. The MDS indicated Resident 61 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, showering/bathing himself, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 61 was taking antipsychotic medication (medication used to manage symptoms of psychosis, a collection of symptoms where a person experiences a loss of contact with reality) and hypnotic medication (medication used to induce sleep).During a review of Resident 61's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 6/18/2026 for Valproic Acid 2.5 Milliliters (ml, a metric unit of volume) by mouth two times a day for mood disorders manifested by sudden irritation without apparent reasons.During a concurrent interview and record review on 6/24/2026 at 3:50 PM with the Director of Nursing (DON), Resident 61's Consultant Pharmacist's Medication Regiment Review dated 3/31/2026 was reviewed. The DON stated Resident 61 had been receiving Valproic Acid for a while. The DON stated that on 3/31/2026 the pharmacist consultant recommended that Resident 61 have a Valproic Acid level done. The DON stated she (DON) reviewed Resident 61's progress notes, laboratory results, and current and past physician orders. The DON stated there were no progress notes, physician orders, or laboratory results that indicated Resident 61 had a Valproic Acid level done. The DON stated there was no documentation that indicated Resident 61 refused to have a Valproic Acid level done. The DON stated Resident 61 did not have a Valproic Acid level done as (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommended by the pharmacist consultant. The DON stated that if Resident 61's Valproic Acid levels were not monitored there was potential for the resident to develop toxic levels of Valproic Acid which could cause the resident to experience adverse side effects.During a review of the facility's Policy and Procedure (P&P) titled Drug Regimen Review reviewed 4/24/2026, the P&P indicated Facility must ensure that a pharmacist reviews each resident's medical chart every month and perform a drug regimen review.During their monthly drug regimen review, pharmacist will report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports will be acted upon by the facility.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure food preferences were honored for three of three sampled residents (Resident 50, Resident 86 and Resident 67) when: a. Resident 86's likes and dislikes was not reflected on the meal tray ticket. b. Resident 50's tray ticket was not updated reflecting food texture preferences and request for soups for three meals. c. Resident 67's did not provide food preference accommodation. These failures had potential to cause decreased food intake, weight loss, and decreased quality of life. Findings: a. During a review of Resident 86's Face Sheet (which includes a resident's identification, medical, and demographic information), dated 6/25/2026, the Face Sheet indicated Resident 86 was admitted on [DATE] with medical diagnoses that included metabolic encephalopathy (brain dysfunction caused by chemical imbalances, systemic illnesses, or organ failure), immunodeficiency (a state of body where immune system that fights diseases or infections is decreased or absent), chronic kidney disease (kidneys cannot filter blood as well as they should). During a review of Resident 86's Minimum Data Set (MDS - resident assessment tool), dated 6/18/2026, the MDS indicated Resident 86's cognitive skill for daily decision making was intact (resident can comprehend concepts, memorize information and make decisions). The MDS indicated Resident 86 was dependent on assistance with activities of daily living (ADLs, such as dressing, toileting, personal hygiene, and transfer) and required two or more helpers with transfers, toileting and showering. During a concurrent observation and interview on 6/23/2026 at 8:20 a.m. in Resident 86's room while the resident was eating breakfast, the tray was noted to contain cottage cheese, oatmeal, green tea, coffee, toast, a sealed apple juice cup, and milk. Resident 86 stated the food was horrible and stated the staff had already been informed. Resident 86 stated she is allergic to eggs and receives cottage cheese as a protein substitute. Resident 86 also stated she does not like apple juice and prefers cranberry juice, yet apple juice continued to be served. Review of the tray ticket dated 6/23/2026, which lists diet orders, allergies, dislikes, and preferences, showed the following: breakfast diet-no added salt, regular texture; allergy-eggs; dislikes-banana, sausage, and bread; preferences-milk, juice, cottage cheese, daily yogurt, melons, and strawberries. During a concurrent interview and record review on 6/23/26 at 2:51 p.m. with Registered Dietician (RD) Resident 86's Nutritional Risk Assessment, dated 6/16/2026 was reviewed. The assessment indicated Resident 86 having multiple food intolerances including eggs, green bell pepper, oats, dried cereals, fish, yogurt. RD stated that the tray ticket for Resident 86 needs to be updated with the allergies and dislikes, because it communicates what diet and foods to serve to Resident 86. RD stated the facility's kitchen should not serve the residents the food they have intolerance to. The tray ticket should include the food intolerance or allergies for the kitchen to know. RD stated that communication about the resident's diet preferences, dislikes, intolerances or allergies with Dietary Supervisor (DS) is done via email. RD stated that a DS also access