STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055181	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Gabriel Conv Center	8035 E Hill Drive Rosemead, CA 91770

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure two of three sampled residents (Resident 6 and 76) was free from unnecessary drugs as indicated in the facility's policy and procedure titled Medication Therapy. 1. For Resident 6 the facility failed to ensure: a. Journavx (a medication used for moderate to severe acute pain) was not administer ed for excessive periods of time from 3/29/2026 to 6/16/2026 while the pharmaceutical recommended to use for the drug for shortest duration, consistent with individual patient treatment goal. b. Journavx pharmaceutical recommendation indicated for moderate to severe acute pain, while Resident 6's was administered Journavx from 4/1/2026 to 6/15/2026 for pain level documented as zero (0) and administered for 148 times. c. Journavx not ordered by the physician to be given via G-tube (gastrostomy- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) for Resident 6 while pharmaceutical recommendation indicated Do not to crush. This deficient practice had the potential for Resident 6 to be at risk for adverse effects (unwanted or dangerous medication-related side effects) such as muscle spasms (painful contractions and tightening of the muscles), increased creatine phosphokinase (CPK- an enzyme in the body found mainly in the heart, brain, and skeletal muscle), and rash. 2. For Resident 76 the facility failed to monitor behaviors, such as anxiety (the fear of the unknown) manifested by agitation and aggression towards others, in response to lorazepam (medication used to reduce anxiety and control seizures) for one of one sample resident (Resident 76). This failure had the potential to result in Resident 76 experiencing undetected adverse (undesired effect of medication) side effects of lorazepam, and delaying implementing interventions. Findings: 1.During a review of Resident 6's admission Record (AR), the AR indicated that Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic respiratory failure (a long-term condition where there's not enough oxygen in the body), and dementia (a progressive state of decline in mental abilities.) During a review of Resident 6's Physician's Order, dated 3/29/2026, this order indicated to administer Journavx Oral tablet 50 milligrams (mg- metric unit of measurement) via G-tube every 12 hours for pain management. During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool) dated 5/19/2026, the MDS indicated that Resident 6 was had moderately impaired cognition (decisions poor, cues/supervision required.) The MDS indicated that Resident 6 received scheduled pain medication regimen. During a review of Resident 6's Medication Administration Record (MAR) dated from 4/1/2026 to (continued on next page)

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

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/15/2026, the MAR indicated 148 out of 152 times of Resident 6's pain level was documented as zero (0) and Journavx was administered every 12 hours daily via G-tube. During a review of Resident 6's MAR, dated from 6/1/2026 to 6/15/2026, the MAR Acetaminophen Liquid indicated Resident 6's pain level was three (3) or four (4), medication was marked ^ referring as administered, and follow up codes were documented as E referring as effective on dates 6/4/2026, 6/5/2026, 6/7/2026, 6/8/2026, 6/14/2026, and 6/15/2026. During a concurrent record review and interview on 6/17/2026 at 1:40 PM with the registered nurse (RN) 1, Resident 6's clinical records including MAR from 3/29/2026 to 6/15/2026 were reviewed. RN 1 stated Resident 6 had been granted oral gratification (a non-nutritional eating protocol designed strictly to provide comfort, taste, and the sensory experience of eating to patients who are tube-fed, near end-of-life, or recovering from severe swallowing difficulties) for a short period of time at beginning of this year but medications were never given to Resident 6 by mouth. RN 1 stated it was not appropriate to have Journavx crushed against the pharmaceutical recommendation indicating DO NOT CRUSH and administered to Resident 6 via G-tube. RN 1 also stated Resident 6 was assessed to have pain usually during wound care and because of the wound existence duration, the pain was more chronic (long standing pain that persists beyond the usual recovery period) than acute (usually sudden in onset and time limited), so the nurse should have contacted Resident 6's attending physician regarding use of Journavx.^ During a telephone interview on 6/17/2026 at 3:01 PM with the facility's Pharmacy Consultant (PC) 1, PC 1 stated Journavx was indicated for moderate to severe acute pain. PC 1 stated he had been aware that Resident 6 received Journavx via G-tube. PC 1 stated there are other alternatives (other available options, choices, or substitutes) to this drug however he had not spoken to the prescribing physician about recommendations because PC 1 stated that Resident 6 pain was not relieved. PC 1 further stated that he did not know that Journavx was a non-crushable medication. During an interview on 6/18/2026 at 11:25 AM with the Director of Nursing DON), the DON stated the LVNs should have reviewed the medication label and acknowledged the notice or warning DO NOT CRUSH. The DON stated that nurses were supposed to look up prescribing information, and the concern for extended use of Journavx indicated for acute pain also should have been brought up to supervisor and DON. DON stated the concern should also have been addressed by speaking to Resident 6's attending physician. According to the Pharmaceutical Recommendations JOURNAVX is a sodium channel blocker indicated for the treatment of moderate to severe acute pain. The medication should be swallowed tablets in a whole and do not chew or crush. Use JOURNAVX for the shortest duration, consistent with individual patient treatment goals. https://www.journaxvx.com During a review of the facility's policy and procedures (P&P) Medication Therapy dated 2001. The P&P indicated the following: Each resident's medication regimen shall include only those medications necessary to treat existing (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	conditions and address significant risks. Medication use shall be consistent with an individual's condition, prognosis, values, wishes, and responses to such treatments. All medication orders will be supported by appropriate care processes and practices. Upon or shortly after admission, and periodically thereafter, the staff and practitioner (assisted by the consultant pharmacist) will review an individual's current medication regimen, to identify whether: there was a clear indication for treating that individual with the medication; the dosage is appropriate; the frequency of administration and duration of use are appropriate; and potential or suspected side effects are present 2. During a review of Resident 76's admission Record, the admission Record indicated that the facility admitted Resident 76 on 4/1/2025 with diagnoses including dementia (a progressive state of decline in mental abilities) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 76's History and Physical (H&P), dated 3/9/2026, the H&P indicated Resident 76 does not have the capacity to understand and make decisions. During a review of Resident 76's Minimum Data Set (MDS - a resident assessment tool), dated 3/26/2026, the MDS indicated, Resident 76 had severe cognitive impairment (major loss in mental abilities significantly affecting daily functioning. The MDS indicated, Resident 76 did not exhibit physical (e.g., hitting, kicking, pushing) and verbal (e.g., threatening, screaming, cursing) behavioral symptoms towards others and other behavior symptoms (e.g., hitting/scratching self, pacing, rummaging) not directed towards others. During a review of Resident 76's Physician Orders, dated 5/28/2026, the Physician Orders indicated, Resident 76 was prescribed lorazepam oral tablet 0.5 milligram (mg – metric unit of measurement, used for medication dosage and/or amount), one tablet by mouth as needed for anxiety manifested by agitation and aggressive behavior towards others for 14 days. During a concurrent interview and record review on 6/17/2026 at 11:18 a.m. with Registered Nurse Supervisor (RNS) 1, Resident 76's physician orders were reviewed. The physician orders indicated no monitoring was done regarding Resident 76's lorazepam use. RNS 1 stated, monitoring should have been done for Resident 76's response to lorazepam use and any lorazepam side effects Resident 76 may have experienced. RNS 1 stated, Resident 76 was at potential risk for experiencing unrecognized side effects, including sleeping more than usual, falls, and respiratory depression. During a concurrent interview and record review on 6/17/2026 at 1:10 a.m. with the Director of Nursing (DON), Resident 76's physician orders were reviewed. The DON stated, no monitoring was done for Resident 76's lorazepam use and monitoring should have been done every shift. The DON stated, the potential risk was that the resident may have experienced adverse effects of the medication and those effects may not have been recognized by the staff. During a review of the facility's policy and procedures (P&P) titled, Behavioral Assessment, Interventions, and Monitoring, revised 3/2019, the P&P indicated, When medications are prescribed for (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	behavioral symptoms, documentation will include: . h. Monitoring for efficacy and adverse consequences. The P&P indicated, If the resident is being treated for altered behavior or mood, the IDT will seek and document any improvements or worsening in the individual's behavior, mood, and function. The IDT will monitor for side effects and complications related to psychoactive medications; for example, lethargy, abnormal involuntary movements, anorexia, or recurrent falling.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards of practice and the facility's policy and procedure titled, Sanitation and Infection Control and Dating and Labeling for food service safety and maintain sanitary food handling practices by failing to discard an expired food item dated 3/28/2026 and wash hands after performing a different task before returning to put away clean dishes. This deficient practice had the potential for contamination of food, clean food-contact items and for residents to be at risk for food borne illness (illness caused by food contaminated with bacteria, viruses, parasites, or toxins). Findings: During an observation on 6/15/2026 at 8:42 AM in the kitchen, there was a bottle Kitchen Bouquet (a liquid food coloring and seasoning that gave pale foods a rich, roasted brown color and added a mild, savory vegetable flavor) that had expired on 3/28/2026. During a concurrent observation and interview on 6/15/2026 at 8:55 AM with the Dietary Supervisor (DS) in the kitchen, the DS stated the bottle was expired but should not have been stored for use, otherwise the sauce would not have been good anymore. The DS stated if the kitchen had expired items, that could affect the taste of the food, and the residents could have gotten sick. During an interview on 6/16/2026 at 12:07 PM, the RD stated there should not have been expired items in the kitchen because the quality of the food would not be guaranteed, which could raise issues with safety and nutritional value including the taste of the food. The RD stated if the kitchen had expired items residents could get an upset stomach. During an observation on 6/17/2026 at 1:40 PM in the kitchen, the Dietary Aid (DA) was observed removing the clean dishes from the dishwasher, picking up dirty dishes and handing them to another kitchen staff putting the dirty dishes into the dishwasher without taking off her gloves. The DA then took soap suds from a container filled with dirty dishes and proceeded to wash her hands over the gloves. The DA proceeded to put away the clean dishes. Then, the DA was observed arranging the food carts for easier access to the dirty plates inside and rinsed her hands without taking off her gloves or using soap before going back to removing the clean dishes. During an interview on 6/17/2026 at 1:59 PM, the Registered Dietician Consultant (RDC) stated the person handling the clean dishes should not touch dirty surfaces and only handle the clean dishes. The RDC stated when washing hands, the kitchen staff were expected to take off their gloves and wash their hands with soap and water. The RDC stated if the kitchen staff did not wash their hands properly, there could be a potential for cross contamination or bacteria, and resident's had different conditions that could affect them. During an interview on 6/17/2026 at 2:33 PM, the DA stated she should not have touched dirty surfaces or moved food carts without washing her hands properly by discarding her gloves and using soap and water. The DA stated if kitchen staff did not wash hands properly that there was an infection control issue and the kitchen staff could transfer bacteria and residents could get sick. During an interview on 6/18/2026 at 8:57 AM, the DS stated if a kitchen aid was putting away the clean dishes, they should not have been touching dirty surfaces otherwise that was considered cross contamination. The DS stated if they wanted to go to a different area, that would have been okay, but the kitchen staff should have washed their hands with soap and water before doing so. The DS stated if proper hand hygiene was not done that was an infection control issue and bacteria could transfer possibly making resident's ill. During a concurrent interview and record review on 6/18/2026 at 11:51 AM with the DS, the facility's undated policy and procedure (P&P) titled Sanitation and Infection Control was reviewed. The P&P indicated facility staff were to conduct hand washing after handling carts, soiled dishes and utensils and disposable gloves were a single use item and should have been discarded after each use, or when damaged or soiled. The P&P indicated washing hands and changing gloves were necessary when beginning a different task. The DS stated the kitchen staff were not following the policy but should have been for infection control and to prevent cross contamination otherwise that could have spread infection from one place to another. During a concurrent interview and record (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review on 6/18/2026 at 11:52 AM with the DS, the facility's undated P&P titled Dating and Labeling was reviewed. The P&P indicated to ensure food safety and prevent contamination within the facility, all food items should have been properly covered, dated, and labeled in dry storage and refrigerator/freezer areas. The P&P indicated no food item that was expired or beyond the best buy date were to be in stock. The DS stated the kitchen staff were not following the policy but should have been because the food item was no longer good and that could have affected the health of the resident and the resident could have gotten sick.