STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055206	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Healthcare Center	1209 Hemlock Way Santa Ana, CA 92707

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to obtain the informed consent prior to administering the psychotropic medications for one of five final sampled residents (Resident 14) reviewed for unnecessary medications. This failure had the potential for the resident not being able to make an informed decision about their treatment plan. Findings: Review of facility's P&P titled P-NP67 Informed Consent effective 7/31/24, showed the licensed nurse will verify informed consent was obtained and will document in the resident's medical record before administering the first dose. Medical record review for Resident 14 was initiated on 6/10/25. Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's H&P examination dated 8/7/24, showed the resident had the mental capacity to make their own decisions. Review of Resident 14's MARs showed the following: - The MAR for 9/2024 showed a physician's order dated 9/17/24, for temazepam (psychotropic medication and sedative) 15 mg by mouth every 24 hours PRN for insomnia for 14 days. The first dose was administered on 9/24/24. - The MAR for 10/2024 showed a physician's order dated 10/20/24, for temazepam 15 mg by mouth at bedtime PRN for insomnia for 14 days. The first dose was administered on 10/23/24. - The MAR for 12/2024 showed a physician's order dated 12/26/24, for temazepam 15 mg by mouth every 24 hours PRN for insomnia for 14 days. The first dose was administered on 12/28/24. - The MAR for 2/2025 showed a physician's order dated 2/6/25, for temazepam 15 mg by mouth at bedtime for insomnia, which was discontinued on 4/1/25. The first dose was administered on 2/6/25. - The MAR for 4/2025 showed a physician's order dated 4/1/25, for temazepam 15 mg by mouth at bedtime for insomnia. The first dose was administered on 4/1/25. (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 14's Informed Consent for the temazepam 15 mg at bedtime for insomnia dated 4/1/24, failed to show who gave the informed consent. Review of Resident 14's medical records failed to show the informed consent was obtained for the temazepam orders started on 9/17, 10/20, 12/26/24, and 2/6/25. On 6/16/25 at 0855 hours, an interview and concurrent medical record review for Resident 14 was conducted with RN 1. RN 1 stated for PRN psychotropic medications, if the order duration was for 14 days, each new order needed a new consent, as well as when changing a PRN order to a routine order. RN 1 reviewed Resident 14's Informed Consent for the temazepam medication dated 4/1/25, and verified the form did not show who gave the informed consent. On 6/16/25 at 1053 hours, an interview and concurrent medical record review for Resident 14 was conducted with LVN 4. LVN 4 reviewed Resident 14's medical records and verified the records failed to show the informed consent was obtained for the temazepam medication orders from 9/17, 10/20, 12/26/24, and 2/6/25.

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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 0558 Level of Harm - Potential for minimal 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 facility P&P review, the facility failed to provide the reasonable accommodation to meet the needs of two final sampled residents (Residents 45 and 63) reviewed for accommodation of needs. * The facility failed to ensure the call lights for Residents 45 and 63 were kept within the residents' reach. This failure had the potential for the residents' care needs not being met. Findings: Review of the facility's P&P titled Communication Call System revised 8/24/24, showed the call alert device will be placed within the resident's reach and facility staff will answer call alerts promptly and in a courteous manner. 1. Medical record review for Resident 45 was initiated on 6/12/25. Resident 45 was admitted to the facility on [DATE]. Review of Resident 45's H&P examination dated 5/23/24, showed Resident 45 had the capacity to understand and make decisions. Review of Resident 45's MDS assessment dated [DATE], showed Resident 45's BIMS score was nine which meant the resident had moderately impaired cognition. Review of Resident 45's MDS assessment dated [DATE], showed Resident 45's Functional Abilities of Section GG 0115 for the ROM of the upper and lower extremities showed no impairment, and Section GG 0130 for upper body dressing showed substantial/maximal assistance needed from the nursing staff. In addition, Resident 45's lower body dressing and personal hygiene functional abilities showed Resident 45 required substantial or maximal assistance. On 6/10/25 at 0840 hours, during the initial tour of the facility, Resident 45 was observed lying in bed awake, alert, and verbally responsive. Resident 45 was asked where her call light button was located and she stated she was looking for it. Resident 45's call light was observed hanging on the bed frame below the bed mattress and was not within her reach. On 6/10/25 at 0901 hours, an observation of Resident 45 and concurrent interview was conducted with LVN 3. Resident 45's call light was observed hanging on the bed frame below the mattress and was not within her reach. LVN 3 verified the above findings. LVN 3 stated Resident 45's call light was placed where Resident 45 could not reach it. When LVN 3 was asked regarding the importance of the call light placement and the implication of inaccessibility for the resident, LVN 3 stated the call light was the resident's means to call for assistance from the staff and must be placed within easy reach. In addition, LVN 3 stated if the call light was not placed within the resident's reach, the resident would not be able to receive the appropriate assistance and meet their daily needs. On 6/10/25 at 0913 hours, an interview was conducted with CNA 7. CNA 7 stated the call light must be placed within the resident's reach for the residents to ask for assistance and communicate their needs. (continued on next page)

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F 0558 Level of Harm - Potential for minimal harm Residents Affected - Some	2. Medical record review for Resident 63 was initiated on 6/10/25. Resident 63 was admitted to the facility on [DATE]. Review of Resident 63's MDS assessment dated [DATE], showed Resident 63's BIMS score was 14 which meant the resident was cognitively intact. Review of Resident 63's H&P examination dated 5/16/25, showed Resident 63 had the capacity to make needs know, however could not make medical decisions. On 6/10/25 at 0940 hours, during the initial tour of the facility, Resident 63 observed lying in bed awake, alert, and oriented to person, place, and time. Resident 63's call light was observed clipped and hung on the right side of his bed. Resident 63 was observed reaching for his call light; however, he was unable to reach it. Resident 63 stated he could not reach his call light. On 6/10/25 at 0957 hours, an observation of Resident 63 and concurrent interview was conducted with LVN 8. O Resident 63's call light was observed clipped and hung on the right side of his bed. LVN 8 verified the above findings. LVN 8 observed Resident 63 attempted to reach for his call light, however, Resident 63 could not reach it. LVN 8 was observed moving the call light to Resident 63's right side and Resident 63 was able to easily reach his call light. LVN 8 stated the call light button must be within the resident's easy reach to alert staff of resident's request for assistance. On 6/16/25 at 0843 hours, an interview was conducted with the DON. The DON was asked about the purpose of the call light, placement, and implications of inaccessibility. The DON stated the call light must be placed within the resident's easy reach to be used when assistance was needed. The DON stated the call light must be placed on the resident's strong side if the resident had any weakness or paralysis. Furthermore, the DON stated the resident's needs would not be met if call light was inaccessible. On 6/16/25 at 1215 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility record review, and facility P&P review, the facility failed to protect the resident's rights to be free from the physical abuse by a resident for one of four final sampled residents (Resident 117) investigated for abuse. * Resident 117 was hit on the right eyebrow by another resident (Resident 113), resulting in a superficial skin tear. In addition, the facility failed to monitor Resident 113 as per facility's abuse protocol after a resident to resident physical altercation. These failures had the potential for not protecting the resident and negatively impact the resident's well-being. Findings: Review of the facility's P&P titled P-AN01 Abuse Prevention and Management revised 5/30/24, showed the facility does not condone any form of resident abuse, neglect, misappropriation of resident property, exploitation, and/or mistreatment. Abuse is defined as the willful, deliberate infliction of injury, unreasonable confinement, involuntary seclusion, and physical or chemical restraint not required to treat symptoms, and/or imposed for the purposes of discipline or convenience, intimidation, exploitation, misappropriation of resident's property, mistreatment, and injuries of unknown source or punishment with resulting physical harm, pain, or mental anguish. Physical abuse is defined as, but not limited to, hitting, slapping, punching, and/or kicking. It also includes corporal punishment, which is physical punishment used to correct and/or control behavior. Review of the facility's P&P titled NP23 Change of Condition Notification dated 8/25/22, under the Documentation section showed the licensed nurse will communicate any changes in required interventions to the care team members involved in the resident's care. The licensed nurse will document each shift for at least 72 hours when there is a change in the resident's condition. 1. Review of the facility's SOC 341 Report of Suspected Dependent Adult/Elder Abuse dated 6/2/25, showed a resident to resident altercation between Residents 113 and 117 reported by RN 1. Resident 117 was reported using foul racial slurs and screaming loudly at Resident 113 when both residents were at the supervised smoke break. The activities personnel who was in the supervised smoking area was unable to intervene on time. Resident 113 struck Resident 117 one time above the right eyebrow which resulted in a superficial skin tear with minimal bleeding. The activities personnel and other staff immediately responded and separated Residents 113 and 117. Review of the facility's Investigative Summary report dated 6/6/25, showed the facility had substantiated the allegation of abuse for Residents 113 and 117, however, the incident was unavoidable. a. Medical record review for Resident 117 was initiated on 6/10/25. Resident 117 was admitted to the facility on [DATE]. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 117's H&P examination dated 4/26/25, showed Resident 117 had fluctuating capacity to understand and make decisions, and had a significant diagnosis of schizoaffective-bipolar type disease. Review of Resident 117's MDS assessment dated [DATE], showed Resident 117 was cognitively intact. Further review of the MDS assessment showed Resident 117 had no behavioral symptoms exhibited such as physical behavioral symptoms directed toward others (for example-hitting, kicking, pushing, scratching, grabbing, or abusing others sexually) and verbal behavioral symptoms directed toward others (for example-threatening others, screaming at others, or cursing at others). Review of the facility's Interview Record regarding the resident to resident altercation dated 6/2/25 at 1226 hours, showed Resident 117 stated he was talking to another resident during the smoke break and Resident 113 jumped up, came over him, and hit him one time on the right side of his face. Resident 117 stated he did not say anything to Resident 113 until after Resident 113 hit him. Resident 117 stated right after Resident 113 hit him, the staff rushed in between them and removed Resident 113 from the smoke break patio. Review of Resident 117's Nursing Note dated 6/2/25, showed at 1130 hours, Resident 117 was observed to be verbally aggressive towards all individuals in the smoking patio including other residents and facility staff during the monitored smoke break. Resident 117 was loud, directing verbal racial slander continuously which prompted Resident 113 to approach Resident 117 and inadvertently struck Resident 117 above the right eyebrow which resulted in a superficial skin tear before the interaction could be prevented by the activity and nursing staff. The two residents were separated immediately and both were assessed. Resident 117's verbal racial slander and foul loud abusive language did not stop towards all the residents and staff. The physician was notified of Resident 117's verbally abusive behavior with a new order for 1:1 supervision (one staff to supervise one resident) for behavior monitoring and to send Resident 117 to an acute care hospital for the abusive verbal behavior when the bed was available. Resident 117 was being monitored for emotional distress due to a resident to resident altercation. Further review of Resident's 117's Nursing Note showed Resident 117 continued to exhibit the verbal aggression behavior toward the facility staff and being followed up by the psychiatric nurse practitioner. Resident 117 was transferred to an acute care hospital in a behavioral or psychiatric department on 6/6/25. b. Medical record review for Resident 113 was initiated on 6/10/25. Resident 113 was readmitted to the facility on [DATE]. Review of Resident 113's H&P examination dated 5/15/25, showed Resident 113 could make needs known, however, could not make medical decisions due to schizophrenia. Review of Resident 113's MDS assessment dated [DATE], showed Resident 113 had moderate impaired cognition. Further review of the MDS assessment showed Resident 113 had exhibited delusional behavior and verbal behavioral symptoms directed toward others occurred one to three days. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Interview Record regarding the resident to resident altercation dated 6/2/25 at 1249 hours, showed Resident 113 verbalized he got upset and slapped someone. Resident 113 stated he was smoking and Resident 117 started calling the staff in foul language. Resident 113 stated he told Resident 117 to shut up and Resident 117 started calling him in foul language. Resident 113 stated he slapped Resident 117 in the face and the staff came right away, stopped him and took him out of the patio. Review of Resident 113's eInteract Change in Condition Evaluation dated 6/2/25, showed at 1130 hours, Resident 113 was in the supervised smoking patio and Resident 117 was also in the smoking patio. Resident 117 was witnessed using racial slurs and screaming to Resident 113. Resident 113 struck at Resident 117 as the activity personnel who was in the smoking patio was about to intervene. The activities personnel and other facility staff responded and immediately separated both residents. Resident 113 was being monitored for emotional distress due to a resident-to-resident altercation. Review of Resident 113's plan of care revised on 10/23/23, showed a care plan problem addressing Resident 113's risk for harm, self-directed or other-directed related impaired thought processes, bipolar disorder and depression. The interventions included to monitor Resident 113 for signs and symptoms of aggression, provide verbal feedback to Resident 113 regarding the behavior, and if Resident 113 poses a potential threat to injure self or others to notify the provider. On 6/11/25 at 1000 hours, an interview was conducted with Resident 113. Resident 113 was asked to describe the physical altercation between himself and Resident 117 which happened on 6/2/25. Resident 113 stated he remembered the black resident yelling foul language to the facility's staff and the residents in the smoking patio. Resident 113 stated this happened just this month of June but could not recall exactly which day. Resident 113 stated he got upset and did not want Resident 117 to hurt the people in the smoking patio, so he told Resident 117 to shut up. Resident 113 stated Resident 117 continued to yell foul words so he hit Resident 117 in the face. Resident 113 stated the facility staff stopped him immediately and he was brought out of the smoking patio. Resident 113 further stated he was so angry during the incident because of the behavior of Resident 117 toward the staff and all of them in the smoking patio. Resident 113 stated he did not see Resident 117 smoking anymore in the patio. On 6/11/25 at 1045 hours, an interview was conducted with CNA 12. CNA 12 stated he was familiar with both Residents 113 and 117. CNA 12 stated Resident 113 would have episodes of yelling at other residents; however, he never witnessed Resident 113 being physically aggressive to the staff or other residents. CNA 12 stated he heard report Resident 117 would initiate fight with other residents, but he had never witnessed the behavior. CNA 12 further stated, however, Resident 117 could be verbally aggressive to the staff and other residents like yelling at them using foul language. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/25 at 1205 hours, an interview was conducted with RN 1. RN 1 stated the resident to resident altercation between Residents 113 and 117 happened on 6/2/25 at around 1130 hours, in the supervised smoking patio during the residents' smoke break. RN 1 stated Resident 117 was using foul racial slander and screaming loudly at Resident 113. Activities personnel who was in the supervised smoking area was unable to intervene on time. Resident 113 struck Resident 117 one time above the right eyebrow which resulted in a superficial skin tear with minimal bleeding. Activity personnel and other staff immediately responded and separated Residents 113 and 117. RN 1 stated both Residents 113 and 117 were assessed. Resident 117's skin tear was treated by the treatment nurse. RN 1 stated she followed the proper protocol of reporting to the CDPH, Ombudsman, and called the police department. RN 1 stated with the kind of residents they had in the facility who the majority were with psychiatric illness, it was hard to prevent resident to resident altercation which was why they used 1:1 supervision as needed and ordered, continuing to monitor the residents who had history of abusive behavior by both nursing and social services staff, make sure the plan of care was implemented, and monitoring the effects of the medications as well as using the non-pharmacological interventions to lessen the behavior. 2. Review of the facility's Daily Charting showed for the new behavioral problem to chart a minimum of 72 hours. The facility document showed for Resident 113 the charting reason was for emotional distress with the start date of 6/2/25, and stop date of 6/5/25. Review of the Order Summary Report showed a physician's order dated 6/2/25, to monitor Resident 113 for signs and symptoms of emotional distress such sadness, crying, poor meal intake, self-isolation, poor motivation, decreased participation in ADLs care, inability to sleep, etc. every day shift for 14 days. Report promptly to the physician. Further medical record review for Resident 113 failed to show documented evidence of continued monitoring/assessment for Resident 113 by the licensed nurses post resident to resident altercation incident. On 6/11/25 at 1130 hours, an interview and concurrent facility document review was conducted with LVN 5. LVN 5 stated any new behavioral problem exhibited the resident was considered change in condition. LVN 5 stated both residents involved in the resident to resident altercation would be monitored every shift for 72 hours. LVN 5 stated whenever there was a change of condition for the resident, the nurses would document it in the Daily Charting green book to remind the nurses of the assessment to be done. LVN 5 stated the monitoring assessment was documented in the nursing progress notes such as if the resident had changes in vital signs, feeling of sadness, poor meal intake, any changes in the skin, or changes in sleeping pattern. On 6/11/25 at 1205 hours, an interview and concurrent medical record review for Resident 113 was conducted with RN 1. RN 1 stated any type of abuse incident was considered a change in condition for both residents involved. RN 1 stated both residents would be monitored by the licensed nurses for any emotional distress such as changes in moods, angry outburst, changes in vital signs, poor meal intake, inability to sleep, not participating in ADLs care, or significant skin changes if the resident was hit, every shift for 72 hours and it would be continued as needed or as ordered by the physician. RN 1 stated the social services staff would do their separate assessment and follow up with the residents involved in the altercation. RN 1 verified the continued monitoring for Resident 113 by the licensed nurses was not completed post resident to resident altercation incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/22 at 1622 hours, an interview and concurrent medical record review and facility record review was conducted with the DON. The DON stated the facility substantiated the resident to resident altercation between Residents 113 and 117. Resident 117 was verbally abusive to the staff and the residents on 6/2/25, during the supervised smoke break in the smoking patio. The DON stated Resident 113 struck Resident 117 even before the facility staff was able to intervene. The DON stated after the incident, the staff were in-serviced to be more vigilant and aware of behavior symptom changes of the residents. The DON stated both Residents 113 and 117 were monitored for any signs and symptoms of emotional distress. The DON acknowledged there was an order for Resident 113 to be monitored for emotional distress every day shift, however, the facility's protocol and policy was to monitor the resident for any change in condition every shift for 72 hours. The DON stated the order was incorrectly entered. The DON verified the continued monitoring for Resident 113 by licensed nurses was not completed post resident to resident altercation incident. The DON stated it was very important to monitor the resident to identify if the change in condition had been escalated, to provide the necessary care to the resident as needed, and to report to the physician any changes in the resident's condition promptly and as needed.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to report an abuse allegation to CDPH, L&C Program and Ombudsman for one of four residents (Resident 82) reviewed for abuse as evidence by: * The facility failed to report Resident 82's allegation of feeling harassed and threatened by Resident 15. This failure of not reporting abuse allegation put the resident at risk for further abuse. Findings: Review of the facility's P&P titled AN01 Abuse Prevention and Management revised 5/2024 showed the facility does not condone any form of resident abuse, neglect, misappropriation of resident property, exploitation, and/or mistreatment. The facility develops policies, procedures, training programs, and screening and prevention systems. The facility will report all allegations of abuse and criminal activity as required by law and regulations to the appropriate agencies. The P&P further showed the health, safety, welfare, dignity, and respect of residents are addressed. Reports of resident abuse, mistreatment, neglect, exploitation, injuries of an unknowns source, and any suspicion of crimes are promptly reported and thoroughly investigated. Moreover, the P&P defined abuse as the willful, deliberate infliction of injury, unreasonable confinement, intimidation, mistreatment. Mental abuse, emotional abuse, and psychological abuse are defined as, but is not limited to, verbal or nonverbal conduct that causes humiliation, intimidation, fear, shame, agitation, or degradation. When the administrator or designated representative receives a report of an allegation of resident abuse, mistreatment, neglect, abuse facilitated or enabled by technology, exploitation or injuries of an unknown source, or suspicion of a crime, the administrator or designated representative will initiate an investigation immediately. The Administrator or designated representative will notify law enforcement, by telephone immediately, or as soon as practicably possible, but no longer than two hours of an initial report and send a written SOC 341 report to the ombudsman, law enforcement, and CDPH licensing and certification within two hours. The Administrator will inform the resident and his/her representative of the results of the investigation and corrective action taken within five working days of the reported incident. The administrator will provide a written report of the results of all abuse investigations and appropriate action taken, to the California Department of Public Health Licensing and Certification and others that may be required by state or local laws, within five working days of the reported allegation. Medical record review for Resident 82 was initiated on 6/10/25. Resident 82 was admitted to the facility on [DATE]. Review of Resident 82's H&P examination dated 9/8/24, showed Resident 82 was alert and oriented with judgement/insight intact. Review of Resident 82's MDS assessment dated [DATE], showed Resident 82 had a BIMS score of 15 which meant the resident was cognitively intact. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 82's Progress Notes categorized as Behavior Note dated 6/8/25, showed At 1030 [hours] during supervised activities in the activity room, resident stated, '[Resident 15] just threatened to have his daughter and boyfriend come mess me up.' Moreover, a Behavior Note dated 6/9 and 6/10/25, showed Resident 82 was on behavior monitoring for complaint of verbal aggression from another resident. Medical record review for Resident 15 was initiated on 6/10/25. Resident 15 was admitted to the facility on [DATE], and was readmitted on [DATE]. Review of Resident 15's H&P examination dated 3/13/25, showed Resident 15 had no mental capacity to make decisions. Review of Resident 15's Progress Note categorized under Behavior Note dated 6/8/25, showed At 1030 [hours] while in supervised activities in the activity room, resident was accused of allegedly stating to another resident 'I am going to have my daughter and her boyfriend come mess you up.' Moreover, progress note categorized as System Note dated 6/9/25, showed Resident 15 was on monitoring for verbally abusive behavior toward others. On 6/10/25 at 0920 hours, during the initial tour of the facility, an interview with Resident 82 was conducted in the resident's room. Resident 82 stated over the weekend on Sunday, 6/8/25, an incident occurred in the activities room between her and Resident 15. Resident 82 stated she felt harassed when Resident 15 told her he was going to get his kids to come out here to jump on me. Resident 82 stated Resident 15 bullied and threatened others and she called the police on Resident 15. On 6/10/25 at 0950 hours, an interview was conducted with the Administrator and DON in the DON's office. The Administrator and DON were notified of the allegations reported by Resident 82 against Resident 15. The Administrator stated he was made aware of the incident between Residents 82 and 15 on Sunday, 6/8/25, and both residents had history of grievances between each other. On 6/10/25 at 1056 hours, a follow up interview was conducted with the Administrator. When asked if he was going to report the allegations of Resident 82 stating she felt harassed, the Administrator stated he will not report and stated, it was not verbal or physical abuse. On 6/11/25 at 1600 hours, a follow-up interview was conducted with Resident 82. When Resident 82 was asked if she felt she was abused with the incident that occurred between her and Resident 15, Resident 82 stated, I felt threatened. On 6/13/25 0630 hours, an interview and concurrent medical record review for Resident 82 was conducted with RN 3. RN 3 verified Residents 82 and 15 were being monitored for the allegations which occurred on Sunday, 6/8/25. RN 3 stated the facility's abuse protocol included separating the residents, notifying the Administrator, completing the SOC 341 form, one to one staff monitoring, calling the CDPH, L&C Program, Ombudsman, and law enforcement, notifying the physician and resident's family, and monitoring for emotional distress. RN 3 stated if a resident stated she was feeling harassed or threatened, it would be considered emotional abuse and should be reported. RN 3 further stated Resident 82 felt threatened, which was why she called the police. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/25 at 0818 hours, an interview and concurrent medical record review for Resident 82 was conducted with RN 1. RN 1 verified Resident 82 reported the incident to her on Sunday, 6/8/25. RN 1 stated she ensured Residents 82 and 15 were separated and notified the Administrator. RN 1 stated residents feeling threatened or harassed was considered abuse and should have been reported. On 6/16/25 at 0909 hours, an interview and concurrent facility P&P review was conducted with the Administrator. The Administrator stated the abuse protocols included investigating what happened, reporting to the CDPH, L&C Program, police department, and Ombudsman, ensuring the residents were separated, one to one staff monitoring, conducting interviews with staff or residents involved, and completing a five-day investigation report. Review of the facility's P&P titled AN01 Abuse Prevention and Management revised 5/2024 showed mental abuse, emotional abuse, and psychological abuse are defined as, but is not limited to, verbal or nonverbal conduct that causes humiliation, intimidation, fear, shame, agitation, or degradation. The Administrator verified Resident 15's threat to Resident 82 would be considered a type of intimidation or fear. The Administrator further verified Resident 82's allegation should have been reported. On 6/16/25 at 1200 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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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, medical record review, and facility P&P review, the facility failed to follow their protocol for written notification of transfer or discharge for four of four final sampled residents reviewed for hospitalization (Residents 10, 15, 86, and 122), one of three residents (Resident 117) reviewed for closed records, and one of three residents (final sampled resident, Resident 122) reviewed for hospice and end of life. * Resident 137's medical record did not show the resident received a discharge summary and a recapitulation of their stay when they discharged to the community. * Resident 10's Notice of Proposed Transfer and Discharge form was not completed for three acute care transfers, and the resident's record failed to show the Ombudsman was notified of the resident's acute care transfer for one of two completed Notice of Proposed Transfer and Discharge forms. * Resident 117's Notice of Proposed Transfer and Discharge form failed to show who was notified of the transfer and Ombudsman notification. * Resident 15's written Notice of Proposed Transfer and Discharge was not completed upon transfer to acute care. * Resident 86's written Notice of Proposed Transfer and Discharge was not completed upon transfer to acute care * Resident 122's written Notice of Proposed Transfer and Discharge was not completed upon transfer to acute care. These failures had the potential for the residents not receiving the accurate information about their transfer/discharge status and their rights to appeal. Findings: Review of facility's P&P titled Notice of Transfer/Discharge revised 10/2017 showed before a resident's transfer or discharge occurs, the facility must notify the resident, the responsible party, and Ombudsman of the transfer, the reason for transfer, and document in the resident's medical record. Review of facility's P&P titled P-NP03 Discharge and Transfer of Residents effective 3/21/25, showed the facility will provide the resident or responsible party with a Notice of Proposed Transfer and Discharge document, and a copy will be placed in the resident's medical record as well as faxed to the Ombudsman. For discharged residents, the facility will provide the resident or their responsible a copy of an evaluation of the resident's discharge needs and discharge plan. 1. Closed medical record review for Resident 137 was initiated on 6/12/25. Resident 137 was admitted to the facility on [DATE], and discharged to the community on 3/18/25. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 137's medical records failed to show the resident received a copy of the recapitulation of the resident's stay including home health services information, follow-up appointments, and a medication list with instructions. On 6/12/25 at 1537 hours, the MRD stated she was unable to locate a signed discharge summary in Resident 137's medical records. On 6/13/25 at 0740 hours, an interview and concurrent closed medical record review for Resident 137 was conducted with the DON. The DON stated when the resident was discharged from the facility, the nurse should print and explain the Discharge Planning Review Form with a medication list, and provide the resident the form with a copy being placed in the resident's medical record. The DON verified they were unable to locate a signed copy of Resident 137's Discharge Summary. 2. Medical record review for Resident 10 was initiated on 6/10/25. Resident 10 admitted to the facility on [DATE]. Review of Resident Census showed the resident was on a acute care hospital leave for the following dates: - On 8/23/24, and returned to the facility on 8/26/25. - On 9/3/24, and returned to the facility on 9/6/24. - On 10/6/24, and returned to the facility on [DATE]. - On 11/17/24, and returned to the facility on [DATE]. - On 4/22/25, and returned to the facility on 5/6/25. Review of Resident 10's Notice of Proposed Transfer and discharge date d 11/17/24, failed to show a copy of the notice was faxed to the office of the Ombudsman. Review of Resident 10's medical records failed to show a written notification of transfer was provided to the resident or the resident's responsible party, and faxed to the Ombudsman for 8/23, 9/3, and 10/6/24. On 6/10/25 at 0801 hours, a telephone interview was conducted with the Ombudsman. The Ombudsman stated the facility was not sending them all the required notifications of the residents' transfers. On 6/11/25 at 1541 hours, an interview and concurrent medical record review for Resident 10 was conducted with the MRD. The MRD stated she was unable to find the Notice of Proposed Transfer and Discharge forms for 8/23, 9/3, and 10/6/24. The MRD stated she was unable to find the documentation of the Notice of Proposed Transfer and discharge date d 11/17/24, was faxed to the Ombudsman. The MRD stated the nursing staff should complete the notification form and fax it to the Ombudsman, and attach the fax confirmation form to the notification and place it in the resident's medical record. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25 at 1438 hours, an interview was conducted with RN 2. RN 2 stated the process for a resident who was discharged or transferred out of the facility was to complete the Notice of Proposed Transfer and Discharge form, fax the form to the Ombudsman, and attach the fax confirmation with the form in the resident's medical record. 3. Closed medical record review for Resident 117 was initiated on 6/10/25. Resident 117 was admitted to the facility on [DATE], and was discharged to an acute care hospital on 6/6/25. Review of Resident 117's Notice of Proposed Transfer and discharge date d 6/6/25, failed to show the reason for the resident's transfer/discharge, and who was notified of the transfer/discharge. On 6/10/25 at 0801 hours, a telephone interview was conducted with the Ombudsman. The Ombudsman stated the facility was not sending them all the required notifications of the residents transfers. On 6/12/25 at 1403 hours, an interview and concurrent closed medical record review for Resident 117 was conducted with the MRD. The MRD verified Resident 117's Notice of Proposed Transfer and discharge date d 6/6/25, failed to show the reason for the resident's transfer/discharge, and who was notified of the transfer/discharge. On 6/12/25 at 1438 hours, an interview was conducted with RN 2. RN 2 stated the process for a resident who was discharged or transferred out of the facility, was to complete the Notice of Proposed Transfer and Discharge form, fax the form to the ombudsman, and attach the fax confirmation with the form in the resident's medical record. 6. Medical record review for Resident 122 was initiated on 6/10/25. Resident 122 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 122's medical record titled eINTERACT Transfer Form V5 and eINTERACT Change in Condition Evaluation - V 5.1 showed Resident 122 was transferred to the acute care facility on the following dates: - On 9/9/24, - On 4/1/25; and - On 4/10/25. Further review of Resident 122's medical record failed to show a copy of the Notice of Proposed Transfer and Discharge was faxed to the Ombudsman on 9/9/24, 4/1, and 4/10/25. On 6/12/25 at 1515 hours, an interview and concurrent medical record review for Resident 122 was conducted with RN 2. RN 2 verified the above findings. RN 2 stated upon a hospital transfer or discharge to home, the facility's protocol was to fax a copy of the Notice of Proposed Transfer and Discharge to the Ombudsman. RN 2 verified the Notice of Proposed Transfer and Discharge should have been faxed to the Ombudsman on the dates Resident 122 was transferred to the acute care hospital; however, RN 2 verified it was not done. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25 at 1534 hours, an interview was conducted with the MRD. The MRD verified she reviewed Resident 122's medical record and did not have copies of the resident's Notice of Proposed Transfer and Discharge from 9/9/24, 4/1, and 4/10/25. The MRD further stated the nursing staff were responsible for faxing the form to the Ombudsman. On 6/16/25 at 1200 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 4. Closed medical record review for Resident 15 was initiated on 6/11/25. Resident 15 was admitted to the facility on [DATE], and was transferred to the acute care hospital on 2/24/25. Review of Resident 15's medical record failed to show documented evidence the resident and/or his responsible party were provided with the written notice of the resident's transfer to an acute care facility. Additionally, Resident 15's medical record failed to show documentation the Notice of Proposed Transfer was sent to the Ombudsman as required. On 6/11/25 at 0826 hours, an interview and concurrent closed medical record review for Resident 15 was conducted with RN 1. RN 1 verified the facility was required to complete the Notice of Proposed Transfer when the residents were transferred to an acute care facility and the notice should be in the resident's medical record unless the the resident's medical record had been thinned in which case it would be stored in the medical records. RN 1 further stated a copy was required to be sent to the Ombudsman and documented. RN 1 then provided a blank copy of the facility's Notice of Proposed Transfer for reference purposes. On 6/11/25 at 1541 hours, the MRD verified there was no Notice of Proposed Transfer for Resident 15's transfer to an acute care facility on 2/24/25, either in the resident's chart or medical records. On 6/12/25 at 0814 hours, RN 2 verified there was no Notice of Proposed Transfer for Resident 15's transfer to an acute care facility on 2/24/25, in the resident's closed medical record. 5. Closed medical record review for Resident 86 was initiated on 6/11/25. Resident 86 was admitted to the facility on [DATE], and was transferred to the acute care hospital on 4/28/25. Review of Resident 86's medical record failed to show documented evidence the resident and/or his responsible party were provided with a written notice of the resident's transfer to an acute care facility. Additionally, Resident 86's medical record failed to show documentation the Notice of Proposed Transfer was sent to the Ombudsman as required. On 6/11/25 at 0826 hours, an interview and concurrent closed medical record review for Resident 86 was conducted with RN 1. RN 1 verified the facility was required to complete the Notice of Proposed Transfer when the residents were transferred to an acute care facility and the notice should be in the resident's medical record unless the medical record had been thinned in which case it would be stored in the medical records. RN 1 further stated a copy was required to be sent to the Ombudsman and documented. RN 1 then provided a blank copy of the facility's Notice of Proposed Transfer for reference purposes. On 6/11/25 at 1541 hours, the MRD verified there was no Notice of Proposed Transfer for Resident 86's transfer to an acute care facility on 4/28/25, either in the resident's chart or medical records. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25 at 0814 hours, RN 2 verified there was no Notice of Proposed Transfer for Resident 86's transfer to an acute care facility on 4/28/25, in the resident's closed medical record.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one final sampled resident (Resident 45) reviewed for ADL care was provided with the necessary care and services to maintain their ADL capabilities. * The facility failed to ensure care and services was provided to maintain good grooming and personal hygiene when Resident 45's fingernails were left dirty and untrimmed. This failure had the potential to result in injuries from scratching and spread of germs when eating. Findings: Review of the facility's P&P titled Grooming Care of the Fingernails and Toenails revised 10/21/21, showed the nail care is given to clean the nail bed and keep the nails trimmed; Medical record review for Resident 45 was initiated on 6/12/25. Resident 45 was admitted to the facility on [DATE]. Review of Resident 45's H&P examination dated 5/23/24, showed Resident 45 had the capacity to understand and make decisions. On 6/10/25 at 0840 hours, during the initial tour of the facility, Resident 45 was observed lying in bed awake, alert, and verbally responsive. Resident 45 was observed with long fingernails. Resident 45's fingernails were also observed with brown discoloration and dirt residue. Resident 45 stated she would like to have her nails trimmed; however, the staff did not offer and provide the nail care to her. On 6/10/25 0901 hours, an observation of Resident 45 and concurrent interview was conducted with LVN 3. Resident 45 was observed with long fingernails with brown discoloration and dirt residue. LVN 3 verified the above findings. When LVN 3 was asked about the frequency of resident's nail care and the possible implications when left dirty and untrimmed. LVN 3 stated the assigned CNA and licensed nurses must check the resident's fingernails every shift and provide nail care. LVN 3 stated the nail care included trimming or filing the nails short and cleaning under the fingernails. In addition, LVN 3 stated if fingernails were left dirty and long, they would cause possible infection to the resident. On 6/10/25 0913 hours, an observation of Resident 45 and concurrent interview was conducted with CNA 7. Resident 45 was observed with long fingernails with brown discoloration and dirt residue. CNA 7 verified the above findings and stated Resident 45 had episodes of refusal to trim her fingernails, however, the nail care must be provided. When CNA 7 was asked about the frequency of personal hygiene and what must be provided, CNA 7 stated personal hygiene included bed bath, shower, hand washing, mouth care, nail care, hair grooming, and dressing. CNA 7 stated the personal hygiene must be provided every day since it can cause infection if not provided. In addition, CNA 7 stated if resident refused any personal hygiene, it must be communicated to the charge nurse and document in the task. Review of the Resident 45's Nail Care task dated 5/30 to 6/11/25, showed the following: (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 5/30/25 at 1933 hours, documented not applicable; - on 5/31/25, failed to showed entry for 3 PM -11 PM shift; - on 6/2/25 at 2048 hours, showed documentation of not applicable; - on 6/3/25 at 0856 and 2243 hours, showed documentation of 'not applicable'; - on 6/7/25, failed to showed entry for 7 AM - 3 PM shift; and 3 PM -11 PM shift; - on 6/8/25 at 1355 hours, showed documentation of not applicable and failed to show entry for 3 PM - 11 PM shift; and - on 6/9/25 at 2218 hours, showed documentation of not applicable. On 6/12/25 at 1442 hours, an interview and concurrent medical record review for Resident 45 was conducted with LVN 7. Resident 45's Nail Care task dated on 5/30 - 6/11/25, was reviewed with LVN 7. LVN 7 verified the above findings. LVN 7 stated the personal hygiene included resident's nail care, mouth care, and washing of the face and hands. LVN 7 stated and verified CNAs' task for personal hygiene including nail care was scheduled twice a day, every morning and evening shift. LVN 7 stated the CNAs must check the resident's nails for cleanliness every shift and provide nail care which included cleaning under the fingernails and trimming or filing it short or smooth. Resident 45's care plan was also reviewed with LVN 7 and LVN 7 verified the care plan failed to show a care plan was initiated for the refusal of trimming the fingernails prior to the date of 6/11/25. In addition, LVN 7 stated if the resident refused the nail care, the licensed nurse must include it in the care plan since there would be a possibility of infection. Resident 45's ADL task scheduled for 6/2025 and assigned to the CNAs to complete was reviewed. The task failed to show the following documentation: - on 6/7/25, morning and evening shift; - on 6/8/25, evening shift; and - on 6/10/25, evening and night shift. On 6/16/25 at 0843 hours, an interview and concurrent medical record review for Resident 45 was conducted with the DON. The DON verified the above findings. The DON stated the oral care, nail care, shower, and hair grooming must be included in personal hygiene. The DON stated the personal hygiene including nail care must be provided by the assigned CNA at least twice a day. If the resident refused or preferred long fingernails, the licensed nurse must document in the care plan regarding the refusal or preference. In addition, the DON stated the licensed nurses and RN supervisor must check their residents if personal hygiene were provided before the shift ended. The DON stated the CNAs must document the ADL care rendered to the residents under tasks in each of the resident's medical record, and the registry staff must document on the ADL form if they did not have access to EHR. The DON stated if the residents' nails were left untrimmed and dirty would cause infection and injuries through scratching. Furthermore, the DON stated if any nursing staff failed to document residents' care or tasks rendered, it would mean they were not completed. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/16/25 at 1215 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the orthostatic hypotension was accurately monitored for one of 26 final sampled (Resident 74). This failure had the potential to not provide the necessary care for the resident monitored for orthostatic hypotension. Findings: Review of the facility's P&P titled Orthostatic Hypotension revised 1/2012 showed the orthostatic vital signs will be taken and recorded when ordered by the physician, and when a sudden drop in blood pressure is suspected as the cause of resident falls, vertigo, feelings of dizziness, and similar occurrences. Orthostatic hypotension is a 20 mmHg drop in your systolic blood pressure or a 10 mmHg drop in your diastolic blood pressure within three minutes of standing up. However, even smaller drops in blood pressure may be significant in the elderly. Medical record review for Resident 74 was initiated on 6/10/25. Resident 74 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 74's H&P examination dated 3/29/24, showed Resident 74 had the capacity to understand and make decisions. Review of Resident 74's Order Summary Report for 6/2025 showed the following physician's orders: - dated 4/1/25, to monitor the orthostatic BP while lying weekly everyday shift on Saturdays for the use of hypertension medications. - dated 4/1/25, to monitor the orthostatic BP while sitting everyday shift on Saturdays for the use of hypertension medications. Review of Resident 74's MARs for May and June 2025 showed the following: - On 5/31/25, the BP readings were 134/66 mmHg for the sitting and lying position - On 6/7/25, the BP readings were 129/72 mmHg for the sitting and lying position. On 6/12/25 at 1050 hours, an interview and concurrent medical record review for Resident 74 was conducted with LVN 5. LVN 5 verified the orthostatic BP readings for lying and sitting were the same values on 5/31 and 6/7/25. LVN 5 further stated orthostatic BP readings should be accurately monitored to ensure the BP medications were adjusted as needed. On 6/16/25 at 1200 hours, an interview was conducted with the Administrator and DON. The DON acknowledged having the same BP readings for both lying and sitting were not accurate and stated the BP readings for lying and sitting would likely fluctuate in the BP readings. The Administrator and DON were informed and acknowledged the above findings.