STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055187	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Post Acute Rehabilitation	14475 Garden View Lane Baldwin Park, CA 91706

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light was within reach for two of two sampled residents (Residents 1 and 50). These failures had the potential to result in Residents 1 and 50 not receiving care or receiving delayed services to meet the residents' needs and could result in a fall or injury. Findings: a. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including difficulty walking, history of falling, displaced intertrochanteric fracture of right femur (broken hip occurring at the top of the right thigh bone), hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body). During a review of Resident 1's Fall Risk Evaluation (FRE- method of assessing a patient's likelihood of falling) dated 1/19/2026, the FRE indicated Resident 1 had one to two falls in the past three months, was bedbound and had a change in condition in the last 14 days, and recent hospitalization history in the last 30 days. During a review of Resident 1's untitled Care Plan (CP) dated 2/1/2026, the CP indicated Resident 1 was at risk for falls/injury due to generalized weakness related to decline in functional strength and endurance associated with multiple medical condition. The CP interventions included for the nursing staff to ensure Resident 1's call light was within reach and encouraged Resident 1 to use it for assistance as needed. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 2/2/2026, the MDS indicated Resident 1 had moderately impaired cognition (ability to understand and process information) for daily decision making. The MDS indicated Resident 1 needed maximum (helper did more than half the effort) assistance from the staff for eating, oral hygiene, toileting, showering, upper/lower body dressing and putting on/off footwear. During an observation on 2/24/2026 at 9:05 am, Resident 1 was awake, lying in bed with call light stuck on the right side of the bed and rails. During a concurrent observation and interview on 2/24/2026 at 9:06 am, with Responsible Party 1 (RP 1), RP 1 stated Resident 1 had right sided weakness and a fall at home. RP 1 stated Resident 1 could not see and reach Resident 1's call light. During a concurrent observation and interview on 2/24/2026 at 9:07 am, with Treatment Nurse 1 (TN 1), TN 1 stated, Resident 1's call light was not within reach. Resident's call light needed to be accessible at all times in case the resident needed assistance from the staff. b. During a review of Resident 50's AR, the AR indicated Resident 50 was admitted to the facility on [DATE] with diagnoses including difficulty walking, history of falling, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. During a review of Resident 50's FRE dated 1/13/2026, the FRE indicated Resident 50 had one to two falls in the past three months, intermittent confusion, was bedbound, had a change in condition in the last 14 days, and recent hospitalization history in the last 30 days. During a review of Resident 50's untitled CP dated 1/15/2026, the CP indicated Resident 50 was at risk for falls related to confusion, cerebrovascular accident (blood flow to a part of the brain is stopped), right hemiplegia and history of fall. The CP intervention indicated for the nursing staff to ensure Resident 50's call light was within reach and encouraged the resident to use it for assistance as needed. During a review of Resident 50's MDS dated [DATE], the MDS indicated Resident 1 had moderately impaired cognition for daily decision making. The MDS indicated Resident 1 needed maximum assistance to (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff for eating, oral hygiene, toileting, showering/bathing self, upper/lower body dressing and putting on/taking off footwear. During an observation on 2/24/2026 at 9:37 am, Resident 50 was awake, sitting in a wheelchair on the bottom right side of the bed with the call light on the left upper side of the bed. During a concurrent observation and interview on 2/24/2026 at 9:38 am with the Director of Staff and Development (DSD), the DSD stated Resident 50 was unable to reach the call light because it was placed on the left upper side of the bed. The DSD stated the purpose of the call light was for the residents to use it to call the staff if they needed help from the staff. The DSD stated the residents' needs would not be met if the call light was not within reach. During an interview on 2/26/2026 at 1:20 pm with Director of Nursing (DON), the DON stated the resident's call light needed to be always accessible to the residents for safety in case they needed assistance from the staff. During a review of the facility's Policy and Procedure (P&P) titled, Call Light, dated 2/2026, the P&P indicated Leave the resident comfortable, ensure the call device is within resident's reach before leaving room.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS - a comprehensive assessment and care screening too) reflected accuracy of assessments for two of two sampled residents (Resident 5 and Resident 106) by failing to: a. Ensure Resident 5 was coded in the MDS dated [DATE] taking Rivaroxaban (anticoagulant-blood thinner).b. Ensure Resident 106 was coded in the MDS dated [DATE] as discharged home with home health. These deficient practices resulted in inaccurate reporting to the Centers of Medicare and Medicaid (CMS, a federal agency that administers the Medicare program and works with state governments to administer the Medicaid and health insurance portability standards) agency and had the potential to negatively affect the resident's care planning and services. Findings: a. During a review of Resident 5's admission Record (AR), the AR indicated Resident 5 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including essential hypertension (elevated blood pressure) and peripheral vascular disease (PVD-a condition involving the narrowing, blockage, or spasm of blood vessels). During a review of Resident 5's Order Summary Report (OSR) dated [DATE], the OSR indicated for licensed staff to administer Rivaroxaban tablet 2.5 mg, give 1 tablet by mouth two times a day for PVD. During a review of Resident 5's History and Physical (H&P) dated [DATE], the H&P indicated Resident 5 did not have the capacity to understand and make decisions. During a review of Resident 5's Care Plan Report (CPR) initiated on [DATE], the CPR indicated Resident 5 was on anticoagulant therapy related to history of PVD. During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5 required substantial/maximal (helper does more than half the effort) assistance for toileting hygiene, shower and bathing. The MDS indicated Resident 5 required partial/moderate (helper does less than half the effort) assistance for oral hygiene, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 5 was independent (setup or clean-up assistance) for eating and personal hygiene. The MDS indicated Resident 5 did not have an anticoagulant medication. During an interview with Registered Nurse Supervisor 1 (RN1) on [DATE] at 7:18 AM, RN1 stated when a resident was on any type of anticoagulants, it should be documented in the MDS to monitor any adverse reactions or risk a resident could have while on high alert medications (such as anticoagulant). During an interview and record review with the MDS Coordinator on [DATE] at 11:40 AM, the MDS Coordinator stated Resident 5's MDS dated [DATE] was not properly documented and no modification to the MDS was submitted or done regarding Resident 5 taking Rivaroxaban. The MDS Coordinator stated the anticoagulant medication Rivaroxaban should have been coded in Resident 5's MDS. During a concurrent interview with the MDS Coordinator on [DATE] at 11:50 AM, the MDS Coordinator stated if the anticoagulant would have been coded in the MDS, it would assist staff to formulate a care plan for Resident 5's use of anticoagulant. The MDS Coordinator stated it was important to code the anticoagulant medication because Resident 5 would not receive services specific to Resident 5's (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	needs. During an interview with the facility's Director of Nursing (DON) on [DATE] at 12:49 PM, the DON stated Resident 5's anticoagulant medication (Rivaroxaban) should be coded correctly in the MDS. The DON stated the MDS Coordinator was responsible for doing the assessment for Resident 5 and submitting the report to CMS (Centers for Medicare & Medicaid Services). The DON stated the MDS must be accurately coded so that staff could formulate a care plan to address Resident 5's needs. The DON stated Rivaroxaban was a high-risk medication and staff needed to monitor Resident 5 for any side effects from taking Rivaroxaban. During a review of the facility's Policies and Procedures (P&Ps) titled, Resident Assessment and Associated Processes, revised 2/2026, the P&P indicated Residents will be assessed, and the findings documented in their clinical health record. These will