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 follow its policies and procedures (P&P) titled Infection Control, unknown date, of maintaining an infection control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection by failing to ensure: 1. Restorative Nursing Assistant (RNA) 1 assisting three of 13 sampled residents (Resident 57, Resident 91, and Resident 97) with their meals performed hand hygiene after leaving each resident and before assisting the next resident. These deficient practices had the potential to expose multiple residents to cross-contamination (transfer of disease-causing organism from one surface or food to another) and/or the transmission of infectious organisms/pathogens. 2. Ensure that the facility's water heaters (Water Heater A, B, C, and D) were flushed to avoid water stagnation and to prevent mineral and growth of waterborne pathogens (microorganisms-bacteria, viruses, and parasites that spread through contaminated drinking or recreational water) such as Legionella (water borne pathogen that may contaminate the facility's plumbing system which may lead to Legionnaires' disease [pneumonia caused by breathing in water mist contaminated with the Legionella bacteria]). 3. Ensure that the Maintenance Supervisor (MS) was aware and knew how to monitor for the growth of biofilm (a thin slimy film of bacteria or other microbes that adhere to surface) along the surfaces of the facility's showers and sinks. 4. Ensure there were no open food items at Nursing Station A (Nursing Station 1). These failures had the potential to result in the spread of infection among the residents, visitors and staff of the facility. These failures had the potential to result in waterborne pathogens growth such as Legionnaire's disease and other viruses and bacteria that could lead to a widespread infection in the facility. Findings: 1. During a review of Resident 57's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included gastro-esophageal reflux disease (GERD, commonly known as acid reflux, was a chronic digestive condition), diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and iron deficiency anemia (a condition where the body did not have enough iron to make the hemoglobin [an iron-rich protein found inside red blood cells] needed for blood to carry oxygen to the tissues). During a review of Resident 57's Nutritional assessment dated [DATE] at 7 PM, the Nutritional Assessment indicated the resident needed assistance with feeding. During a review of Resident 57's History and Physical (H&P) dated 4/4/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 57's Diet Order Summary dated 8/25/2025, the Order Summary indicated the resident was on a regular diet, minced and moist texture (finely chopped or mashed into very small, soft pieces held together by sauce or gravy), thin consistency (a substance that was watery, runny, or flowed easily), and preferred Chinese food, rice, and soup for all meals. During a review of Resident 57's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 5/5/2026, the MDS indicated the resident had moderate cognitive impairment (a person was experiencing noticeable and significant difficulties with thinking, learning, remembering, and other cognitive skills that impacted their daily life). The MDS indicated the resident required supervision or touching assistance (helper provided verbal cues and/or touching/steadying (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assistance) from facility staff for eating. 2. During a review of Resident 91's AR, the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included protein-calorie malnutrition (a severe lack of both protein and calories in a diet), cachexia (a medical condition that caused extreme, unintentional weight loss, particularly the loss of muscle), and encephalopathy (a disease, disorder, or damage that affected the brain's structure or function). During a review of Resident 91's H&P dated 5/27/2026, the H&P indicated the resident did not have the capacity to make decisions. During a review of Resident 91's Diet Order Summary dated 5/18/2026, the Order Summary indicated the resident was on a regular diet, soft and bite-sized texture (food that was tender, moist, and cut into small pieces to chew and swallow safely), and thin consistency. During a review of Resident 91's Nutritional assessment dated [DATE] at 10:53 AM, the Nutritional Assessment indicated the resident needed assistance with feeding. During a review of Resident 91's MDS dated [DATE], the MDS indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident required substantial/maximal assistance (helper did more than half the effort) from facility staff with eating and was on a mechanically altered diet. 3. During a review of Resident 97's AR, the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included DM, adult failure to thrive (a decline caused by chronic diseases and functional impairments which could cause weight loss, decreased appetite, poor nutrition, and inactivity), and anorexia (an eating disorder and serious mental health condition). During a review of Resident 97's H&P dated 9/18/2025, the H&P indicated the resident did not have the capacity to make decisions. During a review of Resident 97's Nutritional assessment dated [DATE] at 4:02 PM, the Nutritional Assessment indicated the resident needed assistance with feeding. During a review of Resident 97's Diet Order Summary dated 12/8/2025, the Order Summary indicated the resident was on a consistent carbohydrate diet (CCHO, a meal plan that required eating a steady, even amount of carbohydrates [a primary macronutrient and the body's main source of energy) every day), puree texture (completely smooth, no lumps, seeds, or chunks and required zero chewing to swallow for adults who have trouble swallowing or chewing), thin consistency, puree rice soup for lunch and dinner for high Hemoglobin A1C (a simple blood test that measured the average blood sugar level over two to three months) lab result. During a review of Resident 97's MDS dated [DATE], the MDS indicated the resident had moderate cognitive impairment. The MDS indicated the resident required substantial/maximal assistance from facility staff with eating and was on a mechanically altered/therapeutic diet (a personalized meal plan prescribed by a doctor or dietician [a food and nutrition expert] to treat a specific medical condition). During an observation in the dining room on 6/15/2026 at 12:26 PM, RNA 1 was observed sitting with (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 57 assisting with feeding and before resident 57 was done with her meal, RNA 1 went to Resident 91 and assisted Resident 91 with feeding without washing or sanitizing hands in between. At 12:43 PM, RNA 1 observed going back to Resident 57 without washing or sanitizing hands to continue assisting Resident 57 with feeding. RNA 1 then proceeded to assist Resident 97 who was sitting at the same table as Resident 57 with feeding without washing or sanitizing hands. During an interview on 6/17/2026 at 3:30 PM, RNA 2 stated facility staff were not supposed to go from one resident to another resident if the resident was not finished with their food. RNA 2 stated if the facility staff needed to go to another resident, the facility staff should have washed their hands before tending to another resident. RNA 2 stated hand washing was to prevent the spread of germs and infection control and if facility staff were not using proper hand hygiene, they could have transmitted an infection or bacteria and that could have affected the resident's health. During an interview on 6/17/2026 at 3:40 PM, Treatment Nurse (TN) 1 stated she was in charge of the dining program for resident safety and facility staff should have sat down with the resident until the resident finished their meal. TN 1 stated facility staff should have washed hands in between residents for infection control otherwise if one resident had an infection the facility staff could have transmitted the infection to another resident. During an interview on 6/18/2026 at 10:11 AM, RNA 1 stated facility staff were not allowed to go from one resident to another resident to assist with feeding and needed to stay with each resident until they were finished. RNA 1 stated if facility staff were done assisting a resident with feeding, the facility staff must wash hands before going to another resident because of infection control otherwise the residents could have gotten sick. RNA 1 stated on 6/15/2026 during lunch time, she went from one resident to another resident because the resident's required translation and because lunch time was a busy time, she hurried to the residents. During an interview on 6/18/2026 at 12:08 PM, the Director of Nursing (DON) stated facility staff were supposed to finish feeding a resident then wash hands to assist another resident with feeding. The DON stated facility staff should not have left the resident during the meal as a respect and dignity factor, so the resident was not interrupted with feeding. The DON stated if the facility staff did not wash hands in between resident's facility staff could have transferred an illness and the residents could have gotten sick. During a concurrent interview and record review on 6/18/2026 at 12:13 PM, the facility's undated policy and procedure (P&P) titled Infection Control was reviewed. The P&P indicated staff were to clean their hands after each direct resident contact using the most appropriate hand hygiene. The P&P indicated situations that required hand hygiene included before and after resident contact, before and after eating, and before and after assisting a resident with meals. The DON stated the facility staff were not following the policy but should have been for infection control so the facility staff did not transmit anything to each other and the residents would not get infected. During a review of the facility's P&P titled Assistance with Meals dated July 2017, the P&P indicated residents shall receive assistance with meals in a manner that met the individual needs of each resident. The P&P indicated for dining room residents who could not feed themselves would be fed with attention to safety, comfort and dignity. 2. During a concurrent observation and interview on 6/16/2026 at 8:29 AM with the MS, the Water Heaters A, B, C, and D were observed. The MS stated that he does not drain the water heaters to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	remove any possible impurities (an unwanted substance that contaminates a material, lowering its purity or making it unclean) growing in the water heater tanks such as minerals or possible water-borne pathogens. During an interview on 6/18/2026 at 2:35 PM with the Infection Prevention Nurse (IPN), the IPN stated that the facility's infection control measures for the water management program included flushing the Water Heater tanks to remove the buildup minerals and possible any water-borne bacteria, such as Legionella, growing in the water heater tanks. 3. During an interview on 6/18/2026 at 8:26 AM with the MS, the MS stated that he was not aware he was responsible for monitoring the facility's sinks, shower rooms, tubs, and drinking areas for biofilm. The MS stated that he did not know what biofilm was. During an interview on 6/18/2026 at 2:40 PM with the Infection Prevention Nurse (IPN), the IPN stated that the MS, housekeepers, and herself were responsible for checking the facility's sinks, facets, shower rooms, showerheads, tubs, and drinking areas for biofilm monthly. The IPN stated that checking for biofilm on the sinks, shower rooms, tubs, and drinking areas was a control measure to monitor the possible growth of waterborne pathogens in the facility's water system. The IPN stated that if there was biofilm found on the surfaces of the sinks, shower rooms, or drinking areas, it was important to clean the area right away to prevent widespread infection within the facility. 4. During observation and interview 6/17/2026 at 3:08 PM at Nursing Station A, there were 4 to 5 unopened snack bars and one open back of chips on the desk at Nursing Station A. Registered Nurse (RN) 1 stated there should not be any snacks, especially open snacks, at the Nursing Station for infection control. During the same interview on 6/17/2026 at 3:10 PM at Nursing Station A, the Medical Records Director stated that she was eating a bag of chips at the Nursing Station A and she just opened a new bag of chips. During an interview on 6/18/2026 at 2:45 PM with the Infection Prevention Nurse (IPN), the IPN stated there should be no food or drinks at the Nursing Station because of infection control. During a review of the facility's P&P titled Infection Control, unknown date, the P&P indicated that this facility has established and will maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. During a review of the facility's same P&P titled Infection Control, unknown date, the P&P indicated that the one of the components of the facility's Infection Control Program included the implementation of measure to prevent transmission of infectious agents. (continued on next page)

