STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055252	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orange Healthcare & Wellness Centre, LLC	920 West LA Veta Street Orange, CA 92868

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure proper medication storage was followed in one of three nurse stations (Nurse Station A), one of two medication rooms (Medication Room A), two of two medication carts (Medication Cart A and Treatment Cart A), and one of two medication refrigerators (Medication Refrigerator A) observe. * Multiple medications were left unattended at Nurse Station A, after the pharmacy delivery. * The facility failed to maintain the recommended medication refrigerator temperatures in Medication Room A. * The facility failed to keep Treatment Cart A free of unnecessary items such as batteries, tools, and insulin syringes. * The facility failed to ensure there were no unlabeled loose medications in Medication Cart A. * The facility failed to ensure the storage bin for the OTC medications in Medication Cart A was free from dirt like debris. * The facility failed to ensure the top exterior part of Medication Refrigerator A was free of white powder like debris. * The facility failed to ensure Medication Cart B storing bin containing Coban (self- adherent, cohesive bandages), etc. was free from dirt like debris. These failures had the potential for the non-nursing staff, residents, and visitors to have access to the medications, as well as the potential for medication degradation and contamination. Findings: 1. Review of the facility's P&P titled Storage of Medication revised January 2025 showed medications are stored safely and securely, and only licensed nurses, pharmacy personnel, and those lawfully authorized ae allowed access to medications. The medications and biologicals are stored safely, securely and properly, following manufacturer's recommendations or those of the supplier. On 1/8/25 at 0523 hours, RN 1 was observed sitting at Nurse Station A and a stack of 19 medication bubble packs, a large paper bag with a pharmacy medication list with nine medications stapled to it, and three plastic bags with a pharmacy paperwork attached to each bag were observed on top of the nurse station counter. CNA 2 asked RN 1 for assistance and RN 1 was observed leaving the nursing station and leaving the medications unattended. A housekeeping staff member was observed sweeping the floor, just outside the nurse station, and a resident was observed on his wheelchair in the lobby, just down a short hallway from the nurse station. On 1/8/26 at 0532 hours, LVN 4 walked into Nurse Station A and grabbed the large paper bag. LVN 4 stated the paper bags were the pharmacy delivery that arrived a little after 0400 hours that morning. On 1/8/26 at 0605 hours, an interview was conducted with RN 1. RN 1 verified the pharmacy delivery (medications) were left unattended at the nurse station when he left to assist CAN 2. RN 1 stated the medications should have been secured in the medication room until the LVNs were available to secure the medications in the medication carts. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the facility's P&P titled Medication Storage in the Facility revised January 2025 showed: - Medications requiring refrigeration or temperatures between 36 degrees Fahrenheit and 46 degrees Fahrenheit are kept in a refrigerator with a thermometer to allow temperature monitoring - Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures. On 1/8/26 at 0810 hours, an interview and concurrent inspection of Medication Room A was conducted with RN 2. RN 2 was asked to unlock the medication refrigerator Immediate observation of the thermometer inside the refrigerator showed the temperature was 30 degrees. The medications stored in the refrigerator included: - Humulin R (insulin used to treat diabetes) and the recommended storage temperature was 36 to 46 degrees Fahrenheit; - insulin lispro (insulin used to treat diabetes) and the recommended storage temperature was 36 to 46 degrees Fahrenheit; - Lantus solostar (insulin used to treat diabetes) and the recommended storage temperature was 36 to 46 degrees Fahrenheit; and -Veltassa powder (used to treat hyperkalemia) and the recommended storage temperature was 36 to 46 degrees Fahrenheit. RN 2 stated the refrigerator temperature should be between 36 and 46-degrees Fahrenheit according to the facility's policy. RN 2 verified a temperature of 30 degrees Fahrenheit was too low for the medication refrigerator. On 1/8/26 at 1247 hours, a follow up observation of the medication refrigerator inside Medication Room A and a concurrent interview was conducted with RN 2. RN 2 was asked to unlock the medication refrigerator. Immediate observation of the thermometer inside the refrigerator showed the temperature was 30 degrees Fahrenheit. RN 2 verified the above findings. 