be comprehensive, accurate, standardized reproducible assessment of each resident and will be conducted initially and periodically as part of an ongoing process through which each resident's preferences and goals of care, functional and health status, and strengths and needs will be identified. b. During a review of Resident 106's AR, the AR indicated Resident 106 was admitted to the facility on [DATE] with diagnoses including muscle wasting (weakening, shrinking, and loss of muscle) and atrophy (decrease in size or wasting away of a body part or tissue), need for assistance with personal care and non-pressure chronic ulcer (non-healing wound) of other part of right foot with unspecified severity. During a review of Resident 106's Discharge Summary and Post Discharge Plan of Care (DSPDPC) dated [DATE], the DSPDPC indicated Resident 106 will be discharged to home with Home Health services for Nursing, Therapy and wound care. During a review of Resident 106's Physician's Order (PO) dated [DATE], the PO indicated to discharge Resident 106 on [DATE] to home with home health to follow up for Physical Therapy/Occupational Therapy, Registered Nurse for medication and wound care nurse. During a review of Resident 106's MDS dated [DATE], the MDS indicated Resident 106 was discharged to home/community. During an interview on [DATE] at 12:23 pm, with the facility's Minimum Data Set Nurse (MDSN), the MDSN stated Resident 106 was discharged home on [DATE] with home health for RN services, PT/OT and wound care. The MDSN stated Resident 106's MDS assessment dated [DATE] needed to be coded discharged to home with home health services and not just discharged home/community. The MDSN stated Resident 106's MDS assessment should have been coded accurately to give accurate information to CMS. During an interview on [DATE] at 12:47 pm with the facility's DON, the DON stated Resident 106's MDS assessment dated [DATE] was not coded accurately as discharge to home under the care of organized home health service. The DON stated the MDS coordinator was responsible for coding the assessment accurately to give accurate information to CMS. During a review of the facility's policy and procedure (P&P) titled, Resident Assessment and Associated Processed, revised 2/2026, the P&P indicated, The facility will electronically transmit encoded, accurate, and complete MDS data to the CMS system. Transmission of MDS data will (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	include the following documents in addition to those mentioned above, resident's transfer, entry, reentry, discharge, & death.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary treatment to prevent pressure ulcer (PU/PI - an injury that breaks down the skin and underlying tissue when an area of skin is placed under pressure) development and promote healing for three of four sampled residents (Residents 7, 9, and 46) by failing to: a. & b. Ensure the low air loss mattress (LALM - a specialty bed that alternates pressure to help heal and prevent pressure injuries) for Residents 7 and 9 were set to alternating pressure and set correctly to the residents' weights. c. Ensure the LALM was set correctly for Resident 46's weight. These failures had the potential to cause pressure ulcers, worsen, and prevent healing for residents with skin and pressure injuries. Findings: a. During a review of Resident 7's admission Record (AR), the AR indicated Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including sepsis (a life-threatening blood infection), Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and difficulty in walking. During a review of Resident 7's Minimum Data Set (MDS – a standardized assessment tool) dated 2/5/2026, the MDS indicated Resident 7 had intact cognition (ability to think). The MDS indicated Resident 7 was independent rolling left and right in bed and used a wheelchair. During a review of Resident 7's History & Physical (H&P) dated 2/28/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 7's Order Summary Report (OSR), the OSR indicated Resident 7 had an active order for a LALM with settings based on weight, to be monitored every shift for placement and function, ordered on 2/23/2026. During a review of Resident 7's Weights and Vitals Summary (WVS) dated 2/23/2026, the WVS indicated Resident 7's weight was 139 pounds (lbs.- unit of measurement). During a review of Resident 7's Skin Check (SC) dated 2/23/2026, the SC indicated a Stage 3 Pressure Injury (St. 3 PI -Full-thickness loss of skin; dead and black tissue may be visible) at the intergluteal cleft (groove between the buttocks) extending laterally (toward the side) to the left buttock. The SC further indicated, a pressure redistribution surface was in place. During a review of Resident 7's untitled Care Plan (CP), revised on 2/23/2026, the CP indicated Resident 7 had a St. 3 PI at the intergluteal cleft extending to the left buttock with an intervention to monitor the LALM settings. During a concurrent observation and interview on 2/24/2026 at 9:11 am with Resident 7 in Resident 7's room, Resident 7 was in bed with the LALM on the static mode (a setting that creates a firm surface) and the weight set at 125 lbs. with a sticker indicating 139. Resident 7 stated, Resident 7 had a wound on Resident 7's buttocks and the mattress felt firm and soft. During a concurrent observation and interview on 2/24/2026 at 9:16 am with the Activity Director (AD) in Resident 7's room, the AD confirmed the LALM setting displayed normal pressure, was on static mode, and was set at about 120 lbs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/26/2026 at 12:54 pm with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 7 was on a LALM for wound management, which was based on Resident 7's last weight of 139 lbs. LVN 1 stated, the LALM should be set to 139 lbs. to relieve pressure on the resident's wound. LVN 1 stated, LVN 1 did not know what the static setting was and stated the LALM was set by the treatment nurses. LVN 1 stated, it was important for the LALM to be at the correct settings to be therapeutic for Resident 7. During an interview on 2/26/2026 at 12:55 pm with the Director of Nursing (DON), the DON stated licensed nurses needed to follow the physician's order for LALM settings based on the resident's weight to allow the LALM to be therapeutic. The DON stated the LALM should not be on static mode and should be in alternating mode. The DON stated there could be delayed wound healing when the airflow was not alternating. During an interview on 2/26/2026 at 1:13 pm with Treatment Nurse 1 (TN 1), TN 1 stated Resident 7's LALM should be in alternating mode and not in static mode. TN 1 stated the static mode setting made the mattress firmer and was not good for the residents because it was uncomfortable, could impair healing, and easier to develop a PI on the resident. TN 1 stated, Resident 7 received wound care treatments and needed the LALM because Resident 7 had multiple medical issues that could contribute to developing another PI. TN 1 stated the small circular sticker on the LALM device indicated the resident's weight and Resident 7's LALM should be set to 139 lbs. During a review of Drive: Med-Aire 8 Alternating Pressure Mattress Replacement System with Low Air Loss Operator's Manual Item #14027, dated 2005, the LALM manual indicated the Med-Aire 8, 14027 System was an air support surface suitable for medium and high-risk pressure ulcer treatment and was specifically designed for the prevention of bedsores (pressure ulcers or injuries). The manual indicated the static/alternating control button was used to shift between alternating and static mode and when in static mode, the mattress would become a firm surface. The manual indicated users could easily adjust the air mattress to a desired firmness according to the patient's weight and comfort. During a review of the facility's policy and procedure (P&P) titled, Low Air Loss, Alternating Pressure Pad or Mattress, revised 2/2026, the P&P indicated it was the policy of the facility to prevent and treat pressure ulcers, alternate pressure under bony prominences and provide resident comfort. The P&P further indicated, Low Air Loss mattress will be set up and serviced according to manufacturer's recommendations. b. During a review of Resident 9's AR, the AR indicated Resident 9 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dysphagia (difficulty swallowing food or liquids), paraplegia (paralysis of the legs and lower body), contracture of muscle, multiple sites, and muscle weakness. During a review of Resident 9's OSR dated 10/9/25, the OSR indicated LALM for wound management; settings to be done based on weight. During a review of Resident 9's MDS dated [DATE], the MDS indicated Resident 9's cognitive (ability to think and reason) skill for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 9 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, putting on/taking off footwear and personal hygiene. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 9's WVS dated 2/1/26, the WVS indicated Resident 9's weight was 103 lbs. During an observation inside Resident 9's room on 2/26/26 at 9:43 AM, Resident 9's was resting on a LALM with settings to approximately 125 lbs. During an interview with the Registered Nurse Supervisor (RNS) on 2/26/26 at 7:32 AM, the RNS stated one of the interventions the facility used for residents with pressure ulcers was the use of LALM. The RNS stated LALM was designed to prevent and treat pressure ulcers. The RNS stated LALM provided continuous airflow and pressure redistribution to the residents who had wounds to keep the skin dry and reduce friction. The RNS stated the LALM settings needed to be set according to the resident's weight or doctor's order. The RNS stated inaccurate LALM setting could increase the risk of skin breakdown potentially causing more harm to the residents. During an interview with the Treatment Nurse (TN) on 2/26/2026 at 11:55 AM, the TN stated the LALM was set based on the resident's weight and if the setting was not accurate, it could create complications. The TN stated the LALM was specifically designed to provide cushion and support. The TN stated it would not be acceptable to have inaccurate setting on a LALM that was supposed to provide comfort and support to the resident's pressure areas. During an interview with the facility's DON on 2/26/2026 at 1:25 PM, the DON stated Resident 9's LALM was set to approximately 125 lbs. The DON stated the setting on Resident 9's LALM needed to be in accordance with Resident 9's weight. The DON stated Resident 9's weight was 103 lbs. The DON stated, if the LALM setting was incorrect, it does not serve the purpose to promote wound healing. The DON stated the purpose of a LALM was to prevent and treat pressure ulcers by redistributing pressure and managing moisture on the resident's skin. During a review of the facility's P&P titled, Low Air Loss, Alternating Pressure Pad or Mattress, revised 2/2026, the P&P indicated, It is the policy of the facility to prevent and treat pressure ulcers, alternate pressure under bony prominences and provide resident comfort. c. During a review of Resident 46's AR, the AR indicated Resident 46 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including pressure ulcer of sacral (large, triangular bone at the base of the spine) region, stage 4 (ulcer that extends into the muscle and bone and causing extensive damage), pressure ulcer of right heel, retention of urine, and acute kidney failure (a sudden decline in kidney function). During a review of Resident 46's MDS dated [DATE], the MDS indicated Resident 46 had intact cognition for daily decision making. The MDS indicated Resident 46 needed maximum assistance (helper does more than half of the effort) from staff for toileting hygiene, shower, lower body dressing, and putting on/off footwear. During a review of Resident 46's untitled CP initiated on 1/10/2026, the CP indicated Resident 46 was at risk for skin breakdown due to multiple scars from old pressure injury at the back and history of pressure injuries. The CP interventions included the use of LAL mattress for Resident 46. During a review of Resident 46's Order Summary Report (OSR) dated 1/10/2026, the OSR indicated LAL mattress for tissue load management, setting set based on weight and to monitor placement and function every shift. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 46's History and Physical (H&P) dated 1/12/2026, the H&P indicated Resident 46 had the capacity to understand and make decisions. During a review of Resident 46's WVS dated 2/23/2026, the WVS indicated Resident 46 weighed 107 lbs. During an observation and concurrent interview on 2/24/2026 at 9:26 am, with the Director of Staff and Development (DSD), Resident 46 was awake and lying on a LAL mattress. The DSD stated Resident 46's LAL setting was set on 125 lbs. The DSD stated, Resident 46's LAL mattress should have been set up according to Resident 46's actual weight of 107 lbs During an interview and record review on 2/24/2026 at 12:40 pm with Treatment Nurse 1 (TN 1) of Resident 46's medical records (PointClickCare - PCC, a cloud-based software) was reviewed. TN 1 stated Resident 46 weighed 107 lbs. on 2/23/2026. TN 1 stated, Resident 46's LAL mattress setting should be based on the actual weight of Resident 46. TN 1 stated the physician's order was not followed for Resident 46 to set the LAL setting based on the resident's actual weight. TN 1 stated Resident 46 could develop a pressure ulcer if the LAL mattress was not set based on the resident's actual weight. During an interview on 2/26/2026 at 12:55 pm with the facility's Director of Nursing (DON), the DON stated, Resident 46's LAL mattress needed to be set based on the resident's actual weight to prevent Resident 46 from developing another pressure ulcer. During a review of Drive: Med-Aire 8 Alternating Pressure Mattress Replacement System with Low Air Loss Operator's Manual Item #14027, dated 2005, the LALM manual indicated the Med-Aire 8, 14027 System was an air support surface suitable for medium and high-risk pressure ulcer treatment and was specifically designed for the prevention of bedsores (pressure ulcers or injuries). The manual indicated the static/alternating control button was used to shift between alternating and static mode and when in static mode, the mattress would become a firm surface. The manual indicated users could easily adjust the air mattress to a desired firmness according to the patient's weight and comfort.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary care and services in accordance with physician's order and to implement its Policy and Procedure (P&P) on fall management for two of three sampled residents (Residents 6 and 72) by failing to:a. Ensure cushion alarm (safety device designed to alert caregivers immediately when a person at risk of falling would stand up or leave a seated/lying position) for Resident 6 was connected in bed and in the wheelchair.b. Ensure Resident 72 was provided with adequate supervision and had an environment free of accident hazards. These failures placed Residents 6 and 72 at risk for injury from fall and recurrent falls.Findings: a. During a review of Resident 6's admission Record (AR), the AR indicated Resident 6 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same site of the body), hemiparesis (partial muscle weakness or reduced strength on one side of the body), and anxiety disorder (an emotion characterized by feelings of tension, worried thoughts, and physical changes). During a review of Resident 6's untitled Care Plan (CP) dated 9/30/2024, the CP indicated Resident 6 was at risk for falls. The CP interventions included the use of cushion alarms in bed and in wheelchair to remind Resident 6 not to get up unassisted. During a review of Resident 6's Order Summary Report (OSR) dated 11/21/2024, the OSR indicated Resident 6 had an order for cushion alarm in bed and in wheelchair to remind Resident 6 not to get up unassisted. The OSR indicated to monitor placement and function of the cushion alarm every shift. During a review of Resident 6's Minimum Data Set (MDS – a resident assessment tool) dated 1/2/2026, the MDS indicated Resident 6 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 6 required substantial/maximal assistance (helper did more than half the effort) with oral and personal hygiene. The MDS indicated Resident 6 was dependent (helper did all the effort, resident did none) with eating, toileting, shower, upper and lower body dressing. During a review of Resident 6's Progress Notes (PN) dated 1/2/2026, the PN indicated Resident 6 was at high risk for fall due to intermittent confusion and poor vision. The PN indicated Resident 6 had a Fall Risk score of 17. During a review of Resident 6's Fall Risk Evaluation (FRE) dated 1/4/2026, the FRE indicated a score of 10 or higher indicated the resident is at high risk for falls. During a concurrent observation inside Resident 6's room and interview on 2/25/2026 at 12:26 pm with Licensed Vocational Nurse 4 (LVN 4), Resident 6 was in bed and on Resident 6's back. LVN 4 stated Resident 6 did not have a cushion alarm in bed or in the wheelchair. LVN 4 stated Resident 6 had history of getting out of bed unassisted. During a concurrent interview and record review on 2/25/2026 at 3:56 pm with LVN 3, Resident 6's medical record (chart) and electronic health record (EHR) were reviewed. LVN 3 stated there was no documented record that Resident 6's active order for cushion alarm in bed and in wheelchair was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discontinued. LVN 3 stated Resident 6 should have a cushion alarm connected in bed and in wheelchair as ordered, to prevent fall and injury. During an interview on 2/26/2026 at 2:07 pm with the Director of Nursing (DON), the DON stated cushion alarm should be applied as ordered by the physician to alert staff that a resident needed immediate assistance, to prevent fall and for the safety of the residents while in bed or in a wheelchair. During a review of the facility's P&P titled, Fall Management