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San Gabriel Conv Center	8035 E Hill Drive Rosemead, CA 91770

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled Legionella Surveillance and Detection, unknown date, the P&P indicated to ensure that water is monitored and cleaned regularly and measures taken to prevent bacterial growth include but are not limited to avoiding stagnate water; run all water sources every three (3) days. During a review of the facility's P&P titled Water Management Program – Key Factors, dated 1/28/2026, the P&P indicated to monitor and document if biofilms were within the facility and to document biofilms when found to be present.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff provided assistance with dining in a manner that promoted and maintained resident dignity in accordance the facility's policy and procedure titled Dignity for one of three sampled residents (Resident 97) when Restorative Nursing Assistant (RNA) 1 who was assisting Resident 97 with eating placed her right index finger over her mouth and said Shush to Resident 97, who refused to eat more and pushed her plate to the side because she was already full. This deficient practice had the potential to affect Resident 97's psychosocial well-being and right to be treated with dignity in a manner that promoted and enhanced quality of life during dining. Findings: During a review of Resident 97's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), adult failure to thrive (a decline caused by chronic diseases and functional impairments which could cause weight loss, decreased appetite, poor nutrition, and inactivity), and anorexia (an eating disorder and serious mental health condition). During a review of Resident 97's History and Physical (H&P) dated 9/18/2025, the H&P indicated the resident did not have the capacity to make decisions. During a review of Resident 97's Nutritional assessment dated [DATE], the Nutritional Assessment indicated the resident needed assistance with feeding. During a review of Resident 97's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 6/11/2026, the MDS indicated the resident had moderate cognitive impairment (a person was experiencing noticeable and significant difficulties with thinking, learning, remembering, and other cognitive skills that impacted their daily life). The MDS indicated the resident required substantial/maximal assistance (helper did more than half the effort) from facility staff with eating and was on a mechanically altered (a customized eating plan where foods were chopped, ground, mashed, or blended to make them softer and easier to chew and swallow)/therapeutic diet (a personalized meal plan prescribed by a doctor or dietician [a food and nutrition expert] to treat a specific medical condition). During a review of Resident 97's Alteration in Nutritional Status related to Mechanically Altered & Therapeutic Diet Care Plan dated 6/11/2026, the Care Plan indicated a goal for the resident to reduce the risk of dehydration and minimize any unplanned weight changes daily. The Care Plan indicated interventions to include diet as ordered, honor resident food preferences, and to respect the resident's right to refuse. During an observation on 6/15/2026 at 12:48 PM in the dining room, RNA 1 was observed sitting with Resident 97 encouraging the resident to eat and Resident 97 was pushing the meal tray to the side. Resident 97 started speaking in a slightly louder tone of voice to RNA 1 and RNA 1 was observed placing her right index finger of her own mouth and said shush (a way to ask or command someone to stop talking or making noise). During an interview on 6/15/2026 at 12:55 PM, RNA 1 stated that when a resident refused to eat, the facility staff would recommend taking the resident to a more comfortable area like their room and report the resident's refusal to eat to the charge nurse or provide a food alternative. RNA 1 stated the facility staff should not shush a resident because that could upset the resident and make them unhappy. During an interview on 6/16/2026 at 2:40 PM, Resident 97 stated she was full and did not want to eat anymore, that was why she pushed her tray to the side. During an interview on 6/17/2026 at 3:23 PM, RNA 2 stated if a resident pushed away their food, facility staff would try to figure out if the resident wanted to eat something else, but they should never shush a resident because that was considered abuse. RNA 2 stated if a facility staff shushed a resident, the resident could be scared and think they were not supposed to say anything or speak up and that could have made them felt mad. During an interview on 6/17/2026 at 3:46 PM, Treatment Nurse (TN) 1 stated if a resident refused to eat, she would first interview the resident as to why they did not want to eat to look at the whole picture. TN 1 stated facility staff should never tell a resident shush because the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had the right to explain what they wanted and that gesture would have been considered abuse and very rude. TN 1 stated if facility staff shushed a resident, the resident could have felt sad and not respected. TN 1 stated the facility was the resident's home, and the facility staff were the visitors to that home and should not shush any residents. During an interview on 6/18/2026 at 12:13 PM, the Director of Nursing (DON) stated the expectation of facility staff when a resident refused to eat was to ask them first in a language the resident understood. The DON stated the facility staff should never have shushed a resident because that was not respectful. During a concurrent interview and record review on 6/18/2026 at 12:16 PM with the DON, the facility's policy and procedure (P&P) titled Dignity dated February 2021 was reviewed. The P&P indicated each resident should have been cared for in a manner that promoted and enhanced the resident's well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The P&P indicated residents were to be treated with dignity and respect at all times and the resident may exercise their right without interference, coercion, discrimination or reprisal from any person or entity associated with the facility. The P&P indicated residents were allowed to choose when to sleep, eat, and conduct activities of daily living and staff were to speak respectfully to residents at all times. The P&P indicated demeaning practices and standards of care that compromised dignity was prohibited. The DON stated the facility staff were not following the policy but should have been so the resident would not have felt disrespected.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Bed-Hold notice for one of two sampled residents (Resident 82) was signed by the resident and/or representative's indicating acknowledgement of receipt of the Bed-Hold notice on 4/21/2026 and 5/1/2026, when Resident 82 was transferred to General Acute Care Hospital (GACH). This deficient practice had the potential to affect resident's rights who required hospitalizations by limiting their awareness of bed-hold and readmission rights to the facility after hospitalization. Findings: During a review of Resident 82's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included chronic respiratory failure with hypoxia (the lungs were permanently damaged and struggled to move enough oxygen from the air into the bloodstream), tracheostomy (a surgically created hole in the front of the neck that went directly into the windpipe [trachea]), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 82's History and Physical (H&P) dated 5/30/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 82's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 6/1/2026, the MDS indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgment, and make decisions). The MDS indicated the resident was dependent (helper did all of the effort) on facility staff for all self-care needs. During a review of Resident 82's Change of Condition (COC) dated 4/21/2026 at 12:02 AM, the COC indicated the resident had a fever of 101.3 degrees Fahrenheit (normal adult body temperature ranged between 97 to 99 degrees Fahrenheit), elevated respiratory rate (RR, the number of breaths taken in one minute, a normal adult RR ranged between 12 to 20) of 30 breaths per minute, elevated heart rate (HR, the number of times the heart beats in one minute, a normal adult HR ranged between 60 to 100 beats per minute) of 97 beats per minute, and elevated blood pressure (BP, the force of blood pushing against the walls of the arteries as the heart pumps through the body, a normal adult BP was 120/80) of 154/95. The COC indicated Resident 82's responsible party and physician were notified, and the resident was transferred to the GACH). During a review of Resident 82's Physician's Order dated 4/21/2026 at 2:14 AM, the Physician's Order indicated for the resident to transfer to the acute care hospital via 911 (an emergency number) for further evaluation of fever, elevated BP, elevated HR, and elevated RR. The Physician's Order indicated if the resident was admitted , Resident 82 had a seven-day bed hold, only one time for seven days. During a review of Resident 82's Notification of Bed Hold dated 4/21/2026, the Bed Hold notice did not indicate the resident's representative was notified, and a signature was not obtained from Resident 82's responsible party regarding notification of the bed hold. During a review of Resident 82's Physician's Order dated 5/1/2026 at 4:48 AM, the Physician's Order indicated for the resident to be transferred to the GACH via 911 due to tachycardia (a racing or abnormally fast heartbeat) and hypotensive (low blood pressure) episode. The Physician's Order indicated for the resident to be on a seven-day bed hold per facility protocol. During a review of Resident 82's COC dated 5/1/2026 at 4:54 AM, the COC indicated the resident had tachycardia of 148 and hypotension of 90/50. The COC indicated Resident 82's responsible party and physician were notified, and the resident was transferred to the GACH. During a review of Resident 82's Notification of Bed Hold dated 5/1/2026, the Bed Hold notice was not signed by the resident's representative to indicate Resident 82's responsible party was notified and explained regarding notification of the Bed Hold. During an interview on 6/17/2026 at 3:40 PM, the Registered Nurse Supervisor (RNS) 2 stated when a resident transferred to the hospital, a Bed Hold notice form was to be filled out for continuity of care, and to ensure the resident was able to return to the facility after hospitalization. The RNS 2 stated the form (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have a verbal or written signature by the resident's representative to ensure the representative was notified, otherwise the document would indicate a bed hold was not established. The RNS 2 stated if a bed hold was not completed there was a possibility that the resident could have a complicated discharge, prolonged hospital stays and lose continuity of care. During a concurrent interview and record review on 3/17/26 at 3:52 PM with RNS 2, Resident 82's Notification of Bed Hold, dated 4/21/2026 was reviewed. The RNS 2 stated, Resident 82's Notification of Bed Hold was not filled out entirely to show the resident's representative was notified. The RNS 2 stated the facility staff should have also signed the form if the resident's representative was informed about the Bed Hold via telephone, otherwise the form was misleading. During a concurrent interview and record review on 3/17/26 at 3:58 PM with