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to complete the post-fall neurological assessments for 72 hours for two of five final sampled residents reviewed for accidents (Residents 10 and 47). This failure had the potential for a delay in identifying and intervening with neurological changes. Findings: Review of the facility's P&P titled Fall Management Program revised 3/31/21, showed for unwitnessed falls, the nurse will conduct neurological assessments for 72 hours following the fall, to be done every 15 minutes for one hour, then every 30 minutes for one hour, then every hour for four hours, and then every four hours until 72 hours post fall. 1. Medical record review for Resident 47 was initiated on 6/10/25. Resident 47 was admitted to the facility on [DATE]. On 6/10/25 at 0907 hours, an observation and interview with Resident 47 was conducted. Resident 47 was observed sitting on the floor next to her bed, a water pitcher was on the floor with a puddle of ice and water. Resident 47 stated she dropped her water pitcher and reached over to pick it up and fell out of bed. RN 1 was notified and she went to Resident 47's bedside. Review of Resident 47's Neurological Flow Sheet initiated 6/10/25 at 0900 hours, showed the neurological assessments were conducted through 6/12/25 at 0200 hours, for a total of 41 hours. The log showed the neurological checks were to be done be done every 15 minutes for one hour, then every 30 minutes for one hour, then every hour for four hours, and then every four hours for 24 hours for a total of 72 hours post fall. On 6/12/25 at 1029 hours, an interview and concurrent medical record review for Resident 47 was conducted with LVN 6. LVN 6 stated Resident 47's post fall neurological assessments were completed at 0600 hours, and no further checks were needed, and had not been done during her shift. LVN 6 stated the protocol was to conduct post-fall neurological checks for 72 hours. Review of the Neurological Flow Sheet showed all the assessment areas were completed, however, the assessments did not continue for 72 hours. LVN 6 stated she saw the log was completed, but did not realize it had not been for the full 72 hours, and should have been. 2. Medical record review for Resident 10 was initiated on 6/10/25. Resident 10 was readmitted to the facility on [DATE]. Review of Resident 10's eINTERACT SBAR Summary for Providers note dated 11/17/24 at 1214 hours, showed the resident was found on her back lying on the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 47's Neurological Flow Sheet initiated 11/17/24 at 1215 hours, showed the neurological assessments were conducted through 11/19/24 at 1415 hours, for a total of 50 hours. The log showed neurological checks were to be done be done every 15 minutes for one hour, then every 30 minutes for one hour, then every hour for four hours, and then every four hours for 24 hours for a total of 72 hours post fall. On 6/16/25 at 1048 hours, an interview and concurrent medical record review for Resident 10 was conducted with LVN 4. LVN 4 stated the post-fall neurological checks were to be completed for 72 hours. LVN 4 reviewed Resident 10's Neurological Flow Sheet for 11/17/24, and verified the neurological checks were not conducted for the full 72 hours.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to administer G-tube enteral feeding formula administration for one of two final sampled residents reviewed for tube feeding (Resident 12). This failure had the potential for the resident to have undesirable outcomes, including aspiration. Findings: Review of the facility's P&P P-DD-16 Enteral Feedings effective 9/7/23, showed when administering enteral feedings, the head of the bed should be elevated 30 degrees during feedings, to check the G-tube placement by aspirating stomach contents. Medical record review for Resident 12 was initiated on 6/10/25. Resident 12 was readmitted to the facility on [DATE]. Review of Resident 12's Order Summary Report showed the following physicians' orders: - dated 5/5/25, for Glucerna 1.5 (an enteral feeding formula) to be administered at 75 ml/hr via a pump for 20 hours a day. - dated 4/1/25, to elevate the head of the bed 30-45 degrees during tube feedings. On 6/12/25 at 1320 hours, an observation and interview for Resident 12 was conducted with LVN 5 at Resident 12's bedside. LVN 5 was observed setting up and administering Resident 12's enteral tube feeding. LVN 5 was observed hanging an enteral feeding set up, connected the tubing to the resident's G-tube, and started the feeding for Resident 12. LVN 5 did not check for gastric residuals or elevate the resident's head of the bed prior to starting the feeding. The resident's head of the bed appeared to be less than 30 degrees. LVN 5 stated she was done with the procedure and started to leave the room. LVN 5 verified she did not check for gastric residuals prior to starting the feeding for Resident 12. LVN 5 stated the resident's head was elevated 30 degrees. When checked with a digital level placed on the frame of Resident 12's head of the bed, the level showed 20 degrees. LVN 5 verified it should be at least 30 degrees to prevent the risk of stomach contents being aspirated.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care and services for two of 26 final sampled residents (Residents 22 and 63) reviewed for oxygen therapy. * The facility failed to ensure Resident 22's nasal cannula tubing was dated and labeled as per the facility's P&P. In addition, the facility failed to ensure the nasal cannula tubing was stored in a set-up bag when not in use for Resident 22. * The facility failed to ensure Resident 63's respiratory changes were identified timely and care planned. These failures had the potential for the residents to not receive the appropriate care and may negatively impact the residents' medical conditions. Findings: 1. Review of the facility's P&P titled Oxygen Therapy revised 11/2017 showed the oxygen is administered under safe and sanitary conditions to meet the resident needs. The oxygen tubing, mask, and cannulas will be changed no more than every seven days and as needed. The supplies will be dated each time they are changed. Humidifier equipment will be maintained and/ or changed per manufacturer's guideline or no more than every seven days. They will be dated each time they are changed. On 6/10/25 at 0857 hours and 1040 hours, during the initial tour of the facility, Resident 22's nasal cannula tubing was observed unlabeled and undated. In addition, the nasal cannula tubing was observed not stored in a set up bag and was placed coiled on top of the oxygen concentrator. Medical record review for Resident 22 was initiated on 6/10/25. Resident 22 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 22's H&P examination dated 4/20/25, showed Resident 22 could make needs known, however, unable to make medical decisions. Review of Resident 22's Order Summary Report dated 6/16/25, showed a physician's order dated 6/6/25, to administer oxygen at three liters per minute via nasal cannula to keep oxygen saturation greater than 92% as needed for SOB. Review of Resident 22's Care Plan Report dated 6/5/25, showed a care plan focus addressing the resident had episode of SOB and congestion. The interventions included to administer the oxygen via nasal cannula at three liters per minute as needed. On 6/10/25 at 1040 hours, an observation and concurrent interview for Resident 22 was conducted with the DON. The DON verified the oxygen nasal cannula tubing was not labeled with the date when it was changed and was not stored in a set up bag. The DON stated the nasal cannula should have been labeled with the date and should have been stored in a bag to keep it clean, sanitary and for infection control purposes. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the facility's P&P titled Change in Condition revised 8/25/22, showed the following: - It is the responsibility of the person who observes the change in condition to report changes to the Licensed Nurse; - The Licensed Nurse will assess the change of condition and determine what nursing intervention are appropriate; - A Licensed Nurse will notify the resident's Physician and legal representative or an appropriate family member when there is a significant change in the resident's physical, mental, or psychosocial status, like deterioration in health, mental or psychosocial status, life-threatening conditions or clinical complications; and - A Licensed Nurse will document the date, time, pertinent details of the event and the subsequent assessment in the medical records and update the Care Plan to reflect the resident's current status. Medical record review for Resident 63 was initiated on 6/10/25. Resident 63 was admitted to the facility on [DATE]. Review of Resident 63's H&P examination dated 5/16/25, showed Resident 63 had the capacity to make needs know, however, could not make medical decisions. On 6/10/25 at 0940 hours, during the initial tour, Resident 63 was observed lying in bed awake, alert, and oriented to person, place, and time. Resident 63's head of the bed was positioned on high [NAME]. Resident 63 was observed coughing and wheezing during the interview. On 6/10/25 at 0957 hours, an observation and concurrent interview for Resident 63 was conducted with LVN 8. LVN 8 was informed of Resident 63's cough with wheezing. LVN 8 stated she administered Resident 63's morning medications and did not have any medications for cough. LVN 8 was requested to check Resident 63's oxygen saturation. On 6/10/25 at 1000 hours, a follow-up observation and concurrent interview for Resident 63 was conducted with LVN 8. LVN 8 stated Resident 63 did not have a documented change of condition this week related to respiratory condition. LVN 8 checked Resident 63's oxygen saturation using a pulse oximeter with a result of 89 % on room air and heart rate of 62 beats per minute. LVN 8 verified the above findings and stated she would obtain another pulse oximeter. On 6/10/25 at 1004 hours, a follow-up observation and concurrent interview for Resident 63 was conducted with LVN 8. Resident 63 was observed coughing with chest congestion and stated he had SOB. Resident 63's oxygen saturation reading on pulse oximeter was observed dropping to 85% on room air. LVN 8 was informed immediately of Resident 63's oxygen saturation of 85% on room air. LVN 8 was observed checking Resident 63's pulse oximeter with reading of 80% on room air and LVN 8 verified the finding. LVN 8 was observed calling for assistance from the staff to obtain oxygen. On 6/10/25 at 1005 hours, a follow-up observation and concurrent interview for Resident 63 was conducted with LVN 8. Resident 63 was observed to have oxygen saturation of 75% on room air. LVN 8 verified the above findings and requested assistance from the nursing staff to check for Resident 63's code status. Three licensed nurses were observed responding to Resident 63's room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/10/25 at 1012 hours, a follow-up observation and concurrent interview for Resident 63 was conducted with RN 1. RN 1 stated Resident 63's oxygen saturation went up to 92% on room air and code status was to do not resuscitate. In addition, RN 1 stated Resident 63 had a moist cough and will administer oxygen at 15 liters per minute then inform the physician. On 6/10/25 at 1130 hours, an interview for Resident 63 was conducted with LVN 8. LVN 8 stated Resident 63 was transferred to the acute care hospital via paramedics due to desaturation and cough. Review of Resident 63's oxygen saturation summary showed on 6/10/25 at 1005 hours, the resident's oxygen saturation was 77% on room air. On 6/12/25 at 1423 hours, an interview and concurrent medical record review was conducted with LVN 7. When LVN 7 was asked about the frequency of checking residents' vital signs and if it included the oxygen saturation. LVN 7 stated she checked each of the resident's vital signs every shift even if there was no order including oxygen saturation. LVN 8 stated when the resident had respiratory diagnosis or problem, the licensed nurses must check the oxygen saturation every shift and document in the EHR. LVN 7 verified the change of condition documentation dated 6/10/25 at 1005 hours was completed, however, Resident 63's medical record failed to show a care plan for Resident 63's desaturation with moist cough was. LVN 7 stated if it was not documented, it was not done. On 6/16/25 at 0843 hours, an interview and concurrent medical record review for Resident 63 was conducted with the DON. The DON stated the residents with respiratory diagnoses must be monitored for symptoms of respiratory distress which included cough, chills, difficulty breathing, and SOB. The DON further stated the residents vital signs must be checked weekly for weekly summary, change of condition monitoring, or the residents had an ordered blood pressure medications. The DON stated the facility's process did not include checking of the vital signs daily which included oxygen saturation for each of the resident even if the residents with respiratory diagnoses. The DON was asked when do the licensed nurses determine to check on the residents' vital signs including the oxygen saturation and he stated only when the residents showed signs or symptoms. The DON verified Resident 63 did not have a care plan for change of condition on 6/10/25. Furthermore, the DON stated licensed nurses must develop a care plan for every change of condition. On 6/16/25 at 1215 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings.