System, revised/reviewed on 2/2026, the P&P indicated, It is the policy of this facility to provide each resident with appropriate assessment and intervention to prevent falls and to minimize complications if a fall occurs. b. During a review of Resident 72's AR, the AR indicated Resident 72 had an initial admission on [DATE] with the diagnoses but not limited to: chronic obstructive pulmonary disease (a lung disease causing difficulty in breathing), protein-calorie malnutrition, essential hypertension (high blood pressure), fracture of right pubis, a history of falling and need assistance with personal care. During a review of Resident 72's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 12/29/2025, the MDS indicated Resident 72 is dependent on lying- to-sitting on side of the bed and had history of fall on admission and had a fracture related to a fall in the six months prior to admission. During a review of Resident 72's Clinical admission Assessment (an initial, comprehensive evaluation of a resident when they are admitted to a facility) dated 12/26/2025, the assessment indicated Resident 72 has weaknesses on right leg, right foot, left leg and left foot. During a review of Resident 72's Nursing Fall Risk Evaluation, dated 12/29/2025, the evaluation indicated Resident 72 is bedbound/incontinent, has a balance problem with standing and walking and is high risk for fall. During a review of Resident 72's care plans initiated on 12/27/2025, the care plan stated Resident 72's bed should be in a low position to minimize the risk for fall. During a concurrent observation on 2/25 /2026 at 10:49 am with Resident 72 inside Resident 72's room, Resident 72 was lying in bed which was not in a low position and no landing pad (a floor pad designed to help prevent injury should a person fall) was in the bedside. During an interview on 2/24/2026 at 10:40 am with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 72 needs supervision in sitting, lying in bed and transferring to bed from a wheelchair and reciprocally. During an interview on 2/26/2026 at 1:00 pm with Registered Nurse Supervisor (RNS) 1, RNS 1 stated Resident 72 was found on the floor on 2/24/2026 at 7:15 pm by the evening shift staff and was sent to the hospital emergency room where they evaluated Resident 72 with no new fracture findings. RN1 stated Resident 72's room should be free from any hazards and nursing assistants should always supervise Resident 72 to prevent any incident. During an interview on 2/27/2026 at 9:52 am with Licensed Vocational Nurse (LVN) 1, LVN stated Resident 72 was found on the floor on 2/24/2026 AT 7:15 pm by the evening shift staff. LVN1 stated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 72's bed is not placed in a low position and has no landing pad could help prevent any injury. During an interview on 2/27/2026 at 1:05 pm with the DON (Director of Nursing), DON stated, the evening shift staff wheeled Resident 72 in the resident's room and left the resident, and when the evening shift staff went back to the resident's room, Resident 72 was found on the floor. DON stated that Resident 72 has high risk of falling, staff should have supervised Resident 72 and bed should be in a low position with landing pads should be in place. During a review of the facility's policy and procedure (P&P) titled, Fall Management System, the P&P indicated that the facility provides an environment that remains as free of accident hazards as possible and to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to conduct competencies for two of five sampled staff (Certified Nurse Assistant 4 (CNA 4) and Licensed Vocational Nurse 2 (LVN 2). These failures had the potential for the residents in the facility not to receive appropriate nursing care and services from CNA 4 and LVN 2.Findings: During a concurrent record review and interview on 2/26/2026 at 10:20 am with the Director of Staff and Development (DSD), CNA 4's employee file was reviewed. The DSD stated CNA 4 was a full-time employee in the facility since 11/11/2024. The DSD stated CNA 4 did not have a skills competency on file for 11/2025. The DSD stated, skills competency should be done yearly to ensure staff understand the tasks assigned and remain competent in providing care and treatment for the residents. The DSD stated, staff competency should be completed by the DSD for all CNAs and the Director of Nursing (DON) for all licensed nurses upon hire and annually, thereafter. During a concurrent record review and interview on 2/26/2026 at 10:20 am with the DSD, LVN 2's employee file was reviewed. The DSD stated LVN 2 was a full-time employee in the facility since 5/22/2025. The DSD stated the DON did not sign and date LVN 2's skills check list upon hire. The DSD stated, if it was not signed, it was not done. During an interview on 2/26/2026 at 1:30 pm with the DON, the DON stated, CNA 4's skills competency should have been completed by the DSD upon hire and annually to ensure employees were competent in providing care and services to the residents. During a review of the facility's policy and procedure (P&P) titled, Nursing Staff Competency, reviewed on 2/2026, the P&P indicated, Within 30 days of the date of hire, the nursing staff member shall complete the orientation competency assessment for the appropriate job category in order to meet the needs of the facility's resident population in accordance with the facility assessment.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide dental care and services to two of three sampled residents (Resident 3 and Resident 72) in accordance with the facility's policy and procedure (P&P) titled, Quality of care.This failure had the potential to result in the residents' poor oral health and reduce quality of life.Findings:During a review of Resident 3's face sheet, the face sheet indicated Resident 3 had an initial admission on [DATE] with the diagnoses but not limited to; hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (partial weakness or reduced strength on one side of the body), muscle weakness, chronic obstructive pulmonary disease (chronic lung disease causing difficulty in breathing).During a review of Resident 3's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 12/30/2025, MDS indicated Resident 3 needs substantial/maximal assistance when performing oral hygiene and personal hygiene.During a review of Resident 3's Clinical admission Assessment, dated 11/20/2025, the assessment indicated Resident 3 has own teeth and examination of oral/dental status was not checked.During a review of Resident 72's face sheet, the face sheet indicated Resident 72 had an initial admission on [DATE] with the diagnoses but not limited to; chronic obstructive pulmonary disease (a disease causing difficulty in breathing), protein-calorie malnutrition, essential hypertension (high blood pressure), fracture of right pubis, history of falling and need assistance with personal care.During a review of Resident 72's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 12/29/2025, MDS indicated Resident 72 needs partial/moderate assistance when performing oral hygiene and personal hygiene.During a review of Resident 72's Clinical admission Assessment, dated 12/26/2025, the assessment indicated Resident 72 has his own teeth, but examination of oral/dental status was not checked. The assessment also indicated Resident 72 has difficulty chewing.During an interview on 2/24/2026 at 10:50 am with Resident 3 and Resident 72, Resident 3 and Resident 72 stated, no dentist has seen nor checked their teeth for a long time now.During an interview on 2/25/2026 at 9:10 am with Certified Nursing Assistant (CNA) 2, CNA 2 stated, Resident 3 is dependent on performing oral hygiene. CNA 2 stated that she does not know if Resident 3 has been seen by a dentist.During an interview on 2/24/2026 at 10:40 am with Certified Nursing Assistant (CNA) 1, CNA 1 stated, Resident 72 is dependent on performing oral hygiene and CNA 1 is not aware if Resident 72 had any dental check with the facility's dentist.During an interview on 2/25/2026 at 1:28 pm with the Social Services Director (SSD), SSD stated Resident 3 and Resident 72 have not been seen by the facility dentist to receive a routine dental care since admission. During an interview on 2/27/2026 at 11:20 am with the Director of Nursing (DON), DON stated, residents were not given routine dental care services which should have been coordinated through the facility's SSD. DON stated that routine dental care is very important to the overall health condition of the residents.During a review of the facility's Dental Visit Report for 2025 and 2026, the report did not indicate Resident 3 and Resident 72 had any routine dental care from the facility's dental provider.During a review of the facility's policy and procedure (P&P) titled, Quality of Care, dated 2/2026, the P&P indicated, Social Services will maintain a system to monitor the dental, optometry, podiatry and audiology evaluations. Dental, optometry and audiology evaluations will be scheduled on annual basis and/or as needed.