3. On 1/7/26 at 1219 hours, an inspection of Treatment Cart A and concurrent interview was conducted with LVNs 1 and 2. The following was observed: - A storage bin in the top drawer, containing different sized batteries, insulin syringes, and miscellaneous tools. LVN 1 stated he did not know why the items listed above were in stored inside the medication cart. LVN 1 stated the batteries and tools could be stored in the central supply and the insulin syringes were not used when providing wound care treatments to the residents. LVN 2 was also present and stated the above items should be kept in central supply. On 1/7/26 at 1230 hours, an interview was conducted with RN 2. RN 2 stated Treatment Cart A should only have wound treatment supplies stored inside and any other items the licensed nurses needed could be found in the central supply. On 1/9/26 at 1254 hours, an interview was conducted with the DON. The DON was informed of the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	above findings. 4. Review of the facility's P&P on Medication Administration dated 8/19/25, showed to prepare medications for one resident at a time and not to pre- pour medications. On 1/8/26 at 0600 hours, right after the medication administration observation with LVN 5 was completed, five cups of pre-poured unlabeled loose medications (tablets and capsules) were observed in the first drawer of Medication Cart A. LVN 5 verified the following unlabeled loose medications in a transparent medication cup: - 1st medication cup: one blue capsule, one white tablet and one yellow tablet; - 2nd medication cup: one yellow tablet; - 3rd medication cup: one white round tablet; - 4th medication cup: one blue tablet and one blue capsule; and - 5th medication cup: one white round tablet. LVN 5 stated the medications from two of the medication cups were for Resident 52, who wanted to take her medications after she got changed. LVN 5 showed four bubble packs, where she dispensed the medications from for two of the five medication cups for Residents 52 and 67. Reconciled the medications against Resident 52's due medication bubble packs. The unlabeled medications on the 1st medication cup were comparable to bubble pack for Resident 67. The 2nd medication cup was comparable to Resident 52's due medication bubble pack. However, LVN 5 was not able to identify the rest of the medications or the resident's name. On 1/8/26 at 0615 hours, an interview was conducted with RN 1. RN 1 was informed and verified the above findings. RN 1 was shown the five pre-poured medication cups with unlabeled medications on the first drawer of Medication Cart A. RN 1 was unable to account for the remaining unlabeled medications, stated these should have been labeled. 5. Review of the facility's P&P on Medication Storage in the Facility dated January 2025 showed the medication storage areas are kept clean, well - lit and free of clutter and extreme temperatures and medication storage conditions are monitored on a routine basis and corrective action taken if problems are identified. On 1/7/26 at 0945 hours, an inspection of Medication Cart A was conducted with LVN 6. Multiple brownish dirt-like debris were observed in one of the storage bins, farthest left of the 1st drawer. LVN 6 verified the findings and stated all the charge nurses clean the medication carts from all shifts; this should have been cleaned. On 1/7/26 at 1006 hours, an observation and concurrent interview was conducted with RN 2. RN 2 verified the above findings and stated the medication cart should have been cleaned and sanitized. 6. On 1/7/26 at 1010 hours, an inspection of Medication Refrigerator A was conducted with LVN 7. The top exterior part of Medication Refrigerator A was observed with white powder- like debris and was partially removed when wiped clean with a paper towel. LVN 7 verified the findings and stated all (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the areas of medication room, including Medication Refrigerator A should have been cleaned by licensed nurses from all the shifts. On 1/7/26 at 1023 hours, an observation and concurrent interview was conducted with the DON. The DON verified the white powder like debris on the top exterior part of the Medication Refrigerator A and stated the refrigerator should have been cleaned. 