RNS 2, Resident 82's Notification of Bed Hold, dated 5/1/2026 was reviewed. The RNS 2 stated Resident 82's Notification of Bed Hold was not filled out entirely but should have been to show the resident's representative was notified. The RNS 2 stated the resident's representative information should have been completed to identify who the facility staff spoke with regarding the bed hold. During an interview on 6/18/2026 at 11:55 AM, the Director of Nursing (DON) stated when residents were transferred to the hospital the facility staff were to notify the resident's representative regarding the Bed Hold notice and if the resident's representative were not present during the transfer, the form could be mailed to them at a later time. The DON stated the form must be filled out entirely to let the resident's representative know the resident had the right to come back to the facility and provided them with reassurance after transferring. During a concurrent interview and record review on 6/18/2026 at 12:05 PM with the DON, Resident 82's Notification of Bed Hold, dated 4/21/2026 was reviewed. The DON stated, Resident 82's Notification of Bed Hold was not filled out entirely but should have been so the resident would know the facility would hold a bed for them after transferring. The DON said if the bed hold was not filled out entirely there could be confusion regarding returning to the facility. During a concurrent interview and record review on 6/18/2026 at 12:07 PM with the DON, Resident 82's Notification of Bed Hold, dated 5/1/2026 was reviewed. The DON stated Resident 82's Notification of Bed Hold was not filled out entirely but should have been so the resident would know they were able to come back to the facility and there would not be a misunderstanding. During a concurrent interview and record review on 6/18/2026 at 12:09 PM with the DON, the facility's policy and procedure (P&P) titled Bed-Holds and Returns dated March 2022 was reviewed. The P&P indicated residents and/or representatives were informed in writing of the facilities bed hold policies which addressed holding or reserving a resident's bed during periods of absence such as hospitalizations. The P&P indicated residents should have been provided written information about the policy at least twice: in the admission packet, well in advance of any transfer and at the time of transfer. The P&P indicated if the transfer for was an emergency, the resident and/or representative should have been notified within 24 hours. The DON stated the facility staff were not following the policy but should have been because the policy tells the facility staff what to do and they must follow what the policy said otherwise there could have been confusion regarding the bed hold. During a review of the facility's P&P titled Transfer or Discharge Notices dated 2021, the P&P indicated the policy was for residents or resident representatives to be notified of impending transfer or discharge and the reasons for the move in writing and in a language and manner they understood. The P&P indicated the resident, and representatives were to be notified in writing of the Notice of Facility Bed-Hold and policies.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive resident specific care plan for two out of two sampled residents (Resident 76 and 82) by failing to: 1. Develop a care plan for Resident 82, who had a change of condition and hospitalized for hypotension low blood pressure) and tachycardia (rapid heart rate) on 5/1/2026. This deficient practice had the potential to result in confusion of resident's care and negatively affect the resident's physical and psychosocial wellbeing. 2. Initiate and implement a care plan addressing the use, monitoring, and potential adverse effects of lorazepam (medication used to reduce anxiety and control seizures) use for Resident 76. This failure had the potential to result in ineffective monitoring of medication's effectiveness and inconsistent implementation of interventions for Resident 76. Findings: 1. During a review of Resident 82's admission Record (AR), the AR indicated the resident was readmitted on [DATE] with chronic respiratory failure (a long-term condition where the lungs cannot adequately pull oxygen into the blood or remove carbon dioxide from the body) with hypoxia (lack of oxygen in the blood), hypoxic ischemic encephalopathy (HIE, a serious brain injury caused by a lack of oxygen and reduced blood flow to the brain) , persistent vegetative state (PVS, a neurological condition where a patient with severe brain damage appears awake but is completely unaware of themselves or their surroundings). During a review of Resident 82's History and Physical Assessment (H&P) dated 5/30/2026 indicated resident does not have the capacity to understand and make decisions. During a review of Resident 82's Minimum Data Set (MDS, an assessment and screen tool) dated 6/1/2026, indicated Resident 82 was in a persistent vegetative state/no discernable consciousness. During a review of Resident 82's Order Summary Report dated 5/1/2026 indicated a physician order was made for resident transfer to General Acute Center Hospital (GACH) via 911 (Emergency) on 5/1/2026 due to tachycardia (an increased heart that exceeds over 100 beats per minute [bpm]) and hypotensive episode (a sudden drop in blood pressure below 90/60 millimeter of mercury [mmHg, unit of measure] that deprives vital organs of necessary blood flow with symptoms often include dizziness, lightheadedness, nausea, or fainting) on 7-day bed hold per facility protocol. During a review of Resident 82's care plans, no care plan was indicated for resident's transfer to GACH due to tachycardia and hypotensive episode. During a concurrent interview and record review of Resident 82's care plans on 6/17/2026 at 2:17 PM, Minimum Data Set Nurse (MDSN) confirmed no care plan was developed for Resident 82 who was transferred to the hospital on 5/1/2026 due to tachycardia and hypotension. MDSN stated the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	importance of the care plan was to address the interventions for the steps to be taken for resident's care. During an interview on 6/18/2026 at 12:43 PM, the Director of Nursing (DON) stated when a resident has a change of condition and transfers to hospital, due to a change of condition, a care plan should be developed or updated. The DON stated the purpose of the care plan was for the staff to know what was going on with the resident and to add more interventions to look out for resident. A review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered dated 3/2023 indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P indicated assessments are ongoing and care plans revised as information about the residents and the residents' conditions change. The P&P indicated the interdisciplinary team (IDT) team reviews and updates the care plan when there has been a significant change in the resident's condition; and when the resident has been readmitted to the facility from a hospital stay. 2. During a review of Resident 76's admission Record, the admission Record indicated, the facility admitted Resident 76 on 4/1/2025 with diagnoses including dementia (a progressive state of decline in mental abilities) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 76's History and Physical (H&P), dated 3/9/2026, the H&P indicated Resident 76 does not have the capacity to understand and make decisions. During a review of Resident 76's Minimum Data Set (MDS - a resident assessment tool), dated 3/26/2026, the MDS indicated, Resident 76 required partial/moderate assistance (helper does less than half the effort) for self-care activities, including oral and toileting hygiene, bathing, and dressing. The MDS indicated, Resident 76 did not exhibit physical (e.g., hitting, kicking, pushing) and verbal (e.g., threatening, screaming, cursing) behavioral symptoms towards others and other behavior symptoms (e.g., hitting/scratching self, pacing, rummaging) not directed towards others. During a review of Resident 76's Physician Orders, dated 5/28/2026, the Physician Orders indicated, Resident 76 was prescribed lorazepam oral tablet 0.5 milligram (mtg – metric unit of measurement, used for medication dosage and/or amount), one tablet by mouth as needed for anxiety manifested by agitation and aggressive behavior towards others for 14 days. During a concurrent interview and record review on 6/17/2026 at 11:18 a.m. with Registered Nurse Supervisor (RNS) 1, Resident 76's care plan was reviewed. The care plan indicated no care plan for Resident 76's lorazepam use. RNS 1 stated, there should be a care plan created for the black box warning associated with lorazepam, changes in condition, and Resident 76's behaviors in response to lorazepam. RNS 1 stated Resident 76 was at potential risk for ineffective monitoring of lorazepam's effectiveness and not achieving the resident's therapeutic goal. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/17/2026 at 1:10 a.m. with the Director of Nursing (DON), Resident 76's care plan was reviewed. The care plan indicated no care plan for Resident 76's Lorazepam use. The DON stated, there should be a care plan created when a resident is receiving psychotropic medications. The DON stated, the potential risk was that there may be ineffective monitoring of the resident's response to the medication and inconsistent implementation of interventions. During a review of the facility's policy and procedures (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 3/2023, the P&P indicated, The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing. e. reflects currently recognized standards of practice for problem areas and conditions.

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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 facilityˆ failed ˆto ˆreviseˆor updateˆthe care plan for one of one sampledˆresidentˆ(Resident 12)ˆto addressˆresident specific activities such as sensory stimulation, conversation, and music in accordance with the facility's policy and procedure titled Care Plans, Comprehensive Person-Centered. ˆ Thisˆdeficientˆpracticeˆhad the potential to result inˆResidentˆ12 notˆreceivingˆappropriate interventionsˆand treatment and/or servicesˆfor ---andˆnegatively affect theˆresident'sˆpsychosocial wellbeing.ˆ Findings:ˆˆ During a review of Resident 12's admission Record (AR), the AR indicated the resident was admitted to facility on 2/22/2026 with diagnoses that included chronic respiratory failure (a long-term condition where the lungs cannot adequately pull oxygen into the blood or remove carbon dioxide from the body) with hypoxia (lack of oxygen in the blood), persistent vegetative state (PVS, a neurological condition where a patient with severe brain damage appears awake but is completely unaware of themselves or their surroundings), and type 2 diabetes mellitus (chronic metabolic disorder characterized by high blood sugar [hyperglycemia] resulting from insufficient insulin [hormone produced by the pancreas that acts as a key, allowing cells to absorb glucose from the blood for energy, and lowering blood sugar levels]) with hyperglycemia. During a review of Residentˆ12's History and Physical (H&P), datedˆ2/23/2026, the H&Pˆdidˆnotˆindicate ifˆtheˆresidentˆhad the capacity to understand and make decisions.ˆˆ During a review of Resident 12's Minimum Data Set (MDS, an assessment and screen tool) dated 5/26/2026, indicated Resident 12 was in a persistent vegetative state/no discernable consciousness. ˆ ˆDuring a review of Resident 12's Documentation Summary Report dated 5/2026 and 6/2026 indicated activities provided for Resident 12 were provide sensory stimulation, supply, conversation, and music. During a review of Resident 12's care plans, the care plan did notˆindicate resident specific activities provided for Resident 12. ˆˆ During a concurrent interview and record review of Resident 12's Documentation Summary Report, dated 5/2026 and 6/2026 with the Activities Director (AD) on 6/17/2026 at 2:45 PM, the AD stated activities for Resident 12 was provided for sensory stimulation, conversation, and music. AD stated Resident 12 usually blinks, and makes facial and body gestures. ˆ During a concurrent interview and record review of Resident 12's care plans on 6/17/2026 at 2:47 PM, AD confirmed Resident 12 did not have a care plan that was patient specific to resident's current activities. AD stated activities staff are able did not update or revise care plans to indicate resident's most current assessment and activities to be provided. AD confirmed care plan for resident activities only included touch and did not include any other activities or resident's interests. ˆ During an interview on 6/18/2026 at 12:48 PM, the Director of Nursing (DON) stated care plans should be patient centered and specific, it gives staff more details to guide them in resident's care. ˆ ˆ ˆ A review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered dated 3/2023 indicated the interdisciplinary team (IDT) in conjunction with the resident and the resident and his/her family of legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The P&P indicated assessments are ongoing and care plans revised as information about the residents and the residents' conditions change.