to resident records, orders and prints out the tray tickets from the electronic system. During an interview on 06/25/2026 at 8:39 a.m. with Resident 86, Resident 86 stated on 6/22/2026 she received a lunch tray with corn, green bell peppers and meat, Resident 86 stated she refused to eat the corn. Residents stated she is allergic to green bell peppers that it would give her a rash. b. During a review of Resident 50's Face Sheet, dated 6/25/2026, the Face Sheet indicated, the facility admitted Resident 50 on 5/12/2023 with medical diagnoses that included osteoarthritis (pain and stiffness in joints, caused by damage to cartilage tissue), malignant neoplasm of nipple and areola (cancer of the skin near breast nipple area), end stage renal disease (kidneys cannot filter blood as well as they should), bilateral ototoxic hearing loss (inner ear damage caused by specific medications, chemicals, or toxins that harm sensory hair cells). During a review of Resident 50's MDS dated [DATE], the MDS indicated Resident 50's cognitive skill for daily decision making was impaired. The MDS indicated Resident 50 was dependent on assistance (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055163	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montecito Heights Healthcare & Wellness Centre, LP	4585 N. Figueroa St. Los Angeles, CA 90065

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with activities of daily living and required two or more helpers with transfers to tub/showering. During a phone interview on 6/22/2026 at 1:54 p.m. with Resident 50's family member (FM), the FM stated she has requested the facility to serve Resident 50 with warm beverages and soups, but the facility did not follow through with the request. During a concurrent observation and interview on 6/22/2026 at 2:00 p.m. while Resident 50's eating lunch and drinking milk, the resident was observed spitting out some of the food. Resident 50 stated the facility had served him porridge, but he preferred a smooth texture without sharp or gritty components which is why he was spitting out. Resident 50's lunch tray contained a cup of water, a cup of pink color liquid (juice) and a glass of milk. The porridge and meat had a gritty texture. Review of Resident 50's tray ticket dated 6/22/2026, the tray ticket indicated the following dislikes - juice, preference - four ounces (oz, unit of liquid measurement) milk, four oz juice and soup with meals daily. During an interview on 6/22/2026 at 2:32 p.m. with Certified Nurse Assistant (CNA) 4, CNA 4 stated when residents are not eating well or are refusing foods, she asks the residents about food preferences and dislikes. Then CNA 4 notifies the charge nurse. The charge nurse then goes to kitchen to request substitute food for the residents. CNA 1 stated it is important for residents to have food they like because it is the residents' right. During a concurrent interview and record review on 6/25/2026 at 8:55 a.m. with the Dietary Aide (DA), Resident 50's lunch tray ticket dated 6/22/2026 was reviewed. The DA stated he served the food according to the tray ticket. The DA noted the tray ticket indicated Resident 50's preference for soup with meals daily and stated that Resident 50 prefers soup for lunch. The DA explained that the facility usually does not serve soup and that he had never encountered serving soup to residents. The DA stated it is important to provide residents with their preferred foods to maintain their satisfaction. The DA stated that if soup was listed on the tray ticket, the resident should have been offered and provided soup. During a concurrent interview and record review on 6/25/2026 at 9:38 a.m. with the Registered Dietitian (RD), Resident 50's Order Summary Report dated 6/25/2026 was reviewed. The report indicated a regular diet with standard portions, pureed texture, regular/thin liquids, and a directive to include soup with every meal, active since 12/02/2025. The RD stated soups are typically part of the fall/winter menus and that staff usually contacts the kitchen when residents request soup. The RD did not confirm whether soup was ever provided or included in the facility's menu. During an interview on 6/25/2026 at 9:42 a.m. with the DS, the DS stated soups are sometimes served at dinner and that the kitchen keeps canned soup but usually prepares soup from scratch. The DS confirmed no soup was provided to Resident 50 during the 6/22/2026 lunch service, despite the diet order and tray ticket indicating it should have been included. The DS added that nursing staff should also check trays as an additional safeguard, noting that human errors can occur. c. During a review of Resident 67's admission Record (AR), the AR indicated the facility admitted the resident onˆ5/29/2026,ˆwith diagnoses includingˆacute embolism and thrombosis of left lower extremity (dangerous blockage of a blood vessel of left lower limb), chronic obstructive pulmonary disease (a group of long term lung diseases that cause damaged airways and trapped air, making it difficult to breathe), and diabetes (chronic condition where your body cannot properly process sugar from the food you eat). During a review of Resident 67's History and Physical (H&P), datedˆ5/30/2026,ˆthe H&Pˆindicatedˆtheresidentˆhas theˆcapacity to understand and make decisions.ˆ During a review of Resident 67's MDS, dated [DATE], Brief Interview for Mental Status (BIMS) score of 15 (intact cognition); a helper sets up and cleans up eating area and resident eats independently; resident requires maximal assistance help with toileting and hygiene. During anˆinterview on 6/22/26 atˆ10:00ˆa.m.ˆwith Resident 67, Resident 67 stated that the staff and kitchen did not provide the requested cottage cheese and yogurt preferences. Resident 67 reported discussing the issue with the RD, but no changes were made. During a record review of meal percentages, dated June 2026, the task sheet indicated 17 opportunities of eating 51 to 75 percent of food on 6/2/2026 1200 and 1700, 6/3/2026 0800 and 1200, 6/7/2026 0800, 6/9/2026 0800 and 1200, 6/10/2026 1700, 6/12/2026 0800, 6/14/2026 0800 and 1200, 6/15/2026 0800, 6/17/2026 1700, 6/18/2026 0800 and 1700, 6/19/2026 0800 and 1200 and 3 (continued on next page)