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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 one of one sampled resident (Resident 66) was assisted with eating at eye level and called by Resident 66's legal (official name recognized by government on documents), proper and preferred name. These failures had the potential for Residents 66 to lose dignity and individuality.Findings: During a review of Resident 66's admission Record (AR), the AR indicated Resident 66 was admitted on [DATE] and re-admitted on [DATE] with diagnoses including parkinsonism (brain conditions that cause slowed movements, stiffness, and tremors), asthma (a chronic lung disease that causes inflammation and muscle tightening of the airways, making it harder to breathe), and dysphagia (difficulty swallowing). During a review of Resident 66's Order Summary (OS), the OS indicated Resident 66 had an active order for a no-added salt fortified diet, pureed texture meals with thin liquids, ordered on 11/7/2025. During a review of Resident 66's History & Physical (H&P) dated 11/28/2025, the H&P indicated the resident had intellectual disability. During a review of Resident 66's untitled Care Plan (CP) revised on 12/23/2025, the CP indicated Resident 66 had an Activities of Daily Living (ADL) self-care performance deficit related to limited mobility, impaired balance, confusion, with a goal to maintain Resident 66's current level of functions, including eating. During a review of Resident 66's Minimum Data Set (MDS) assessment dated [DATE], the MDS indicated Resident 66 had severely impaired cognition (ability to think) and required partial/moderate assistance (helper does less than half the effort) for eating. During an observation on 2/24/2026 at 12:20 pm in the dining room, Resident 66 was being fed by Treatment Nurse 2 (TN 2). TN 2 was sitting on a black stool about 1/2 foot above Resident 66 on the resident's right side. TN 2 was side to side with Resident 66 and looking down at the resident during feeding. During an interview on 2/24/2026 at 12:38 pm with TN 2, TN 2 stated Resident 66 was a feeder, someone who needed assistance with feeding. TN 2 stated, TN 2 was seated higher up since Resident 66's wheelchair was low and TN 2 was unable to lower the stool. TN 2 stated TN 2 could have used a lower chair to assist Resident 66 with eating at eye-level. TN 2 stated TN 2 was not at eye-level and was not facing Resident 66 because TN 2 was paying attention to the other residents in the dining room. During an interview on 2/26/2026 at 1:58 pm with the Director of Nursing (DON), the DON stated, for resident safety and engagement, residents should be fed by the nursing staff at eye-level and facing the resident to monitor how the resident tolerated the feeding. The DON stated labeling residents as feeders and feeding the resident while looking down on them was a dignity issue. During a review of the facility's policy and procedure (P&P) titled, Dignity and Privacy, revised 2/2026, the P&P indicated, it was the policy of the facility that all residents be treated with kindness, dignity, and respect. The P&P indicated, the staff shall display respect for Resident's when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to maintain a safe and clean areas for residents.This failure had the potential to negatively affect the residents' quality of life.Findings:During a review of the facility's map, it was noted that the facility has four shower rooms, three nurses' stations (north, center, and south), and two medication rooms located in the center and south stations.During a concurrent observation and interview conducted on 2/25/2026 at 8:50 am with Certified Nursing Assistant (CNA) 1 in the shower room near the north nurses' station, CNA 1 reported that most residents follow a shower schedule and that nursing assistants and housekeeping staff are responsible for cleaning the shower rooms. The shower room adjacent to resident rooms in the north station had an exhaust fan with a protective grill that was visibly covered with dust.During an interview on 2/26/2026 at 2:05 PM with Infection Preventionist and Maintenance, Maintenance stated the exhaust fan removes excess moisture inside the shower room and cleaning it helps prevent bacterial growth. Infection Preventionist stated it is important to keep all care areas clean to protect the residents from any source of infection.During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and control Program, the P&P indicated the facility's program addresses detection, prevention and control of infections among residents and personnel including effective cleaning and disinfecting equipment to include bathing areas.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement its facility's Policy and Procedures (P&P) on the use of cushion pad alarms (safety devices designed to alert caregivers immediately when a person at risk of falling stand up or leave a seated/lying position) for one of one sampled resident (Resident 12). This failure placed Resident 12 at risk of injury and psychological distress related to the use of cushion pad alarms. Findings: During a review of Resident 12's admission Record (AR), the AR indicated Resident 12 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including muscle weakness (decrease or loss of strength), osteoporosis (weak and brittle bones), and anxiety (an emotion characterized by feelings of tension, worried thoughts, and physical changes). During a review of Resident 12's Minimum Data Set (MDS - a resident assessment tool) dated 1/23/2026, the MDS indicated Resident had moderately impaired cognition (ability to understand and process information). The MDS indicated Resident 12 required partial/moderate assistance (helper did less than half the effort) with eating, oral hygiene, and personal hygiene; substantial/maximal assistance (helper did more than half the effort) with toileting, shower, and upper body dressing; and dependent (helper did all the effort) with lower body dressing. During an observation inside Resident 12's room and interview on 2/24/2026 at 10:29 am with Treatment Nurse 2 (TN 2), Resident 12 was sitting in Resident 12's wheelchair. TN 2 stated Resident 12 had a cushion alarm connected to Resident 12's bed and wheelchair. During a concurrent interview and record review on 2/25/2025 at 12:37 pm with Licensed Vocational Nurse 4 (LVN 4), Resident 12's medical record (chart), electronic health record (EHR) and Order Summary Report (OSR), dated 2/2026, were reviewed. LVN 4 stated Resident 12 did not have an order for cushion pad alarms for bed and wheelchair. LVN 4 stated there was no documented record that consent was obtained prior to the use and application of cushion pad alarms for bed and wheelchair. LVN 4 stated cushion pad alarms were considered as restraints because it restricted the residents' mobility in bed and in the chair. LVN 4 stated the use of cushion pad alarms needed a physician's order for the safety of the residents. LVN 4 stated consent should be obtained prior to the use and application of cushion pad alarms to ensure that the resident or responsible party were aware of the risks and benefits of the use of cushion pad alarms to prevent causing anxiety and discomfort to the resident from hearing the alarm. During an interview on 2/26/2026 at 1:48 pm with the Director of Nursing (DON), the DON stated all cushion pad alarms should have a physician's order and consent should be obtained from the resident and/or responsible party before its use and application to ensure that its use was appropriate and necessary for the safety of the resident. During a review of the facility's P&P titled, Restraint, Physical revised 2/2026, the P&P indicated, Restraints include lab cushions and lap trays the resident cannot remove easily. Any resident using a restraint will have a current order with the following components: The exact type of restraint; The circumstances for usage; The medical reason for usage; A release/exercise statement. Any resident using a physical restraint must have a current signed consent in the clinical chart that identifies the risks/benefits of the restraint, the medical symptom for the restraint usage, and alternatives to the restraint.