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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 observation, interview, and record review, the facility failed to ensure one of three sampled resident (Resident 6) with gastrostomy tube (as known as G-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) was provided care and services to prevent skin irritation, breakdown, and infection as indicated in the resident's care plan and facility policy and procedure (P&P) titled Gastrostomy/Jejunostomy (a feeding tube placed directly into the small intestine) Site Care. This deficient practice had the potential to cause worsened skin breakdown on Resident 6's G-tube site and further lead to infection and complications. Findings: During a review of Resident 6's admission Record (AR), the AR indicated that Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic respiratory failure (a long-term condition where there's not enough oxygen in the body), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and dementia (a progressive state of decline in mental abilities). During a review of Resident 6's Physician's Order dated 4/15/2026, the order indicated to cleanse G-tube site with NS (normal saline- a saltwater solution) pat dry, cover with DD (dry dressing). During a review of Resident 6's Order Summary Report (OSR) dated 4/22/2026, the OSR indicated to provided enteral feeding (deliver fluid food and fluid into the stomach) Glucerna 1.5 (a calorically dense formula) at 35 cc (cubic centimeter- a metric unit of volume) per hour for 20 hours via pump to provide 700 cc/1050 Kcal (kilocalories- calories are a unit of energy) per day. During a review of Resident 6's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 5/19/2026, the MDS indicated that Resident 6 was moderately cognitively impaired (decisions poor, cues/supervision required.) The MDS also indicated that Resident 6 had a feeding tube used as nutritional approach, and Resident 6 had mechanically altered diet (require change in texture of food or liquids). During a review of Resident 6's Care Plan ENHANCED BARRIER PRECAUTIONS- (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms) High risk for infection related to. feeding tube. revised on 5/27/2026, the Care Plan indicated to monitor signs and symptoms of infection and to notify MD (medical doctor) if any sign and symptom of infection. During a concurrent observation and interview on 6/15/2026 at 11:00 AM with the Licensed Vocational Nurse (LVN) 1 in Resident 6's room, Resident 6 was observed with light-brown colored soiled drainage gauze on G-tube stoma (a surgical connection between an internal organ and the skin on the outside of body) site covered by a four-by-four gauze, with skin redness surrounding her G-tube site. LVN 1 stated Resident 6's stoma site looked irritated. LVN 1 stated he did not know if there was leaking on Resident 6's stoma. LVN 1 stated that he was supposed to check the dressing as he assessed Resident 6 in the morning and he should have notified the treatment nurse immediately about the issue. During a concurrent observation and interview on 6/15/2026 at 11:10 AM with the Treatment Nurse (TN) 1 in Resident 6's room, Resident 6 was observed with light-brown colored soiled drainage gauze on G-tube stoma site covered by a four-by-four gauze, and skin redness surrounding her G-tube site, measuring approximately four to five centimeters (a unit of length in the metric system) in diameter. TN 1 stated she changed the dressing and noticed the drainage and skin redness this morning. TN 1 stated she was not sure how long Resident 6 has had rashes or skin irritation which and could further lead to infection and skin breakdown if not treated. TN 1 stated she was supposed to call and notify the physician regarding the likelihood of leak and skin irritation. During an interview on 6/16/2026 at 3:58 PM with TN 2, TN 2 stated that she observed pinkish change on the skin surrounding Resident 6's stoma site, measuring approximately one inch (unit of length) in diameter, during care on 6/13/2026 and 6/14/2026. TN 2 stated she assumed the pinkish surrounding Resident 6's stoma as normal however TN 2 stated pinkish skin color was not Resident 6's natural skin tone. TN 2 stated she did not document it or inform the physician and other licensed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staffs. During an interview on 6/18/2026 at 11:00 AM with the Director of Nursing (DON), DON stated that the nurse should have informed the doctor on any change of condition and document it, the nurse also should check residue, measure leak and calculate frequency of gauze change, and monitor for improvement or worsening. During a review of the P&P titled Gastrostomy/Jejunostomy Site Care revised in 3/2023. The P&P indicated the purposes of this procedure are to promote cleanliness and to protect the gastrostomy site from irritation, breakdown, and infection. The P&P indicated to assess the stoma site for signs of redness, pain or soreness, swelling, or drainage. Report any of these signs of infection immediately to your supervisor and the resident's physician. During a review of the P&P Enteral Feeding- Safety Precautions revised in 3/2023. The P&P indicated the following: observe for signs of skin breakdown, infection and irritation; document all assessments, findings, and interventions in the medical record; report unusual findings and/or signs of complications to the physician.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 82) who was at risk for developing pressure injury (a skin breakdown due to prolonged unrelieved pressure, shear and friction on skin) the low air loss mattress (LAL, a specialized medical bed with air-filled tubes connect to a pump to relieve pressure points) was not set according to the manufacturer's Operational Manual. The LAL mattress was set at 160 that corresponded with the resident's assessed weight, it was set for 400 pounds resident. This deficient practice had the potential to compromise pressure redistribution and therapeutic support necessary for the prevention and healing of pressure injuries. Findings: During a review of Resident 82's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included chronic respiratory failure with hypoxia (the lungs were permanently damaged and struggled to move enough oxygen from the air into the bloodstream), tracheostomy (a surgically created hole in the front of the neck that went directly into the windpipe [trachea]), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 82's History and Physical (H&P) dated 5/30/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 82's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 6/1/2026, the MDS indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgment, and make decisions). The MDS indicated that the resident had moisture associated skin damage (MASD, skin irritation, soreness, and breakdown caused by the skin being wet for too long) and was at risk for pressure ulcers/injuries. The MDS indicated that the resident had skin and ulcer/injury treatments that included a pressure reducing device for the bed, application of nonsurgical dressings, and applications of ointments/medications. During a review of Resident 82's Weight Calculations Range Report, the Report indicated the resident weighed 169 pounds. During a review of Resident 82's Physician's Order dated 6/5/2026 at 12:20 PM, the Physician's Order indicated for the resident to have a low air loss mattress for skin care management every shift. During an observation in Resident 82's room on 6/15/2026 at 9:52 AM, the resident's LAL mattress had a yellow circle sticker under the weight setting of 160, but the LAL weight setting was set at 400 (set for 400 pound residents). During an interview on 6/15/2026 at 9:58 AM, the Treatment Nurse (TN) 3 stated the number on the LAL mattress should have been set according to the resident's weight and not set at 400. TN 3 stated the setting on the LAL mattress was to help with skin maintenance, especially with pressure wounds. TN 3 stated he was unsure why Resident 82's LAL mattress setting was not correctly. TN 3 stated without the correct setting the resident could have been uncomfortable because the mattress would have been too hard, and that could cause a pressure injury. During an interview on 6/17/2026 at 4:03 PM, the Registered Nurse Supervisor (RNS) 2 stated the purpose of the LAL mattress was for fragile skin or residents at risk for skin breakdown and the settings of the LAL mattress should have been checked at least every two hours. The RNS stated the LAL mattress was set according to the resident's weight to optimize skin maintenance. RNS 2 stated the LAL mattress should have been set to Resident 82's weight and not at 400 to provide the optimal level of firmness to maintain Resident 82's skin properly. The RNS stated if the LAL mattress was not set at the right setting, that could have increased the risk of skin breakdown for Resident 82 and could affect the resident's comfort. During an interview on 6/18/2026 at 12:18 PM, the Director of Nursing (DON) stated the LAL mattress was used to prevent skin pressure injuries and lift the pressure on wounded areas and should have matched the resident's weight and checked constantly. The DON stated if the weight was set at 400 for Resident 82, that was not correct because if the weight setting did not match the residents weight, the LAL mattress was not relieving the pressure on the resident and there could be a slow (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	healing process. During a concurrent interview and record review on 6/18/2026 at 12:25 PM with the DON, the facility's policy and procedure (P&P) titled Pressure-Reducing Mattresses dated 6/2025 was reviewed. The P&P indicated the objective of the policy was to provide mattresses that prevented and/or minimized pressure on the skin and to offer enhanced comfort when preferred by the resident. The P&P indicated to follow the manufacturer's instructions and adjust the LAL mattress to a desired firmness based on the resident's weight. The P&P indicated for residents using the Proactive (Protekt Aire) mattress, to refer to the setting guidelines. The DON stated the facility staff were not following the policy but should have been to relieve the pressure on the resident skin, otherwise that could have slowed the healing process. During a review of the undated Operation Manual for the LAL mattress Proactive Protekt Aire 4000DX/5000DX, the Operation Manual indicated for the weight/pressure set up, users could adjust the air mattress to a desired firmness according to the patient's weight or the suggestion from a health care professional.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to provide adequate supervision for one of three sample residents (Resident 76), who was considered a high fall risk, by failing to: 1. Immediately respond to the Pad alarm (a pad with sensors that will alarm on the chair or bed when a resident stands up unassisted to help prevent falls by alerting staff) when the alarm turns on to check Resident 76. 2. Ensure Resident 76 had frequent visual supervision as part of the Falling Star Program (a visual safety program used in long-term care facilities to prevent residents from falling). 