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	055163	A. Building B. Wing	06/25/2026

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	instances of eating 26-50 percent of food on 6/7/2026 1200, 6/14/2026 1700, and 6/15/2026 1200. During a concurrent interview and record review on 6/25/2026 at 9:07 a.m. with RD, Resident 67's Nutritional Risk Assessment, dated 6/8/2026 was reviewed. The Nutritional Risk Assessment indicated that the RD and DS reviewed and updated Resident 67's food preferences noting that when a menu was not preferred, Resident 67 requests cottage cheese or cereal with milk. During a continued interview and record review on 6/25/2026 at 9:07 a.m. with RD, Resident 67's Nutrition/Dietary Progress Note, dated 6/22/2026 was reviewed. The Nutrition/Dietary Progress Note indicated that RD met with Resident 67who requested cottage cheese for breakfast and yogurt for lunch. The RD agreed to the preferences and communicated them to the DSS. The RD stated that staff failed to honor the resident's food preferences from 6/9 through 6/21. During a review of facility's policies and procedure (P & P) titled Dietary Profile and Resident Preference Interview, dated 11/11/2025, the P & P indicated Resident preferences will be documented in the medical record and tray-card and update promptly, as needed. The dietary profile shall be reviewed and revised as necessary, but at least quarterly. The Dietary Department will provide residents with meals consistent with their preferences and Physician order as indicated on the tray card. If the preferred item is not available, a suitable substitute should be provided. The Dietary Manager may update food preferences as often as necessary.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to document infection prevent education to one out of one sampled resident (Resident 25) in a consistent and timely manner.This failure of incomplete and missing documentation had the potential for Resident 25 to not receive necessary care and treatment.Findings: During a review of Resident 25's admission Record, the admission Record indicated that Resident 25 was originally admitted on [DATE] and readmitted on [DATE] with a diagnosis of UTI, chronic kidney disease (damaged kidneys that prevents blood filtration), and malignant neoplasm of the cervix uteri (a type of cancer that causes healthy cells in the cervix to become abnormal).During a review of Resident 25's Minimum Data Set (MDS- a resident assessment tool) dated 4/30/2026, the MDS indicated that Resident 25 is cognitively intact (ability to think coherently and make decisions independently) and uses a walker to ambulate (walk). The MDS indicated that Resident 25 requires supervision for eating, oral hygiene, and upper body dressing, and moderate assistance with toileting, showering, and lower body dressing.During an observation on 6/22/2026 at 10:08 a.m. in Resident 25's room, Resident 25's nephrostomy tube was touching the floor and the nephrostomy bag was hooked on Resident 25's walker. Resident 25 stated she hooks the nephrostomy bag on the walker for convenience when ambulating.During an interview on 6/24/2026 at 10:10 a.m. with Licensed Vocational Nurse 3 (LVN 3) LVN 3 stated that resident education must be provided and documented when the resident has specific treatment preferences . LVN 3 stated that timely documentation is important, so all staff are aware and informed, to monitor resident progress, and promote resident safety. LVN 3 stated documentation should be input as soon as a task is completed so there is no miscommunication.During an interview on 6/25/2026 at 9:20 a.m. with the Registered Nursed Supervisor (RN 1), RN 1 stated that documentation of any education must be completed or there is no proof that education was provided. RN 1 stated documentation should occur once a task is completed, or as soon as possible.During an interview on 6/25/2026 at 12:03 p.m. with the Director of Nursing (DON), the DON stated the physician order to monitor for signs and symptoms of infection for Resident 25 was input in May 2026, but the first documentation of infection prevention education provided to Resident 25 was on 6/18/2026. The DON stated the nephrostomy tubing education for Resident 25 should have been documented in a timely manner but was not.During a review of Resident 25's care plan dated 4/29/2026 and revised on 5/21/2026, the care plan indicated that Resident 25 will show no signs or symptoms of infection using resident education and reporting of symptoms as interventions.During a review of the facility's policy and procedure (P&P) titled, Completion and Correction dated 3/25/2026, the P&P indicated that all documented entries will be recorded in a timely manner, and any late entries should be documented as soon as possible.