7. On 1/7/26 at 1027 hours, an inspection of Medication Cart B was conducted with RN 2. Medication Cart B was observed to have dirt like debris to one of the storage bins storing Coban and other items. RN 2 stated the dirt like debris were rusts and could not be removed. RN 2 attempted to clean the dirt like debris and was able to partially remove it. On 1/7/26 at 1119 hours, an observation and concurrent interview was conducted with the IP. The IP verified the above findings and stated the storage bin should have been cleaned. On 1/9/25 at 1508 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 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 following: * A stainless-steel blender was stored wet. * Time Temperature Control for Safety (TCS) Foods (food that require time and temperature controls to limit the growth of illness causing bacteria) was not handled safely as the leftover chicken was not maintained at the proper temperature. In addition, there was no documentation of the leftover chicken cooked on the previous day on the cooling down log. These failures had the potential to cause foodborne illness for the residents who consumed food prepared in the kitchen.Findings: Review of facility's document titled Diet Type Report dated 1/6/26, showed 77 out of 85 residents were receiving food from the kitchen. a. According to the USDA Food Code 2022, Section 4-901.11, Equipment and Utensils, Air-Drying Required, items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items prevents them from drying and may allow an environment where microorganism can begin to grow. On 1/6/26 at 0754 hours, an observation and concurrent interview was conducted with the DSS. A stainless-steel blender was observed on food preparation area. The blender was observed with the lid closed. The DSS opened the lid of the blender, and the blender was observed to be stored wet. The DSS verified the observation and stated the kitchen staff should have air dried the blender before storing it. b. According to the USDA Food Code 2022 Section 3-501.14 Cooling, (A) Cooked time/temperature control for safety food shall be cooled: (1) Within two hours from 57 Celsius (C) [135 Fahrenheit (F)] to 21 C (70 F); and (2) Within a total of six hours from 57 C (135 F) to 5 C (41 F) or less. Review of the facility's P&P titled Hazardous Foods Cooling Monitor dated 7/1/2014, showed the dietary department employees will follow food handling rules for hazardous foods. Hazardous foods included.chicken/turkey/Shellfish. Under the section procedure showed hot food should be cooled from 140 F to 70 F within two hours and cooled from 70 F to 41 F or lower in an additional 4 hours. Further review of the P&P showed to record the temperature of food every hour, and action taken to achieve proper temperature cooling on cooling monitor log. On 1/6/26 at 0754 hours, an observation and concurrent interview was conducted with the DSS. A container of cooked chicken dated 1/5/26, was observed in the reach in refrigerator. The DSS was asked to measure the temperature of cooked leftover chicken, the temperature reading showed 43 F. The DSS verified the observation and stated the temperature of the leftover chicken should have been less than 41 F. The DSS was asked to show the cooling monitor log, however, the DSS verified the cooling down process was not documented for the leftover chicken. The DSS could not verify if the cooling down process was followed for the above leftover chicken. The DSS was observed discarding the leftover chicken. On 1/9/26 at 1142 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure appropriate infection control practices were followed.* The facility failed to test the water supply, and inspect the HVAC filters per the facility's water management program.* The clean linen cart for transferring clean linen in the laundry room had frayed edges and peeling layered duct tape and a non-cleanable surface. * The facility failed to ensure one of three blood glucose monitors (a portable device to measure blood sugar levels at home using a tiny blood sample) was cleaned and disinfected according to the manufacturer's instructions after the blood glucose monitor was used on Residents 3, 33, and 40. These failures resulted in the risk for the spread of microorganisms potentially contaminated areas throughout the facility. Findings: 1. Review of the facility's Legionella (type of bacteria) Water Management plan showed the following: - Maintaining a disinfectant residual of 0.1 mg/liters of free chlorine can help prevent Legionella growth in the water system. The facility will measure the residual disinfectant monthly. - To prevent Legionella growth, the best pH for water is between 6 and 7. The facility will measure the water pH level monthly. - Monitor ventilation systems to ensure optimal performance for removal pf particulates, and elimination of excess moisture. The facility will inspect all HVAC