3.Re-evaluate Resident 76's falls prevention interventions identified during the Interdisciplinary Team (IDT, group of healthcare professionals who collaborate to create a plan of care for residents) meeting on 2/11/2026. As a result Resident 76 had unwitnessed fall in the bathroom on 2/10/2026 and sustained a hematoma (localized collection of blood that pools outside of blood vessels, usually caused by trauma on the forehead, and a recurrent fall on 4/24/2026 when the Certified Nurse Assistant (unknown CNA) unbuckled Resident 76 from shower chair (stable, water-safe seat designed for the bathtub or shower) in the shower room, turned around to reach for the soap, and Resident 76 leaned out of the shower chair tipping it over. In addition, these failures had the potential to result in recurrent falls for Resident 76 sustaining further severe injuries and hospitalization related to fall. Findings: During a review of Resident 76's admission Record (AR), the AR indicated that the facility admitted Resident 76 on 4/1/2025 and readmitted Resident 76 on 2/11/2026 with diagnoses that included heart failure (the heart cannot pump blood efficiently to the rest of the body), dementia (a progressive state of decline in mental abilities), history of falling, and abnormalities of gait (specific balance) and mobility. During a review of Resident 76's initial Fall Risk Assessment record, dated 4/2/2025, the record indicated that Resident 76 was a high risk for falls. During a review of Resident 76's care plan, dated 4/2/2025, the care plan indicated that Resident 76 was at risk for falls and injury due to dementia, poor body balance, and poor safety awareness. The care plan's interventions included visibly observe Resident 76 frequently and provide Resident 76 with a safe and cluttered-free environment. During a review of Resident 76's care plan, dated 4/2/2025, the care plan indicated that Resident 76 was placed on the Falling Star Program because she was at risk for falls. The care plan's interventions included to frequent visual monitoring and to place Resident 76 close to the nursing station for close observation. During a review of Resident 76's Minimal Data Set (MDS, a resident assessment), dated 1/2/2026, the MDS indicated that Resident 76's cognitive (a resident's thought process) skills were severely impaired. The MDS indicated that Resident 76 was frequently incontinent (loss of control of bladder and bowel) of urine and stool. The MDS indicated that Resident 76 used a walker (an assistive mobility tool) and a wheelchair (an assistive mobility device with wheels) as her mobility device. The MDS indicated that Resident 76 did not have any falls since admission. During a review of Resident 76's Change of Condition Evaluation (CoC) record, dated 2/10/2026 timed at 12 AM, the CoC indicated that Resident 76 had an unwitnessed fall and was in a sitting position on the floor in front of the bathroom [door]. The report indicated Resident 76 had a large bump on [her] forehead and was transferred to the General Acute Care Hospital (GACH) 1 for further evaluation. During a review of Resident 76's Post-Fall Evaluation record, dated 2/10/2026 timed at 12:30 AM, the record indicated that Resident 76 was attempting to ambulate to the bathroom at the time of the fall. During a review of Resident 76's GACH 1 Discharge Summary record, dated 2/11/2026 timed at 7:51 AM, indicated Resident 76 sustained a superficial hematoma on the forehead from the fall with the discharge instructions that included to ensure fall precautions are taken at [the facility]. The record indicated that Resident 76's fall was most likely a mechanical fall (a fall caused by an external, environmental factor [like a slip, trip, or stumble] rather than an underlying medical condition) given [Resident 76's] was frail [in] nature and reliant on walker for ambulation. During a review of Resident 76's IDT Narrative, dated 2/11/2026 timed at 9:40 AM, indicated that Resident (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	76's bed will be placed in the lowest position, will remain on the Falling Star Program, bed will have a bed alarm, and wheelchair will have a chair alarm to alert staff that resident is high risk for falls. During a review of Resident 76's Nursing Progress Notes (PN), dated 4/24/2026 timed at 9:25 AM, the PN indicated that the Resident 76's Certified Nurse Assistant (CNA) (unknown) at the time had unbuckled the seatbelt on the shower chair and turned around to reach for the soap when Resident 76 suddenly tried to reach out to grab [the] shower head leaning forward causing [the]chair to tip over and [Resident 76] to fall off the [shower]chair. The PN indicated that Physician 2 was notified and recommended x-rays (medical imaging) of her left leg, bilateral hips, and lower back. During a review of Resident 76's IDT Narrative record, dated 4/24/2026 at 10:30 AM, the record indicated that Resident 76 will have continuous monitoring for any condition changes. The record did not show any documented evidence of revised or updated interventions related to Resident 76's fall on 4/24/2026 to prevent recurrent fall. During an observation on 6/15/2026 at 9:10 AM in Resident 76's room, Resident 76 was observed lying in bed with the floor mat noted on the right side of the bed. Resident 76 was observed turning in bed, and an alarm started beeping. A staff member came into Resident 76's room to turn off the bed alarm. During another observation on 6/17/2026 at 4:21 PM in Resident 76's room, an alarm started beeping. Resident 76 was observed standing on the right side of the head of the bed touching the wall and the bedside table while saying beep .beep. Resident 76 opened the drawer of the bedside table, pulled out the bed alarm, and turned off the alarm. However, the beeping noise started again and continued to persist until CNA 1 who was outside of the resident's room and was asked to assist Resident 76's by the survey team. Resident 76 remained standing at the head of the bed attempting to turn off the bed alarm. During the same observation and interview on 6/17/2026 at 4:25 PM with CNA 1 in Resident 76's room, CNA 1 was observed opening the drawer of the bedside table and turning off the bed alarm (about 5 minutes since the bed alarm started). CNA 1 was observed talking to Resident 76 and assisting Resident 76 to sit back in her bed that was in low position. CNA 1 stated that Resident 76 had a bed and a chair alarm because she was on the Falling Star program and the alarm was used to alert staff when Resident 76 moves in bed or in the chair and the staff was to check on Resident 76 right away if the alarm was heard. CNA 1 stated that Resident 76 does stand up from the bed to turn off the bedside alarm herself. During a concurrent interview and record review on 6/18/2026 at 11:50 PM with Registered Nurse (RN) 1, Resident 76's Fall Risk Assessments dated 2/10/2026 and 4/24/2026, were reviewed. RN 1 stated that Resident 76 was at high risk for fall and she had a bed and a chair alarm to alert staff to check on Resident 76 right away. RN 1 stated that Resident 76 does get out of bed a lot to turn off the bed alarm when it starts making noises. RN 1 stated that Resident 76's care plan was not revised and no new interventions from her fall on 2/10/2026 was added or changed from her fall on 4/24/2026. During a concurrent interview and record review on 6/18/2026 at 3:35 PM with the Director of Nursing (DON), Resident 76's care plans and IDT Narrative records, dated 2/10/2026 and 4/24/2026, were reviewed. The DON stated that there was no documented evidence that the interventions to prevent fall was evaluated for the effectiveness or not effectiveness of the interventions to prevent recurrent falls. During the same interview on 6/1/2026 at 3:40 PM with the DON, the DON stated that the purpose of the bed or chair alarms was to notify staff to promptly respond to the alarm to visually check on and visualize Resident 76's behavior to prevent another fall. During the same interview on 6/18/2026 at 3:45 PM with the DON, the DON stated when Resident 76 fell on 4/24/2026, the CNA did not supervise Resident 76 in the bathroom when she turned around to reach the soap to continue bathing Resident. During a review of the facility's policies and procedures (P&P) titled Personal Alarm, unknown date, the P&P indicated to attend residents promptly when alarm sounds and provide appropriate assistance. During a review of the facility's policies and procedures (P&P) titled Fall Risk Assessment, dated 3/30/2023, the P&P indicated that the facility will establish a resident-centered falls prevention plan based on relevant assessment information, evaluate functional and psychological factors that may increase fall risks, identify environmental factors that may contribute to falling, and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to identify and address modifiable fall risk factors and interventions to minimize the consequences of risk factors that are not modifiable. During a review of the facility's P&P titled Falling Star Program, dated March 2025, the P&P indicated that the purpose of the program was to identify any residents who may be at higher risk for falling to increase awareness and provide safety measures. The P&P indicated that recommendations to ensure a successful program would be to include the evaluation for appropriate ?useful' interventions for fall reduction.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sample residents (Resident 8), who received hospice care (compassionate care for people who are near the end of life) and services was assessed and reassessed for the intensity of pain, characteristics, patterns, frequency, timing and duration and location of pain associated with the administration of Tramadol (a prescription pain medication to treat moderate to severe pain) in accordance with the resident's care plan and facility's policy and procedures (P&P) titled Pain Management. Resident 8 continued to receive Tramadol multiple times between May 2026 and June 2026 for a pain level of 0 - 4/10 on the numerical pain scale (a way to rate pain intensity, ranging from 0 - no pain to 10 - worst pain left) without pain assessment and reassessment documented in the clinical record. These deficient practices had the potential to result in unnecessary use of pain medication or uncontrolled pain experience that could lead to functional decline, and poor quality of life. Findings: During a review of Resident 8's admission Record (AR), the AR indicated that the facility admitted Resident 8 on 2/7/2024 and readmitted Resident 8 on 3/2/2026 with diagnoses that included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), cerebral infarction (stroke, decrease or blockage of blood flow to the brain), Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high blood sugar) and foot ulcer (an opening or sore generally found in the stomach or on the skin), and contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the left and right knee. During a review of Resident 8's care plan, dated 2/12/2024, the care plan indicated that Resident 8 received tramadol and was at risk for adverse effects (undesired effect of medication) with interventions that included to review pain medication efficacy, assess whether the pain intensity was acceptable to the resident, and if the pain control was not adequate, notify the physician to adjust/change therapeutic regimen, as appropriate. During a review of Resident 8's Minimal Data Set (MDS, a resident assessment), dated 3/16/2026, the MDS indicated that Resident 8's cognitive (a resident's thought process) skills were severely impaired. The MDS indicated that Resident 8 did not receive a schedule pain medication regimen, and the MDS indicated that Resident 8 did not experience pain. The MDS indicated that Resident 8 received opioids (prescribed pain medications to treat moderate to severe pain). During a review of Resident 8's care plan, revised on 3/23/2026, the care plan indicated that Resident 8 received hospice care related to end-stage Alzheimer's disease. The care plans interventions included to assess for non-verbal indicators of pain, administer pain medication as ordered, and to monitor the effectiveness of the pain medicine and notify the physician as needed. During a review of Resident 8's Hospice 1's Medication Profile record, an order, dated 4/3/2026, indicated that Resident 8 received Tramadol 50 mg oral tablet with instructions to take 1 tablet by the gastrostomy (g-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) every 8 hours routine for moderate pain. During a review of Resident 8's History and Physical (HP), dated 5/13/2026, the HP indicated that Resident 8 does not have the capacity to understand and make decisions. During a review of Resident 8's Order Summary Report, an order, dated 5/22/2026, indicated that Resident 8 received Tramadol HCL 50 mg oral tablet with instructions to give 1 tablet by g-tube every 8 hours for moderate pain (5-7/10 pain on the pain scale). During a review of Resident 8's Order Summary Report, an order, dated 5/30/2026, indicated that Resident 8 received serviced care from Hospice 1. During a review of Resident 8's MDS, dated [DATE], the MDS indicated that Resident 8's cognitive skills were severely