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure for one of six sampled residents' (Resident 108) order for Remeron (a medication to treat depression [a feeling of severe sadness or hopelessness]) included a specific indication for a specific diagnosed condition and the hours of sleep was monitored, as indicated in the facility's policy titled Chemical Restraints and Psychotropic (medications that alter chemical levels in the brain which impact mood and behavior) Medication Management. This deficient practice had the potential to result in the use of unnecessary psychotropic drug, which may result in significant adverse (harmful) consequences to Resident 108.Findings: During a review of Resident 108's admission Record (AR), the AR indicated Resident 108 was admitted to the facility on [DATE] with diagnoses including depression (a feeling of severe sadness or hopelessness) and polyneuropathy (damage or disease affecting peripheral nerves featuring weakness, numbness, and burning pain). During a review of Resident 108's History and Physical (H&P) dated 2/21/2026, the H&P indicated Resident 108 had the capacity to understand and make decisions. During a review of Resident 108's Order Summary Report (OSR) dated 2/21/2026, the OSR indicated for licensed staff to administer Remeron oral tablet as needed manifested by inability to sleep and stay asleep related to insomnia for 14 days. During an interview on 2/24/2026 at 1:58 pm with Registered Nurse 1 (RN 1), RN 1 stated Resident 108 was ordered Remeron and the indication for use was not a specific diagnosis. RN 1 stated Resident 108's hours of sleep were not monitored. RN 1 stated, Resident 108's hours of sleep should have been monitored while on Remeron to determine if the resident was able to sleep or not. During an interview on 2/26/2025 at 12:52 pm with the facility's Director of Nurses (DON), the DON stated psychotropic medications should have been administered with specific diagnosis. The DON stated, Insomnia is not a diagnosis for Remeron use. The DON stated Resident 108's target behavior for inability to sleep should have been monitored by Licensed Nurse to monitor residents' hours of sleep to determine if the medication was effective or not. During a review of the facility's policy and procedure (P&P) titled, Chemical Restraints and Psychotropic Medication Management, revised 4/2025, the P&P indicated, Residents do not receive psychotropic drugs pursuant to an as needed (PRN) order unless medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. The specific condition requiring the use of psychotropic medication(s) is diagnosed and documented in the clinical record. Psychotropic medication was prescribed to treat a specific diagnosed condition, as documented in the clinical record. Monitoring for adverse consequences and effectiveness of medications are in place. The LN shall review the classification of the drug, the appropriateness of the diagnosis, its indication, behavior monitors and related adverse side effects prior to verification of admission orders with the Attending Physician.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to update the resident's care plan for one of three sampled residents (Resident 72).This failure had the potential to compromise Resident 72's safety and prevent the provision of necessary care.Findings:During a review of Resident 72's face sheet, the face sheet indicated Resident 72 had an initial admission on [DATE] with the diagnoses but not limited to: chronic obstructive pulmonary disease (a chronic lung disease causing difficulty in breathing) , protein-calorie malnutrition , essential hypertension (high blood pressure) , fracture of right pubis , a history of falling and need assistance with personal care.During a review of Resident 72's Minimum Data Set (MDS-a resident assessment tool) dated 12/29/2025, the MDS indicated Resident 72 is dependent on lying- to-sitting on side of the bed and had history of fall on admission and fracture related to a fall prior to admission.During a review of Resident 72's Clinical admission Assessment, dated 12/26/2025, the assessment indicated Resident 72 has weaknesses on the right leg, right foot, left leg and left foot.During a review of Resident 72's Physical Therapy evaluation, dated 12/29/2025, the evaluation indicated Resident 72 exhibited decreased stride length, decreased velocity and uneven step length associated with knee instability.During a review of Resident 72's Nursing Fall Risk Evaluation, dated 12/29/2025, the evaluation indicated Resident 72 is bedbound/incontinent, has a balance problem with standing and walking and is high risk for fall.During a review of Resident 72's medical records, the Situation, background , assessment (SBAR- a structured communication tool used in healthcare) communication form dated 2/24/2026, the form indicated Resident 72 had a fall and a right hip x-ray (a medical imaging technique that utilizes rays to visualize the interior of the body) was ordered by the physician.During a review of Resident 72's General Acute Care Hospital Emergency Department care note, dated 2/25/2026, the note indicated Resident 72 had no new fracture as a result from the fall.During a review of Resident 72's care plans on 2/25/2026 at 8:45 am, the care plans indicated the fall risk care plan had not been updated following the resident's fall on 2/24/2026.During a concurrent observation and interview on 2/25 /2026 at 10:49 am with Resident 72 inside Resident 72's room, Resident 72 was lying in bed which was not in the lowest position. Resident 72 stated he cannot remember what happened on 2/24/2026 at 7:15PM.During an interview on 2/27/2026 at 9:52 am with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 72 was found on the floor on 2/24/2026 at 7:15 pm by the evening shift staff. LVN 1 stated the care plan was not revised after the incident happened. LVN 1 stated it is important nurses update it so they can better care for the residents after the fall. LVN1 also stated that Resident 72 has no landing pad (a floor pad designed to help prevent injury should a person fall) that could help prevent any injury. During an interview on 2/27/2026 at 1:05 pm with the Director of Nursing (DON), DON stated the nurses did not update Residents 72's care plan to include Resident 72's bed is in a low position and placing a landing pad. DON stated that Resident 72's care plan should have been revised so staff would know how to care for the residents.During a review of the facility's policy and procedure (P&P) titled, Change in condition, the P&P indicated, The nurse will transcribe the treatment and plan of care relative to the change of condition on the resident's Electronic Medical Record (EMR). During a review of the facility's policy and procedure (P&P) titled, Fall Management System, the P&P indicated a fall without injury is still a fall and the resident's care plan will be updated.

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Garden View Post Acute Rehabilitation	14475 Garden View Lane Baldwin Park, CA 91706

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide required assistance during activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily) for one of one sampled resident (Resident 51).This failure placed Resident 51 at risk of physical injury during bed mobility and overall decline in quality of life.Findings: During a review of Resident 51's admission Record (AR), the AR indicated Resident 51 was admitted to the facility on [DATE] with diagnoses including quadriplegia (paralysis from the neck down, including legs, and arms), left hand contracture (a stiffening/shortening at any point, that reduces the joint's range of motion) and cerebral palsy (condition that affects how the person moves and controls their muscles) During a review of Resident 51's Minimum Data Set (MDS - a resident assessment tool) dated 2/2/2026, the MDS indicated Resident 51 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 51 was dependent (helper did all the effort, resident did none and assistance of 2 or more helpers were required for the resident to complete the activity) with eating, oral hygiene, toileting, shower, upper/lower body dressing and personal hygiene. During a review of Resident 51's undated/untitled Care Plan (CP), the CP indicated Resident 51 was totally dependent on staff for repositioning and turning in bed and Resident 51 required total assistance with personal hygiene. During a concurrent observation inside Resident 51's room and interview on 2/24/2026 at 9:48 am with Certified Nurse Assistant 5 (CNA 5), CNA 5 was alone while cleaning and turning Resident 51 on Resident 51's left side. CNA 5 stated Resident 51 was totally dependent on staff and required 2-person assistance for shower, toileting, upper/lower body dressing and personal hygiene. CNA 5 stated Resident 51 should be cleaned and turned with the assistance of 2 persons for the safety of the resident and to prevent injury both to the resident and the staff. During an interview on 2/25/2026 at 2:06 pm with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated Resident 51 had quadriplegia and hand contracture. LVN 4 stated Resident 51 was dependent on staff for all ADLs. LVN 4 stated Resident 51 could not turn and hold position during toileting and personal hygiene and needed 2-person assistance. LVN 4 stated Resident 51 should not be cared for by one person only to prevent injury to the resident during bed mobility and to ensure Resident 51 was cleaned thoroughly after toileting to prevent skin breakdown. During an interview on 2/26/2026 at 1:53 pm with the Director of Nursing (DON), the DON stated dependent residents required the assistance of 2 or more persons during ADLs to complete the activity to ensure residents were provided adequate care and for the safety of the residents. During a review of the facility's Policy and Procedure (P&P) titled, ADL, Services To Carry Out, reviewed 2/2026, the P&P indicated, It is the policy of this facility that residents are given the appropriate treatment to maintain or improve his/her abilities. Residents who are unable to carry out activities of daily living (ADL) will receive necessary services to maintain personal hygiene.