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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, medical record review, and facility P&P review, the facility failed follow their pain protocol and physician's orders for one of two final sampled residents (Resident 47) reviewed for pain. * Resident 47's order for hydrocodone-acetaminophen (a controlled pain medication) to be administered prior to therapy (PT/OT) was administered daily at 0800 hours, regardless of the resident's actual therapy time, including on days no therapy was received. * Resident 47 had two PRN medications orders for pain without pain level parameters. * Resident 47's MAR showed the resident was administered PRN pain medications for a pain level of zero. These failure resulted in the resident receiving unnecessary pain medication as well as putting the resident at risk for pain during therapy services. Findings: Review of the facility's P&P titled P-PA01 Pain Management effective 5/26/23, showed the pain medications will be administered as ordered. Medical record review for Resident 47 was initiated on 6/10/25. Resident 47 was admitted to the facility on [DATE]. a. Review of Resident 47's MARs for May and June 2025 showed a physician's order dated 5/3/25, for hydrocodone-acetaminophen 5-325 mg tablet, to be administered daily prior to therapy sessions. The MARs showed the medication was administered daily at 0800 hours. Review of Resident 47's therapy notes showed the resident received PT and OT services. The records failed to show the resident received therapy services on May 6, 8, 11, 12, 19, 21, 25, 26, and 28, 2025, and June 1 and 4, 2025. On 6/12/25 at 1018 hours, an interview and concurrent medical record review for Resident 47 was conducted with LVN 6. LVN 6 stated she administered Resident 47's hydrocodone-acetaminophen medication yesterday at 0727 hours, and this morning at 0724 hours. LVN 6 stated Resident 47 had therapy yesterday afternoon, and had not had therapy yet today. On 6/12/25 at 1022 hours, an interview was conducted with the DOR and OT. The DOR stated Resident 47's treatment times varied, sometimes they were in the morning, and sometimes in the afternoon. The DOR and OT stated they did not coordinate with the LVN for the resident's therapy visits. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25 at 1029 hours, an interview and concurrent medical record review for Resident 47 was conducted with LVN 6. LVN 6 stated she was usually assigned to Resident 47, and the resident did not receive PT or OT daily. LVN 6 stated Resident 47 had a routine hydrocodone-acetaminophen order every morning at 0800 hours. When asked to review the hydrocodone-acetaminophen order, LVN 6 stated the order showed to be administered prior to therapy. LVN 6 stated she was not aware the order specified to be prior to therapy and administered it daily since the electronic MAR showed it was due at 0800 hours. LVN 6 stated for premedicating for pain prior to therapy, the medication was usually administered an hour before the therapy session. On 6/12/25 at 1128 hours, an interview and concurrent medical record review for Resident 47 was conducted with the DON. The DON stated for the medications used to premedicate for pain prior to therapy, the medication should be administered 30 minutes to one hour before therapy, and if there was no therapy scheduled for the day, the medication should not be administered. The DON reviewed Resident 47's physician order for hydrocodone-acetaminophen medication and verified the order was entered incorrectly in the record and should not be given daily at 0800 hours unless therapy was scheduled within the hour. On 6/12/25 at 1140 hours, a follow-up interview for Resident 47 was conducted with LVN 6. LVN 6 stated the therapy staff did not come to her to schedule Resident 47's therapy treatments. On 6/12/25 an interview and concurrent facility record review was conducted with the DOR. The DOR reviewed their computer program and stated if the therapy department was aware Resident 47 needed to be premedicated prior to services, it would be listed in the resident's precaution list, and was not. The DOR reviewed the residents therapy treatment dates and verified Resident 47 did not receive therapy services on May 6, 8, 11, 12, 19, 21, 25, 26, and 28, 2025, and June 1 and 4, 2025. b. Review of Resident 47's MARs for 6/2025 showed: - A physician's order dated 3/31/25, to administer acetaminophen (a pain medication) 325 mg tablet by mouth, every four hours PRN for pain. - A physician's order dated 2/4/25, to administer a lidocaine 5% patch (topical pain relief) to the resident's left shoulder for pain, PRN every 12 hours. On 6/12/25 at 1029 hours, an interview and concurrent medical record review for Resident 47 was conducted with LVN 6. LVN 6 stated the PRN pain medication orders should have an ordered pain level for when the medication should be administered. LVN 6 stated the pain levels were from 0-10, with 1-4 being mild pain, 5-7 was moderate pain, 8-10 was severe pain, and zero being no pain. LVN 6 reviewed Resident 47's medical record and verified the physicians' orders for the PRN lidocaine 5% patch and acetaminophen should have pain levels for when to be administered. On 6/12/25 at 1128 hours, an interview and concurrent medical record review for Resident 47 was conducted with the DON. The DON stated if a resident had two or more physicians' orders for PRN pain medications, the order should specify the pain level for when to administer the medication. c. Review of Resident 47's MARs for June 2025, showed: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A physician's order dated 3/31/25, to administer acetaminophen (a pain medication) 325 mg tablet by mouth, every four hours PRN for pain. Acetaminophen 325 mg medication was documented as administered on 6/1/25, for a pain level of zero. - A physician's order dated 2/4/25, to administer a lidocaine 5% patch to the resident's left shoulder for pain, PRN every 12 hours. The lidocaine 5% patch was documented as administered on 6/1/25, for a pain level of zero. LVN 6 reviewed Resident 47's MAR for 6/2025 and verified the MAR showed a lidocaine patch and acetaminophen were documented as administered on 6/1/25, for a pain level of zero. LVN 6 stated the PRN pain medications should not be administered when there was no pain. On 6/12/25 at 1128 hours, an interview and concurrent medical record review for Resident 47 was conducted with the DON. The DON stated the PRN pain medications should not be administered for a pain level of zero, since zero meant no pain.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility P&P review, and facility document review, the facility failed to ensure the orders for NPO were followed and the Pre and Post Dialysis Assessment forms were completed for one of one final sampled resident investigated for dialysis (Resident 33). This failure had the potential of not identifying potential negative outcomes for the dialysis residents. Findings: Medical record review for Resident 33 was initiated on 6/10/25. Resident 33 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 33's H&P examination dated 12/4/24, showed the resident had the capacity to make decisions. Review of Resident 33's Order Summary Report for 6/2025 showed the following physician's orders: - dated 12/3/24, to observe AV shunt dressing LUA and change as directed by the physician - dated 2/28/25, for Enhanced Barrier Precautions related to dialysis catheter - dated 3/7/25, for Hemodialysis every Monday, Wednesday, and Friday - dated 6/5/25, for a medical appointment on 6/10/25, due to swollen left upper extremity with instructions to be NPO after midnight the night before the procedure - dated 6/5/25, for NPO after midnight, blood pressure medication only with normal sip of water a. Review of the facility's P&P titled MR29 Physician Orders revised 11/16/22, showed the licensed nurse will confirm the physician's orders are clear, complete, and accurate. On 6/10/25 at 1320 hours, an interview was conducted with LVN 4. LVN 4 verified Resident 33 returned from his medical appointment with a rescheduled appointment for Thursday 6/12/25, due to Resident 33 not maintaining the NPO as ordered. LVN 4 stated Resident 33 was supposed to be NPO prior to the 6/10/25 appointment; however, the resident ate breakfast. LVN 4 stated there was a need for better communication between the nursing staff and kitchen. LVN 4 further stated the medical appointment scheduled for 6/10/25, was for the swelling to Resident 33's dialysis site. On 6/16/25 at 1054 hours, a telephone interview was conducted with the Medical Office Receptionist 1 from Resident's 33 medical appointment center. Medical Office Receptionist 1 verified they had to reschedule Resident 33's appointment due to resident eating breakfast the day of the appointment scheduled on 6/10/25, and not maintaining NPO as ordered. Medical Office Receptionist 1 further stated rescheduling the medical appointment had the potential for Resident 33 to develop blood clots and cause a delay in care. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Review of the facility's P&P titled P-NP37 Dialysis Management revised 1/2024 showed a pre and post dialysis evaluation will be completed by the licensed nurse. All documentation concerning dialysis services and care of the dialysis resident will be maintained in the resident's medical record. The nursing staff will send a dialysis communication form to the dialysis center every time a resident is scheduled for off-site dialysis. The dialysis provider's nurse will be responsible for documentation of dialysis treatment and providing the resident's post dialysis weight. Review of Resident 33's Pre and Post Dialysis Assessments - Dialysis Unit Assessment sections were observed to be incomplete on 6/9 and 6/6/25. On 6/16/25 at 0847 hours, an interview and concurrent medical record review for Resident 33 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated the Dialysis Unit Assessment section of the Pre and Post Dialysis Assessment forms were completed by the dialysis staff at the dialysis center. RN 1 stated the forms should have been completed and the facility staff should have called the dialysis center to complete. On 6/16/25 at 1200 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0755 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the pharmaceutical services to ensure accurate reconciliation of the controlled medication for one of 26 final sampled residents (Resident 82). Resident 82's hydrocodone (a controlled medication for pain) controlled medication count sheet was not maintained accurately for medication reconciliation. This failure posed the risk for diversion of controlled medications. Findings: Review of the facility's P&P titled Controlled Medications dated 4/2008 showed the following: - When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the Medication Administration Record; - Date and time of administration; - Amount administered; - Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply; and - Initials of the nurse administering the dose on the MAR after the medication is administered. Medical record review for Resident 82 was initiated on 6/12/25. Resident 82 was admitted to the facility on [DATE]. Review of Resident 82's Order Summary Report dated 6/11/25, showed a physician's order dated 3/31/25, for hydrocodone-acetaminophen (an opioid medication used to treat pain) 5-325 mg, give one tablet by mouth every six hours as needed for moderate (5-7), severe (8-9) or excruciating (10) pain. On 6/11/25 at 1448 hours, a controlled medication reconciliation for Resident 82 was conducted with LVN 3. Review of Resident 82's Individual Narcotic Record showed the hydrocodone-acetaminophen tablet 5-325 mg medication was signed out on the following dates: - 6/3/25 at 0400, 1000, and 1610 hours; - 6/4/25 at 1130 and 1730 hours; - 6/6/25 at 1000 hours; - 6/7/25 at 1600 hours; - 6/8/25 at 1500 hours; (continued on next page)

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F 0755 Level of Harm - Potential for minimal harm Residents Affected - Some	- 6/9/25 at 0800 and 1540 hours; - 6/10/25 at 1050 and 1650 hours; and - 6/11/25 at 0400 and 0900 hours. However, review of Resident 82's electronic MAR for 6/2025 failed to show documented evidence the hydrocodone-acetaminophen tablet 5-325 mg medication was administered to Resident 82 on the dates mentioned above, as shown in the Individual Narcotic Record. LVN 3 verified the above findings. On 6/11/25 at 1500 hours, an interview for Resident 82 was conducted with LVN 3. LVN 3 stated she did not document on the MAR after administering Resident 82's controlled medication due to bad habit. LVN 3 stated the correct process for administering the controlled medication was to assess the resident for pain, check the order on the MAR, prepare the medication, sign the narcotic record, administer the medication and document on the MAR. On 6/11/25 at 1543 hours, an interview was conducted with Resident 82. Resident 82 stated she had pain and requested pain medications from the charge nurse. Resident 82 stated she received the pain medication hydrocodone today at 0900 hours. On 6/16/25 at 0843 hours, an interview was conducted with the DON. The DON stated the licensed nurses must sign the controlled medication log and sign the MAR for accountability. On 6/16/25 at 1215 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, facility P&P review, and facility document review, the facility failed to ensure to follow the puree recipe for puree vegetables for 21 residents on puree diet. This failure posed the risk of the residents not receiving food prepared by methods that conserve nutritive value. Findings: Review of the Diet Type Report dated 6/11/25, showed 21 of 133 residents received puree food prepared from the kitchen. Review of the facility's P&P titled Standardized Recipes date revised 7/1/14, showed the food products prepared and served by the dietary department will utilize standardized recipes. On 6/11/25 at 1045 hours, an observation of the puree meals preparation was conducted with [NAME] 1. [NAME] 1 stated she was preparing to puree the vegetables for a total of 21 residents and would prepare the vegetables for 24 servings. During the puree preparation for the broccoli and carrots, [NAME] 1 was observed measuring three cups of cold milk poured into a measuring cup and adding the cold milk to the cooked broccoli and carrots while the recipe showed for 24 servings to add one half cup to one- and one-half cups of warm fluid such as milk or low sodium broth. The DDS verified the findings and stated [NAME] 1 did not follow the recipe for the puree vegetables and the recipe should have been followed.