impaired. The MDS indicated that Resident 8 did experience pain and was on a scheduled pain medication regimen. The MDS indicated that Resident 8 received opioids. During a review of Resident 8's Medication Administration Record (MAR) for May and June 2026, the MAR indicated that Resident 8 received Tramadol from 5/22/2026 - (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/31/2026) and for a pain level of 0-4/10 (28 times) and from 6/1/2026 - 6/18/2026 for a pain level of 0-4/10 (48 times). During a concurrent observation and interview on 6/15/2026 at 9:20 AM in Resident 8's room, Resident 8 was observed lying in bed, awake, and with bilateral upper and lower extremity contractures. Resident 8 stated that he had pain but I do not know where. During a concurrent interview and record review on 6/18/2026 at 10:48 with Licensed Vocational Nurse (LVN) 2, Resident 8's MAR for June 2026 was reviewed. LVN 2 stated that Resident 8 received scheduled Tramadol medication around lunch time, between 12 PM - 1PM. During a concurrent interview and record review on 6/18/2026 at 11:04 AM with Registered Nurse (RN) 1, Resident 8's Active Orders and MAR for May 2026 and June 2026, were reviewed. RN 1 stated, according to the Active Orders list, Resident 8 had an active order to receive Tramadol 50 mg for moderate pain with the parameters of 5 - 7/10 on the pain scale. RN 1 stated, according to the May 2026 and June 2026 MAR, the Licensed Nurse administered Tramadol almost every 8 hours for a pain level of 0 - 4/10 on the pain scale, which was not within the physician's orders parameters. During the same concurrent interview and record review on 6/18/2026 at 11:15 AM with RN 1, Resident 8's Nursing Progress Notes from May 2026 to June 2026 were reviewed. RN 1 stated, there was no documented evidence that indicated resident was assessed and reassessed for the intensity of pain, characteristics, patterns, frequency, timing and duration and location of pain associated with the administration of Tramadol. During an interview on 6/18/2026 at 3:05 PM with the Director of Nursing (DON), the DON stated that it was important to assess the resident's pain characteristics and to administer the proper pain medication based on the resident's pain level and the physician's orders and parameters. The DON stated it was important to reassess the resident's pain level after providing pain medication to determine if the medication was effective or not. During a review of the facility's policies and procedures (P&P) titled Pain Management, dated March 2020, the P&P indicated that pain management is a multidisciplinary care process that includes identifying the characteristics of pain, identifying and using specific strategies for different levels and sources of pain, monitoring for the effectiveness of interventions, and modifying approaches as necessary. The P&P indicated that acute pain (or significant worsening of chronic pain) should be assessed after the onset and reassessed as indicated until relief is obtained. During a review of the facility's same P&P titled Pain Management, dated March 2020, assessing pain included the characteristics of pain such as the location, intensity of pain, characteristics of pain, patterns of pain, and the frequency, timing and duration of the pain. The P&P indicated that the pain management interventions shall reflect the sources, type, and severity of pain.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. During an observation, interview, and record review, the facility failed to evaluate why the alternative interventions were ineffective prior to installing four bedrails for one of three sample residents (Resident 10). In addition, Resident 10 was not monitored for the use of side rails as indicated in the facility's policies and procedure (P&P) titled, ?Bed Safety and Bed Rails (adjustable metal or rigid plastic bars that attach to the head and foot of the bed), dated March 2023. These failures had the potential for Resident 10 to be at risk for entrapment (when a resident can get caught by the head, neck, chest, or other body part in the right spaces around the bedrail) and physical injuries such as bruising or fractures (broken bone), which may result in hospitalization or death. Findings: During a review of Resident 10's admission Record (AR), the AR indicated that the facility admitted Resident 10 on 3/30/2026 with diagnoses that included acute and chronic respiratory failure (resident's lungs cannot carry enough fresh oxygen to the rest of the body) with hypoxia (the body does not receive enough oxygen to properly function), Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing)) with hyperglycemia (high blood sugar), and generalized muscle weakness. During a review of Resident 10's Supportive and Safety Device/Restraint Physical - Initial record, dated 3/30/2026, the record indicated that the only alternative intervention prior to the implementation of bed rails was to provide one to one activities and supervision to Resident 10. but the record did not show any documented evidence as to why the alternative did not work. During a review of Resident 10's Order Summary Report, an order, dated 3/30/2026, indicated that Resident 10 had bilateral full bed rails due to being a fall risk. During a review of Resident 10's history and physical (HP), dated 4/2/2026, the HP indicated that Resident 10 did not have the capacity to understand and make decisions. During a review of Resident 10's care plan, dated 4/2/2026, the care plan indicated Resident 10 had all bed rails up and locked when in bed to minimize risk of falls and injury. The care plan's intervention indicated to attempt to use less restrictive devices on an ongoing basis. During a review of Resident 10's Minimal Data Set (MDS, a resident assessment tool), dated 4/3/2026, the MDS indicated that Resident 10's cognitive (a resident's thought process) was moderately impaired. The MDS indicated that Resident 10 was dependent (helper does all the work) for activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily) and functional mobility (such as repositioning in bed and transferring from bed or chair to bed). The MDS indicated that Resident 10 did not have any prior falls within the last 2 - 6 months prior to admission to the facility. The MDS indicated that Resident 10 had daily use of bed rails. During an observation on 6/15/2026 at 9:39 AM in Resident 10's room, Resident 10 was observed lying asleep in bed with all four bed rails up and locked. During a concurrent interview and record review on 6/17/2026 at 4:15 PM with License Vocational Nurse (LVN) 3, Resident 10's signed Physical Restraint Informed Consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) record, dated 3/30/2026, was reviewed. LVN 3 stated that she did not know the reason for Resident 10's four bed rail use. LVN 3 stated that Resident 10 used to get out of bed a lot before, but she stated that Resident 10 stopped the behavior about one month ago. During a concurrent interview and record review on 6/17/2025 at 3:55 PM with the Director of Nursing (DON), Resident 10's electronic Active Order list was reviewed. The DON stated the facility attempted alternative measures prior to bedrails used by placing Resident 10 bed in a low position, but the DON stated there was no documented evidence of an active order to place Resident 10 in a low bed. The DON stated there was no other alternative attempted and the reason for its inability to meet Resident 10's needs prior to placing four bed rails on Resident 10 bed. During the same interview on 6/17/2026 at 4 PM with the DON, Resident 10's care plan and Active Orders list, dated 4/2/2026, were reviewed. The (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON stated that Resident 10's bed rail care plan did not indicate any monitoring for bed rails while in use and the Active Orders list did not show any active order to monitor the safe use of Resident 10's bed rails. The DON stated it was important to monitor the use and safety of bed rails to prevent entrapment, which may lead to potential injury such as fractures. During a review of the facility's policy and procedure (P&P) titled Bed Safety and Bed Rails, dated March 2023, the P&P indicated that the use of bed rails or side rails is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. During a review the facility's same P&P titled Bed Safety and Bed Rails, dated March 2023, the P&P indicated that if attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails. This interdisciplinary evaluation includes: an evaluation of the alternatives to bed rails that were attempted and how these alternatives failed to meet the resident's needs.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the Pharmacist Consultant (PC) 1 identified and reported the medication irregularities to the attending physician and the facility's medical director and director of nursing during the medication regimen review for one of three sampled residents by failing to: 1. Administered Journavx (Suzetrigine a pain medication) tablet via Gˆtube (a tube surgically inserted into the stomach for delivery of fluids and medications) without crushing from 3/29/2026 to 6/16/2026. A pharmaceutical recommendation indicated not to crush Journavx tablet. 2. Continuously administer Journavx tablet from 6/1/2026 to 6/15/2026 after effective administration of Acetaminophen (a pain medication) was documented. This deficient practice increased the risk for Resident 6 to experienced adverse effects (unwanted or dangerous medication-related side effects) related to pain medication, such as muscle spasms (painful contractions and tightening of the muscles), increased creatine phosphokinase (CPK- an enzyme in the body found mainly in the heart, brain, and skeletal muscle), and rash. Findings: During a review of Resident 6's admission Record (AR), the AR indicated that Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic respiratory failure (a long-term condition where there's not enough oxygen in the body), Pressure ulcer Stage Four (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of sacral region (bottom of the spine), and dementia (a progressive state of decline in mental abilities.) During a review of Resident 6's Physician's Order dated 3/29/2026, this order indicated that she was prescribed Journavx Oral tablet 50 milligrams (mg- metric unit of measurement, used for medication dosage) via G-tube every 12 hours for pain management. During a review of the consultant pharmacist's MRR dated months of 4/2026, 5/2026, and 6/2026 indicated there was no documentation the pharmacist identified the irregularity in the medication regimen of Resident 6. The MRR had no documentation that the physician or the DON was notified that Journeaux tablet was continued to be administered even after the effective administration of Acetaminophen was documented, and no documentation the Pharmacy Consultant (PC) 1 informed the prescribing physician that Journavx should not be crushed when administered to Resident 6. During a review of Resident 6's medication administration record (MAR) from 3/29/2026 to 6/15/2026, the MAR indicated Resident 6's pain level was documented as zero (0) and Journavx was administered every 12 hours daily via G-tube. During a review of Resident 6's MAR from 6/1/2026 to 6/15/2026, the MAR Acetaminophen Liquid indicated Resident 6's pain level was three or four, medication was marked ˆ referring as administered and follow up codes were documented as E referring as effective on dates 6/4/2026, 6/5/2026, 6/7/2026, 6/8/2026, 6/14/2026, and 6/15/2026. During a concurrent telephone interview and record review on 6/17/2026 at 3:01 PM with the facility's PC 1, Resident 6's clinical records were reviewed. PC 1 stated he had not sent a notice to Resident 6's physician who prescribed Journavx and recommended other alternatives to this drug although he had been aware that Resident 6 received Journavx for pain management by G-tube. PC 1 stated the reason for not sending a notice to the prescriber was because based on his review Resident 6 was still in pain despite documentation in MAR from 6/1/2026 to 6/15/2026 indicated effective after given Acetaminophen. PC 1 further stated he did not inform the physician that the Journavx tablet could not be crushed because he did not know that the medication was non-crushable. During an interview on 6/18/2026 at 11:25 AM with the Director of Nursing DON), the DON stated that the licensed nurses administering medications were supposed to identify Journavx's medication label indicating DO NOT CRUSH, and the concern should have been addressed by speaking to Resident 6's attending physician. DON also stated that medication use should be consistent with an individual's condition, so when a non-crushable medication was administered in crushed form could have not been effective but instead increase risk (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of adverse effects on residents. During a review of the facility's policy and procedures (P&P) Medication therapy dated in 2001. The P&P indicated that each resident's medication regimen should include only those medication necessary to treat existing conditions and address significant risks; all medication orders will be supported by appropriate care processes and practices; upon or shortly after admission , and periodically thereafter, the staff and practitioner (assisted by the consultant pharmacist) will review an individual's current medication regimen, to identify whether: There is a clear indication for treating that individual with the medication.the dosage is appropriate; the frequency of administration and duration of use are appropriate; and potential or suspected side effects are present. The P&P also indicated that the medical director and consultant pharmacist should collaborate to address issues of medication prescribing and monitoring with the practitioner and staff.