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide necessary care and services for a resident with indwelling catheter (also known as foley catheter {FC}, a tube that allows urine to drain from the bladder into a bag that is usually attached to the thigh) in accordance with the facility's Policy and Procedure (P&P) on urinary catheter care for one of four sampled residents (Resident 46). This failure had the potential for Resident 46 not to receive care or receive delayed care and treatment for urinary tract infection (UTI, an infection in the bladder/urinary tract). Findings: During a review of Resident 46's admission Record (AR), the AR indicated Resident 46 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including pressure ulcer of sacral (large, triangular bone at the base of the spine) region, stage 4 (ulcer that extends into the muscle and bone and causing extensive damage), pressure ulcer of right heel, retention of urine, and acute kidney failure (a sudden decline in kidney function). During a review of Resident 46's MDS dated [DATE], the MDS indicated Resident 46 had intact cognition for daily decision making. The MDS indicated Resident 46 needed maximum assistance (helper does more than half of the effort) from staff for toileting hygiene, shower, lower body dressing, and putting on/off footwear. During a review of Resident 46's Order Summary Report (OSR) dated 1/12/2026, the OSR indicated Resident 46 had an order for licensed staff to insert an indwelling catheter French (a type of catheter) 16 (size of the catheter) per 10 millimeters (ml, unit of measurement) to closed drainage system (a sterile, self-contained urinary catheter attached to a collection bag to create a sealed circuit). During a review of Resident 46's untitled Care Plan (CP) dated 1/12/2026, the CP indicated Resident 46 was at risk for infection related to indwelling device catheter and history of Multidrug-Resistant Organism (MDRO - refers to bacteria or other germs that have developed resistance to at least three or more classes of antibiotics) infection. The CP interventions included for nursing staff to observe Enhanced Barrier Precautions (EBP - an infection control strategy in nursing homes requiring staff to wear gowns and gloves during high-contact care for residents at high risk for harboring MDROs) during the provision of close contact care and to monitor for sign and symptoms of active infection and notify physician. During a concurrent observation inside Resident 46's room and interview on 2/24/2026 at 9:31 am with the Director of Staff and Development (DSD), Resident 46 was in bed. Resident 46 had a foley catheter hanging on the right side of the bed. Resident 46's had approximately two inches of white sediments inside the foley catheter tubing. The DSD stated Resident 46's foley catheter tubing should not have white sediments inside. The DSD stated white sediments in the tubing could be a sign of UTI. During an interview on 2/26/2026 at 1:17 pm, with the facility's Director of Nursing (DON), the DON stated licensed nurses should monitor all residents with foley catheter every eight hours for signs and symptoms of infection such as burning upon urination, presence of sediments in the tubing, blood in the urine, fever and alteration in level of consciousness, to prevent UTI. During a review of the facility's policy and procedure (P&P) titled, Indwelling Urinary Catheter Care, revised 2/2026, the P&P indicated, It is the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and as needed (PRN) to promote hygiene, comfort, and decrease the risk of infection.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary care and services for gastrostomy tube (GT - a tube inserted through the abdomen that delivers nutrition/medication directly to the stomach) site in accordance with the physician's order for one of one sampled resident (Resident 51). This failure had the potential for complications related to tube feedings for Resident 51.Findings: During a review of Resident 51's admission Record (AR), the AR indicated Resident 51 was admitted to the facility on [DATE] with diagnoses including quadriplegia (paralysis from the neck down, including legs, and arms), left hand contracture (a stiffening/shortening at any point, that reduces the joint's range of motion) and gastrostomy (a surgical opening fitted with a device to allow feedings/medication to be administered directly to the stomach). During a review of Resident 51's untitled Care Plan (CP) dated 2/19/2024, the CP indicated Resident 51 had a tube feeding related to dysphagia (difficulty swallowing). The CP had a goal for Resident 51 to remain free of side effects or complications related to tube feeding. During a review of Resident 51's Order Summary Report (OSR) dated 11/29/2025, the OSR indicated Resident 51 had an order for licensed staff to clean GT site with normal saline (NS), pat dry, and apply split gauze dressing (a specialized absorbent, and pre-cut pad designed to fit securely around medical devices that protrude from the skin such as GT) daily and secure with paper tape every shift. During a review of Resident 51's Minimum Data Set (MDS - a resident assessment tool) dated 2/2/2026, the MDS indicated Resident 51 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 51 was dependent (helper did all the effort, resident did none and assistance of 2 or more helpers were required for the resident to complete the activity) with eating, oral hygiene, toileting, shower, upper/lower body dressing and personal hygiene. During a review of Resident 51's Treatment Administration Record (TAR), dated 2/23/2026, the TAR indicated Resident 51's tube feeding site dressing was changed on 2/23/2026. During a concurrent observation inside Resident 51's room and interview on 2/24/2026 at 9:48 am with Certified Nursing Assistant 5 (CNA 5), Resident 51 was lying in bed on Resident 51's back with gastrostomy tube. CNA 5 stated Resident 51's G-tube dressing was loose and dated 2/22/2026. During an interview on 2/25/2026 at 1:30 pm with Treatment Nurse 1 (TN 1), TN 1 stated g-tube sites needed to be cleaned, pat dry, covered with a split type of gauze daily and as needed and secured with a tape to prevent infection around the g-tube stoma (surgically created opening on the surface of the abdomen that connects an internal organ to the outside of the body) and accidental pulling which might cause injury to the stoma. During an interview on 2/26/2026 at 1:52 pm with the Director of Nursing (DON), the DON stated for Resident 51, the g-tube site should be cleaned daily as ordered by the physician. The DON stated g-tube dressing should be kept clean and in place to prevent infection and tugging during bed mobility. During a review of the facility's policy and procedure (P&P) titled, Gastrostomy Tube Care and Management, revised 4/2025, the P&P indicated, It is the policy of this facility to provide proper care and maintenance of gastrostomy tubes. Clean all stoma sites daily, per MD orders.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one of seven sampled residents (Resident 109) was free from significant medication error by failing to administer Morphine Sulfate Contin (MS Contin- controlled medication used for pain) Oral Tablet Extended Release (ER-long acting) 15 milligrams (mg- unit of measurement) at the correct administration time. The medication was administered too early than the ordered scheduled time of administration. This failure had the potential to place Resident 109 at risk for adverse side effects related to overdosing, such as lethargy, respiratory depression (slow breathing and carbon dioxide retention) and hypotension (low blood pressure).Findings: During a review of Resident 109's admission Record (AR), the AR indicated Resident 109 was admitted to the facility on [DATE] with diagnoses including cutaneous abscess (pocket of pus in the skin from an infection) of the left upper arm and pain in the left shoulder. During a review of Resident 109's History & Physical (H&P) dated 2/23/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 109's Order Summary Report (OSR), the OSR indicated an active order for MS Contin Oral Tablet ER 15 mg to be given by mouth every 12 hours as needed for severe pain of 7-10 (on a pain rating scale of zero being no pain, and 10 being the worst possible pain, severe pain was rated as 7-10 on a 1-10 scale), ordered on 2/25/2026. During a review of Resident 109's untitled Care Plan (CP) dated 2/20/2026, the CP indicated the resident had acute pain due to an open wound to the left shoulder, with interventions for MS Contin on 2/25/2026 and to administer medications/treatments as ordered. During a