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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, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen as evidenced by: * The facility failed to ensure the kitchen utensils were clean and free of food particles or residue. * The facility failed to ensure the kitchen utensils had a smooth cleanable surface and in good condition. * The facility failed to ensure the heavy-duty blenders used for puree preparation, the clear plastic bucket containers used for the juices on the tray line and food storage were air dried prior to storing and stacking and to ensure the blender was air dried prior to puree preparation. * The facility failed to ensure the cutting boards were kept in a sanitary condition and with cleanable surface. * The facility failed to ensure the sanitary condition of the hood over the stove was maintained. * The facility failed to ensure the ice machine drainpipes had an air gap and not touching the drains. * The facility failed to ensure the ice machine utilized for the residents and staff was maintained in a sanitary condition. * The facility failed to ensure the microwave utilized to warm up the food was in a sanitary condition. * The facility failed to ensure the countertop mounted can opener was in sanitary condition and free of residue. These failures had the potential for cross contamination and foodborne illnesses for the residents consuming the food prepared in the facility's kitchen. Findings: Review of the facility's Diet Type Report dated 6/10/25, showed 133 of 133 residents consumed the foods prepared in the kitchen. 1. Review of the facility's P&P titled Dietary Department- General revised date 6/1/2014, showed the primary objectives of the dietary department include maintenance of standards for sanitation and safety. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2017, 4-602.13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 6/10/25 at 0810 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DDS. The following was observed: - Three stainless steel knives with black handles were observed dirty with dry crusted residue and had fuzzy films. - One stainless steel slotted serving scoop with a gray handle was observed dirty and had food residue. - Three stainless steel spatulas with cream handles were observed dirty with dry food residue and had fuzzy films. - One stainless steel spatula with black handle was observed dirty and had dry watermarks and fuzzy film. - One stainless steel slotted serving spoon was observed dirty and had dry watermarks and fuzzy film. - One stainless steel dough cutter was observed dirty and had dry watermarks and fuzzy film. - One stainless steel pizza cutter with black handle was observed dirty and had dry watermarks and fuzzy film. - Two sets of stainless-steel measuring spoons were observed dirty and had dry crusted residue. - Two stainless steel measuring cups were observed dirty and had dry crusted residue. The DDS acknowledged the above findings and stated the dirty utensils had to be washed again to prevent cross contamination. 2. Review of the facility's P&P titled Dietary Department- General revised date 6/1/14, showed the primary objectives of the dietary department include maintenance of standards for sanitation and safety. According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 6/10/25 at 0810 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DDS. The following was observed: - One stainless steel knife with a white handle was observed peeling, discolored, partially burnt and had a chipped blade. - Three rubber spatulas with red handles were observed worn out, discolored, chipped/ cracked at the edges. - One rubber spatula with a red handle was observed partially melted. - One stainless steel serving scoop with a gray handle was observed partially melted. - One stainless steel serving scoop with a black handle was observed partially melted. - One stainless steel slotted serving scoop with a gray handle was observed partially melted. - One stainless steel slotted serving scoop with a black handle was observed partially melted. - One stainless steel serving scoop with a blue handle was observed peeling and partially melted. - Three stainless steel spatulas with the cream handles were observed discolored and partially melted. - One stainless steel spatula with a black handle was observed partially melted. - One stainless steel tong with a red handle was observed partially melted. - One stainless steel whisk with a gray/ purple rubber handle was observed partially melted. The DDS verified the above findings and stated the worn-out and old utensils should have been discarded and replaced. 3. Review of the facility's P&P titled Blender Use and Cleaning date revised 10/1/2014, showed to allow the container and lid to air dry. Allow the base to air dry. According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required, that after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the USDA Food Code 2022, 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, cleaned equipment and utensils shall be stored in a self-draining position that allows air drying. On 6/10/25 at 0810 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DDS. The following was observed: - Five rectangular clear bucket containers used for storage of juices on tray line were observed wet with visible water inside and stacked on top of each other. - Three square clear bucket containers used for food storage were observed wet with visible water inside and stacked on top of each other. - One heavy-duty blender and one clear plastic blender stored on the countertop shelf was observed still wet with visible water inside and on the lid. The DDS verified the above findings and stated all kitchen utensils and equipment should have been air dried to prevent bacteria growth and cross contamination. During the puree preparation observation on 6/11/25 at 1045 hours, a concurrent observation and interview was conducted with the DDS. A clear plastic blender was observed washed in the dishwashing machine and was still wet and with visible water when [NAME] 1 used the blender to puree lasagna casserole. The DDS acknowledged the findings and stated it was supposed to be air dried. 4. According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. On 6/10/25 at 0810 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DDS. The green, white, yellow, red, light blue, and brown cutting boards were observed fuzzy, heavily marred and had deep grooves. The DDS verified the above findings and stated the cutting boards should have been replaced. 5. Review of the facility's P&P titled Hood and Filter- Operation and Cleaning date revised 10/1/2014, showed the hood and filter system should be cleaned at least weekly, or more often as necessary. Hoods will be kept free of grease and dust. Due to potentially high fire hazard, it is important that hood filters are part of the cleaning schedule and are kept free of grease and dust. According to the USDA Food Code 2022 Section 4-204.11 Ventilation Hood Systems, Drip Prevention. The dripping of grease or condensation onto food constitutes adulteration and may involve contamination of the food with pathogenic organisms. Equipment, utensils, linens, and single service and single use articles that are subjected to such drippage are no longer clean. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/10/25 at 0810 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DDS. The kitchen hood over the stove was observed with black, dirt, and greasy residue. The DDS acknowledged the findings and stated the cook cleaned the hood daily as they go because of fire hazard and an outside company serviced for the kitchen hood was conducted on 4/17/25. 6. Review of the facility's P&P titled Backflow Prevention, Air Gap dated 2022, showed an air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch). According to the USDA 2017 Food Code, Section 5-202.13, Backflow Prevention, Air Gap, an air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment, shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch). On 6/10/25 at 0909 hours, during the initial kitchen tour, an inspection of the ice machine in the kitchen and concurrent interview was conducted with the Maintenance Supervisor. The drainpipe was observed resting closed on the ground and touching the drain. The Maintenance Supervisor acknowledged the findings and stated it needed to be fixed to prevent back flow. On 6/10/25 at 1620 hours, an inspection of the ice machine in the ice machine room and concurrent interview was conducted with the Maintenance Supervisor. The drainpipe was observed resting closed on the ground and touching the drain. The Maintenance Supervisor acknowledged the findings and stated it needed to be fixed to prevent back flow. 7. Review of the facility's P&P titled Ice Machine- Operation and Cleaning revised date 10/1/2014, showed maintenance staff will clean the ice making mechanism according to manufacturer's guidelines. According to the USDA Food Code 2017, Section 4-601.11, the equipment food-contact surfaces and utensils shall be clean to sight and touch. On 6/10/25 at 0909 hours, during the initial kitchen tour, an inspection of the ice machine in the kitchen and concurrent interview was conducted with the Maintenance Supervisor. Review of the sticker posted on the Ice Machine from the outside company showed the ice machine was last cleaned and sanitized on 5/13/25, and the next service was due in one month. Observation of the internal panel of the ice machine was made with the Maintenance Supervisor. The internal panel of the ice machine adjacent to the water curtain located directly above and lateral to the ice bin, a black dirt residue was observed. The Maintenance Supervisor and DDS verified the above findings and stated the ice machine needs to be cleaned by the outside company and ice will not be served to the residents because of cross contamination. 8. Review of the facility's P&P titled Microwave Oven- Operation and Cleaning revised date 10/1/14, showed the microwave oven will be cleaned after each use. Sanitize the inside of the microwave oven with sanitizing solution. Allow to air dry. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the USDA Food Code 2022 Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 6/10/25 at 0810 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DDS. The kitchen microwave on a countertop shelf was observed to be dirty with dry residue on the glass plate and dry food residue inside the microwave. The DDS verified the findings and stated it should have been cleaned for infection control purposes. 9. Review of the facility's P&P titled Can Opener Use and Cleaning revised date 10/1/14, showed the dietary staff will use the can opener according to the manufacturer's guidelines. The can opener will be sanitized between uses. According to the USDA Food Code 2017, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 6/12/25 at 0936 hours, a concurrent observation and interview was conducted with the DDS. The countertop mounted can opener was observed dirty with dry, crusted residue on the blade. The DDS acknowledged the findings and stated the can opener should have been washed after each used.