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on observation, interview, and record review, the facility failed to notify Physician 1 (On-Call Attending Physician) that one of three sample residents (Resident 90) the laboratory test result of positive urine culture (presence of bacteria in the urine) and sensitivity (laboratory test to determine the most effective medication to treat an infection) on 6/13/2026 at 10:27 PM. This failure resulted in Resident 90 receiving delayed treatment for infection and received first IV (intravenous, a method to deliver fluids or medication directly into the vein) antibiotic (medication used to treat infection) medication for her urinary tract infection (UTI, an infection in the bladder/urinary tract) on 6/15/2026 at 9:20 AM. This failure had the potential to result in worsening UTI, permanent kidney damage, hospitalization, and death. Findings: During a review of Resident 90's admission Record (AR), the AR indicated that the facility admitted Resident 90 on 5/18/2025 with diagnoses that included chronic kidney disease (damaged kidneys cannot filter out waste or excess fluids), acquired cyst (a fluid filled pocket that visually appears as a lump on any part of the body) of the kidney, hydronephrosis (swelling of the kidneys) with renal and ureteral calculous obstruction (blockage of the urinary tubes), and dementia (a progressive state of decline in mental abilities) During a review of Resident 90's History and Physical (HP), dated 8/9/2025, the HP indicated that Resident 90 did not have the capacity to understand and make decisions. During a review of Resident 90's care plan, dated 5/19/2025, the care plan indicated that Resident 90 was at risk for fluid retention due to her chronic kidney disease and hypoalbuminemia (low albumin [protein used to keep fluid within the blood vessels]). The care plan's intervention included to monitor for signs of excess fluid such as swelling and abnormal breath sounds and signs of fluid deficit such as decrease urine output and altered laboratory results, and to notify the physician as indicated. During a review of Resident 90's care plan, dated 7/31/2025, the care plan indicated that Resident 90 had bladder incontinence (lack of bladder or bowel control) due to dementia. The care plan's interventions indicated to monitor for incontinent episodes, to monitor for signs and symptoms of UTI. During a review of Resident 90's care plan, dated 7/31/2025, the care plan indicated that Resident 90 had the potential for unavoidable and recurrent UTI related to right renal cyst and bilateral hydronephrosis. The care plan's interventions indicated to follow up with laboratory results such as the urinalysis (UA, urine test) and urine culture and sensitivity as ordered. During a review of Resident 90's Minimal Data Set (MDS, a resident assessment tool), dated 4/16/2026, the MDS indicated that Resident 90 cognitive (a resident's thought process) skills for daily decision making were severely impaired. The MDS indicated that Resident 90 was dependent (helper does all the effort) on staff for activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily). The MDS indicated that Resident 90 was always incontinent (no control over bladder and bowel) of urine and stool. During a review of Resident 90's Lab Results Report record, reported date on 6/13/2026 timed at 8:29 PM, the record indicated that Resident 90's preliminary urine culture results with 50,000 - 99,000 colonies of Proteus Mirabils (a common bacteria that naturally lives in the intestines that may migrate from the intestines into urethra and bladder) were reported to the facility on 6/12/2026 at 11:06 PM with a positive urine culture. The record indicated that Resident 90's final urine culture results and sensitivity was reported to the facility on 6/13/2026 at 10:27 PM. During a concurrent observation and interview on 6/15/2026 at 12:30 PM with Licensed Vocational Nurse (LVN) 3, in Resident 90's room, Resident 90 was observed lying in bed with a new IV site in the left hand with an IV antibiotic infusing into the IV site. LVN 3 stated that Resident 90 was just started on a new IV antibiotic this morning (6/15/2026). During a concurrent interview and record review on 6/17/2026 at 2:43 PM with LVN 3, Resident 90's Lab Result Report record, reported date on 6/13/2026 timed at 8:29 PM, was reviewed. LVN 3 stated that the record indicated that Resident 90's UA and urine culture were collected by the laboratory on 6/10/2026 at 4:30 AM and the results of the UA and urine culture were (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported to the facility on 6/13/2026 at 10:27 PM. LVN 3 stated she did not know about the positive UA or urine culture until the morning of 6/15/2026 until RN 1 notified her. During a concurrent interview and record review on 6/17/2026 at 2:50 PM with RN 1, Resident 90's Lab Results Report, record, reported date 6/13/2026 timed at 8:29 PM, was reviewed. RN 1 stated that the record indicated that Resident 90's UA and urine culture were collected on 6/10/2026 at 4:30 AM and the final urine culture and sensitivity results were reported to the facility on 6/13/2026 at 10:27 PM. RN 1 stated, she found the abnormal laboratory results first thing in the morning on 6/15/2026 and she notified Physician 1 of the abnormal results. RN 1 stated, it was the responsibility of the Licensed Nurse to look at the lab results and notify the physician of any abnormal or critical results promptly. During a concurrent interview and record review on 6/18/2026 at 2:50 PM with the Infection Preventionist Nurse (IPN), Resident 90's Lab Results Report, record, reported date 6/13/2026 timed at 8:29 PM, and nursing progress notes, dated from 6/8/2026 to 6/15/2026, were reviewed. The IP stated that the record indicated the facility received a report from the laboratory that Resident 90's final urine culture and sensitivity result on 6/13/2026 at 10:27 PM. The IP stated there was no documented evidence in the nursing progress notes that the final urine culture and sensitivity results were reported to Physician 1 on 6/13/2026 or 6/14/2026. The IP stated that the Licensed Nurse (unknown) who received the results on 6/13/2026 did not notify Physician 1. The IP stated, if the Licensed Nurse was unable to notify Physician 1 promptly, the Medical Director should have been notified. The IP stated that because of the delay in care, Resident 90's antibiotic treatment was not started until 6/15/2026. During an interview on 6/18/2026 at 3:10 PM with the Director of Nursing (DON), the DON stated that when the facility receives an abnormal or critical abnormal lab results (a lab result that is outside of the facility's reference range), it was the responsibility of the Licensed Nurse to notify the physician promptly to prevent a delay in treatment. During a review of the facility's policies and procedures (P&P) titled Change in Resident's Condition, dated March 2023, the P&P indicated that the facility promptly notifies the resident, his or her attending physician, and the resident's representative of changes in the resident's medical/mental condition and/or status. During a review of the same facility's P&P titled Change in Resident's Condition, dated March 2023, the P&P indicated that the nurse will notify the resident's attending physician or physician on call when there has been a need to alter the resident's medical treatment significantly. The P&P indicated that except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on interview and record review, the facility failed to ensure an informed consent for the use of lorazepam (medication used to reduce anxiety and control seizures) was signed by a physician for one of one sampled resident (Resident 76). This failure had the potential to result in no validation that Resident 76's representative received information on the purpose, risks/benefits, and potential side effects of the lorazepam.Findings: During a review of Resident 76's admission Record, the admission Record indicated, the facility admitted Resident 76 on 4/1/2025 with diagnoses including dementia (a progressive state of decline in mental abilities) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 76's History and Physical (H&P), dated 3/9/2026, the H&P indicated Resident 76 does not have the capacity to understand and make decisions. During a review of Resident 76's Minimum Data Set (MDS - a resident assessment tool), dated 3/26/2026, the MDS indicated Resident 76 had severe cognitive impairment (major loss in mental abilities significantly affecting daily functioning). The MDS indicated Resident 76 did not exhibit physical (e.g., hitting, kicking, pushing) and verbal (e.g., threatening, screaming, cursing) behavioral symptoms towards others and other behavior symptoms (e.g., hitting/scratching self, pacing, rummaging) not directed towards others. During a review of Resident 76's Physician Orders, dated 5/28/2026, the Physician Orders indicated, Resident 76 was prescribed lorazepam oral tablet 0.5 milligram (mg - metric unit of measurement, used for medication dosage and/or amount), one tablet by mouth as needed for anxiety manifested by agitation and aggressive behavior towards others for 14 days. During a concurrent interview and record review on 6/17/2026 at 11:18 a.m. with Registered Nurse Supervisor (RNS) 1, Resident 76's informed consent for the use of lorazepam was reviewed. The informed consent indicated no prescriber's signature. RNS 1 stated that the prescriber would call the family to explain the benefits and risks of the medication to the resident's representative and sign the informed consent. RNS 1 stated, the prescriber should have signed the informed consent. RNS 1 stated, Resident 76's representative was at potential risk for not being fully informed of the purpose, risks/benefits, and potential side effects of lorazepam. During a concurrent interview and record review on 6/17/2026 at 1:10 a.m. with the Director of Nursing (DON), Resident 76's informed consent for the use of lorazepam was reviewed. The DON stated, informed consent should be obtained prior to administering psychotropic medication to the resident. The DON stated, the prescriber should have signed the informed consent. The DON stated, the potential risk was a resident may receive a medication that may not be align with the resident's medical wishes. During a review of the facility's policy and procedures (P&P) titled, Policy: Psychotherapeutic Drug Informed Consent, revised 1/2026, the P&P indicated, The prescriber must sign an informed consent form after explaining all necessary information to the residents or their representatives.