medication pass observation on 2/26/2026 at 8:51 am, Licensed Vocational Nurse 1 (LVN 1) administered oral tablet of MS Contin ER 15 mg to Resident 109 for nine out of ten (9/10) left arm abscess pain. LVN 1 charted the medication administration in the electronic medication administration records (eMAR- a daily documentation record used by a licensed nurse to document medications and treatments given) and then in the Controlled Drug Record (CDR). During a review of the Resident 109's eMAR, dated 2/1/2026 through 2/28/2026, the eMAR indicated MS Contin oral tablet ER 15 mg was documented as given on 2/25/2026 at 4:20 pm and on 2/26/2026 at 8:50 am. During a review of Resident 109's Controlled Drug Record (CDR-a controlled drug record/accountability record of medications that are considered to have a strong potential for abuse), dated 2/25/2026, the CDR indicated, Morphine sulfate ER tablet 15 mg was previously administered on 2/26/2026 at 4:20 am and LVN 1 administered the tablet again at 8:50 am. During an interview on 2/26/2026 at 8:56 am with LVN 1, LVN 1 stated the pill count matched the doses given in the CDR and the bubble pack showed that a total of three doses had been given to Resident 109, but the dose given at 2/26/26 at 4:20 am was not charted in the eMAR. During a concurrent observation and interview on 2/26/2026 at 8:59 am with Resident 109 in Resident 109's room, Resident 109 was alert and sitting up in bed. Resident 109 stated Resident 109 received medication around 4 am (today) for the pain in Resident 10's arm. Resident 109 could not recall the name of the medication. During a follow up interview on 2/26/2026 at 9:03 am with LVN 1, LVN 1 stated the licensed nurses should document every time a medication was administered, follow medication rights, and check if given. LVN 1 stated LVN 1 gave the MS Contin ER 15 mg tablet before it was due which could cause resident 109 to become lethargic, experience low blood pressure and heart rate, and cause a change in condition. During an interview on 2/26/2026 at 11:12 am with Registered Nurse 3 (RN 3), RN 3 stated RN 3 took care of Resident 109 the night prior and gave Resident 109 MS Contin ER 15 mg on 2/25/2026 at 4:20 am for severe pain. RN 3 stated, RN 3 admitted RN 3 had forgotten to document the medication administration in the eMAR. RN 3 stated the CDR and eMAR should be checked before giving the medication and because the dose was given too early, Resident 109 could experience adverse side effects, decreased respirations, and cardiac issues. During an interview on 2/26/2026 at 2:02 pm with the Director of Nursing (DON), the DON stated for medication administration, the nurses must follow the five rights of (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication administration and review the prior administration by checking the CDR and the eMAR. The DON stated, Resident 109's medication administration of the MS Contin ER 15 mg on 2/26/2026 at 8:50 am was a medication error. The DON stated licensed nurses should document on both the CDR and eMAR for controlled drugs so the following nurse would know when the next medication was available to the resident to prevent medication errors from occurring for resident's safety. The DON stated, Resident 109 could experience lethargy, altered mental status, and decreased respiration and would be monitored for 72 hours. During a review of the facility's policy and procedure (P&P) titled, Controlled Medications-Storage and Reconciliation, revised 4/2025, the P&P indicated, it was the policy of the facility to safeguard access and storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse. The P&P indicated, the facility would maintain a process for monitoring, administration, documentation, reconciliation, and destruction of controlled substances. During a review of the facility's P&P titled, Medication Administration, dated 1/2019, the P&P indicated, medications were administered within 60 minutes of scheduled time. The P&P further indicated, the individual who administered the medication dose recorded the administration on the resident's MAR directly after the medication was given. The P&P further indicated, at the end of each medication pass, the person who administered the medications reviewed the MAR to ensure necessary doses were administered and documented.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation , interview and record review , the facility failed to maintain medicationˆrelated equipment and storage areas in a clean and appropriate manner, resulting in the presence of contaminated equipment and unsecured, loose medication pills in the medication room.This deficient practice had the potential to cause contamination, medication errors, and unsafe conditions for residents.Findings:During a review of the facility's map, it was noted that the facility has four shower rooms, three nurses' stations (north, center, and south), and two medication rooms located in the center and south stations.During a concurrent observation and interview on 2/26/2026 at 1:15 pm with Registered Nurse Supervisor (RNS) 1 in the center station medication room, crackers were observed stored inside one of the medication room cabinets, and a can of insect repellent spray was observed on top of the cupboard in close proximity to medications. Five unidentified loose medication pills were found on the floor next to the medication destruction container. RNS1 stated food items should not be inside the medication room since these can attract pests. RNS1 stated that any discontinued and expired medications should be placed inside the destruction container.During an interview on 2/27/2026 at 11:29 am with the DON (Director of Nursing), DON stated there should be no food items inside the medication room since these can attract pest infestation. DON stated nurses are responsible for keeping the medication rooms clean to avoid any possible infection that could happen. DON also stated if nurses do not manage the discontinued and expired medications by not placing them in the destruction container, this compromises the safety of our residents. During a review of the facility's policy and procedure (P&P) titled, Medication Storage, the P&P indicated outdated, contaminated, or deteriorated medications are immediately removed from stock , disposed of according to medication disposal and medication storage areas are kept clean and free of clutter.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement and follow infection prevention procedures to prevent the transmission of infectious organisms for one of four sampled residents (Resident 80) by failing to ensure the resident's nasal cannula (NC- a flexible tube with two small prongs that sits in the nostrils to deliver oxygen) was not touching the floor. This deficient practice had the potential to result in infection to Resident 80. Findings: During a review of Resident 80's AR, the AR indicated Resident 80 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dysphagia (difficulty swallowing food or liquids) and gastrostomy status (a surgical procedure used to insert a tube, often referred to as a G-tube [GT], through the abdomen and into the stomach for medication/feeding). During a review of Resident 80's MDS dated [DATE], the MDS indicated Resident 80's cognitive (ability to think and reason) skill for daily decision making was severely impaired (never/rarely made decisions). The MDS also indicated Resident 80 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During a review or Resident 80's Order Summary Report (OSR) dated 1/12/26, the OSR indicated continuous Oxygen at 2 liter per NC to keep oxygen at 92% every shift. During an observation inside Resident 80's room on 2/24/26 at 9:43 AM, Resident 80's NC tube was touching the floor. During a concurrent observation inside Resident 80's room on 2/24/26 at 1:57 PM, Resident 80's NC tube was still touching the floor. During an interview with the Infection Control Nurse (IPN) on 2/25/26 at 11:37 AM, the IPN stated if Resident 80's NC was touching the floor, it could result in an infection. The IPN stated the NC should not be touching the floor. The IPN stated, when not in use, the NC should be placed inside a bag and safely stored so it will not be touching the floor. During an interview with the Registered Nurse Supervisor (RNS) on 2/26/2026 at 7:18 AM, the RNS stated if Resident 80's NC was touching the floor, it was an infection control issue and was not sanitary. The RNS stated the resident's NC should not touch the floor and change every week or as needed. During an interview with the facility's Director of Nursing (DON) on 2/26/2026 at 1:32 PM, the DON stated Resident 80's NC should not be touching the floor for infection control. During a review of the facility's Policies and Procedures (P&P) titled, Use of Oxygen, revised 5/2007, the P&P indicated, It is the policy of this facility to promote resident safety in administering oxygen. The following guidelines will be observed in oxygen administration: The tubing should be kept off the floor.