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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 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and facility P&P review, the facility failed to ensure the garbage was properly stored in two of three garbage dumpsters. This failure had the potential to attract pest/rodents that carried diseases. Findings: Review of the facility's P&P titled Waste Management revised 4/21/22, showed to maintain appropriate waste containers. The container must be closable, puncture resistant, and leak-proof. Dispose of non-regulated waste in appropriate, non-combustible waste containers. When waste bags are ¾ full, close bag and remove from area. Dispose bag into large, covered waste bin or cart in soiled utility. Discard soiled, disposable incontinence products in covered waste bin or cart in the soiled utility room. Food waste will be placed in covered garbage and trash cans. According to the 2022 FDA Food Code, the outside garbage receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. On 6/10/25 at 0735 hours, an observation of the garbage dumpsters was conducted. One of the three outside garbage dumpsters was observed with the lid fully propped open by the bulky boxes, preventing the lid from closing. The Maintenance Supervisor was informed of the above observation with a photograph of the garbage dumpster taken on 6/10/25 at 0735 hours. On 6/11/25 at 1151 hours, an observation and concurrent interview was conducted with the Maintenance Supervisor of the facility's two of three outside garbage dumpsters. The garbage dumpsters were observed with the lids partially propped open by the trash bags and bulky boxes, preventing the lids from fully closing. The Maintenance Supervisor verified the above findings and stated the dumpster lids should be completely closed at all times, to prevent flies from getting in and out of the trash and for infection control purposes.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure one final sampled resident (Residents 22) had the accurate and complete medical record. * The facility failed to ensure Resident 22's meal intakes were accurately documented. This failure had the potential for the resident's health care needs to not be met as the medical record was incomplete and inaccurate. Findings: Review of the facility's P&P titled Completion and Correction revised 1/1/12, showed the following: - Entries will be recorded promptly as the events or observations occur; - Entries will be complete, legible, descriptive, and accurate; and - Any person(s) making observations or rendering direct services to the resident will document in the record. Medical record review for Resident 22 was initiated on 6/12/25. Resident 22 was admitted to the facility on [DATE]. Review of Resident 22's H&P examination dated 4/20/25, showed Resident 22 had the capacity to make needs known, however, cannot make medical decisions. Review of Resident 22's Amount Eaten under Nutrition task dated 6/2025 failed to show the amount the resident ate on the following dates: - 6/1/25, breakfast and lunch - 6/2/25, dinner, - 6/3/25, dinner, - 6/4/25, dinner, - 6/5/25, dinner; and - 6/7/25, lunch and dinner. On 6/12/25 at 1437 hours, an interview and concurrent medical record review for Resident 22 was conducted with LVN 7. Resident 22's record of Amount Eaten under Nutrition task dated 6/2025 showed missing documentation of the amount eaten. LVN 7 verified the above findings. In addition, LVN 7 stated the documentation of the amount of the meal the resident had consumed was important especially if the resident had any weight loss or at risk for weight loss. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	On 6/16/25 at 0843 hours, an interview was conducted with the DON. The DON stated the CNAs must document on the resident's medical record under tasks to record the amount eaten and the registry staff would document on paper. The DON stated if the information was not documented, there would be no proof the task was completed. The DON stated the CNAs must enter the meal intakes after each meal. If the resident refused, the CNAs must offer replacement of the meal. In addition, the DON stated if the resident still refused the meal, the CNAs must report to the charge nurse and the charge nurse would complete a change of condition documentation and formulate or update the care plan. On 6/16/25 at 1215 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings.

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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 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** 3. Review of the facility's P&P titled Hand Hygiene revised 9/1/20, showed hand hygiene is the primary means to prevent the spread of infections. Hand hygiene should be performed before donning and after doffing personal protective equipment, immediately upon entering, and exiting a resident's room. On 6/11/25 at 0819 hours, a medication administration observation for Resident 39 was conducted with LVN 5. LVN 5 was observed checking Resident 39's BP at his bedside. LVN 5 then left the resident's room and went to the medication cart just outside the resident's doorway. LVN 5 donned gloves, used disinfectant wipes to clean the BP equipment, removed the gloves, wrote the BP results on a pad of paper using a pen, retrieved the resident's medication and placed it in a small medication cup and brought the medication to the resident in his room. After the medication administration, LVN 5 removed the breakfast tray from the roommate's bed (Resident 100) as Resident 100 entered the room in his wheelchair. LVN 5 lifted the plate dome from a second tray on Resident 100's bedside tray table, and replaced the lid back on the plate. LVN 5 then exited the room with the meal tray from Resident 100's bed and brought it to a staff member down the hallway. LVN 5 came back to the medication cart and performed hand hygiene. LVN 5 verified she failed to perform hand hygiene when leaving and entering the resident's room as well as after disinfecting the BP equipment and removing her gloves, and when going from Resident 39 to his roommate's bedside, removing one meal tray, and touching the other breakfast tray on the tray that stayed in the room. On 6/11/25 at 1251 hours, an interview was conducted with the IP. The IP stated hand hygiene should be conducted after disinfecting equipment and removing gloves, and when going from one resident and then touching another resident's meal tray. 4. Review of the facility's P&P titled Hand Hygiene revised 9/1/20, showed the facility staff follow the hand hygiene procedures to help prevent the spread of infections to other staff, residents, volunteers and visitors. The following situations require appropriate hand hygiene included before eating, after using the bathroom, after contact with blood, other body fluids, secretions, excretions, mucous membranes, non-intact skin, wound drainage, soiled dressing and before donning and after doffing personal protective equipment (PPE). Medical record review for Resident 36 was initiated on 6/10/25. Resident 36 was admitted to the facility on [DATE], and was readmitted on [DATE]. Review of Resident 36's MDS assessment dated [DATE], showed Resident 36's BIMS score was 4 which meant the resident had severe cognitive impairment. Review of Resident 36's Care Plan Report revised 4/28/25, showed a care plan focus addressing Stage 3 pressure injury. The interventions included to cleanse the left buttock Stage 3 pressure injury with normal saline, pat dry, apply Silvadene external cream 1% (a topical antimicrobial drug for the prevention and treatment of wound sepsis) to wound bed topically and cover with foam dressing. Review of Resident 36's Order Summary Report dated 6/11/25, showed a physician's order dated 5/25/25, to cleanse left buttock Stage 3 pressure injury with normal saline, pat dry, apply Silvadene external cream 1% to wound bed topically and cover with foam dressing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055206	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Healthcare Center	1209 Hemlock Way Santa Ana, CA 92707

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/25 at 0840 hours, a wound care observation for Resident 36 and concurrent interview was conducted with LVN 1. LVN 1 was observed performing a wound care treatment on Resident 36's left buttock pressure injury. Further observation showed LVN 1 did not perform hand hygiene in between donning and doffing gloves during the wound care. LVN 1 verified the findings and stated she was not sure if she needed to perform hand hygiene in between donning and doffing gloves and will check on their P&P. On 6/12/25 at 1542 hours, an interview was conducted with LVN 6. LVN 6 was asked regarding the facility's hand hygiene practices and stated the hand hygiene should have been performed by the staff in between donning and doffing of gloves to prevent any cross contamination. Based on observation, interview, medical record review, and facility P&P review, the facility failed to maintain infection control as evidenced by: * The facility failed to ensure one laundry rolling rack with clean residents' clothing were appropriately covered. * The facility failed to ensure LVN 4 followed EBP while performing a dressing change on Resident 33's dialysis access site. * The facility failed to ensure LVN 5 performed appropriate hand hygiene during a medication administration observation. * The facility failed to ensure LVN 1 performed hand hygiene between donning and doffing gloves during Resident 36's wound care. These failures put the residents a risk for increased risk of infection and transmissions of diseases. Findings: 1. Review of the facility's P&P titled Laundry - Resident Clothing revised 1/2012 showed the clean laundry on the cart is covered or placed in the hampers with a clean protective sheet. On 6/11/25 at 0819 hours, an observation of the laundry rolling rack with clean residents' clothing was observed partially covered with a sheet with the residents' clothing touching the handrails. On 6/12/25 at 0732 hours, an observation of the laundry rolling rack and concurrent interview was conducted with Laundry Aide 1 next to room [ROOM NUMBER]. The laundry rolling rack with clean resident's clothing was observed partially covered with the residents' clothing touching the handrails and wall next to room [ROOM NUMBER]. Laundry Aide 1 requested for the Director of Housekeeping to be present during the interview to interpret. Laundry Aide 1 verified the findings. Laundry Aide 1 stated the residents' clothing should be covered to prevent contamination of the clean clothes. On 6/16/25 at 1200 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055206	A. Building B. Wing	06/16/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the facility's P&P titled IPC303 Enhanced Barrier Precautions revised 10/2024 showed the purpose of EBP is to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact. Multidrug-resistant organism (MDRO) transmission is common in long term care facilities like nursing homes, contributing to substantial resident morbidity and mortality and increased healthcare costs. For residents for whom EBP are indicated, EBP is employed when performing the following high contact resident care activities for those at risk of transmission or acquisition of MDROs such as device care or use, wound care, chronic wounds. The P&P further showed to facilitate compliance with EBP, make PPE, including gown and gloves, available outside the resident room. Gowns and gloves are to be donned before each high contact task. Medical record review for Resident 33 was initiated on 6/10/25. Resident 33 was admitted to the facility on [DATE], and was readmitted on [DATE]. Review of Resident 33's H&P examination dated 12/4/24, showed the resident had the capacity to make decisions. Review of Resident 33's Order Summary Report dated 6/2025 showed the following physician's orders dated: - 12/3/24, to observe the AV shunt dressing LUA and change as directed by the physician - 2/28/25, for Enhanced Barrier Precautions related to the dialysis catheter - 3/7/25, for Hemodialysis every Monday, Wednesday, and Friday On 6/10/25 at 1320 hours, an observation of Resident 33 and concurrent interview was conducted with LVN 4 inside Resident 33's room. LVN 4 was observed performing a dressing treatment on Resident 33's dialysis site to the left upper arm AV shunt with scant amount of blood noted. Further observation showed LVN 4 did not wear PPE while performing the dressing change. LVN 4 verified the findings. LVN 4 stated the residents on dialysis, G-tube, and with catheter need to be placed on EBP to ensure communicable diseases were not spread and PPE included gown and gloves. LVN 4 stated he should have worn a gown while performing Resident 33's dressing treatment to prevent contamination of bodily fluids from transferring from resident to resident. On 6/16/25 at 1200 hours, an interview was conducted with the Administrator and DON. The DON stated he expected the nurses to wear PPE when performing dressing changes for residents on dialysis. The Administrator and DON were informed and acknowledged the above findings.