filters monthly. Review of the facility's Water Management Plan Monthly pH/Chlorine Testing Log for 2025 showed checkmarks for monthly chlorine and pH testing. The log failed to sure what the testing results were, and whether the results were an acceptable range. Review of the facility's electronic Logbook Documentation showed the HVAC filters were inspected and filters changed quarterly on 1/30, 4/23, 7/30, and 10/28/25. The facility was unable to locate the documentation to show the filters were inspected monthly. On 1/8/26 at 1052 hours, an interview and concurrent facility document review was conducted with the Director of Maintenance and Property Management. The Property Management reviewed the electronic maintenance logbook and stated the HVAC air filters were changed quarterly (every three months) and verified there were no documentation to show the filters were inspected monthly. On 1/8/26 at 1307 hours, a follow up interview and concurrent facility document review was conducted with the Director of Maintenance and Property Management. The Director of Maintenance and Property Management verified the monthly pH/Chlorine testing log failed to show the testing results, and if the results were an acceptable range. 2. On 1/8/26 at 0938 hours, a laundry room observation was conducted with Housekeeper 1. A wheeled linen cart frame with a flexible tarp-like bag was observed. The linen cart's edges were frayed and torn in places and one area had multiple layers of red duct tape, which was also peeling. Housekeeper 1 stated the cart was used to transport clean dry linen from the dryer to the folding table. When asked what she used to disinfect the cart and clean the linen folding table, Housekeeper 1 stated she used wipes, but was unable to locate any wipes in the laundry room. On 1/8/26 at 0950 hours, an interview was conducted with the Director of Maintenance. The Director of Maintenance verified the clean linen cart's tarp-like surface and frayed edges/tape were not cleanable surfaces. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/8/26 at 1343 hours, an observation and concurrent interview was conducted with the Director of Maintenance. The Director of Maintenance provided a container of Clorox Healthcare Germicidal Bleach Wipes and stated the wipes were the product used to disinfect the laundry room clean linen cart. The front of the container showed it was to be used on treated, hard, nonporous surfaces. 3. Review of the facility's P&P on Blood Glucose Monitoring dated 5/2/23, showed to clean the monitoring device after each use as noted in the manufacturer's instructions. Review of the Manufacturer's Instructions of the Assure Blood Glucose Monitoring system dated 9/2024 (www. akrayusa.com) showed the cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfecting procedure. The disinfecting procedure is needed to prevent the transmission of bloodborne pathogens. Only wipes with EPA registration numbers listed in http://www.epa.gov/pesticide-registration/selected-epa-registered-disinfectants have been validated for use in cleaning and disinfecting the blood glucose meter. On 1/8/26 at 0558 hours, a medication administration observation was conducted with LVN 5. LVN 5 was observed cleaning the glucometer after checking Resident 3, 33, and 40's blood sugar with an alcohol pad (70 % alcohol). LVN 5 verified the glucometer was wiped clean with the alcohol pads. On 1/8/26 at 0732 hours, an interview was conducted with the IP. The IP stated the glucometers must be cleaned and disinfected using the Super Sani-Cloth wipes (germicidal, bactericidal, tuberculocidal, and virucidal disposable wipes). On 1/9/25 at 1508 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged the above findings.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **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 nonsampled resident (Resident 104) was safe to self-administer medications. * Resident 104 was observed with one unidentified medication tablet and an unlabeled white bottle containing various medication tablets on his bedside table. Resident 104 had no assessment and physician's order addressing Resident 104's self-administration of the medications. This failure had the potential for the resident to administer the medications inaccurately, and the risk of adverse reactions from the medications. Findings: Review of the facility's P&P titled Medication - Self Administration revised [DATE], showed the following:- Residents will be assessed and monitored for their ability to self-administer medications. This must include physician approval, which will be documented in the resident's medical record.- The licensed nurse completes the Self Administration of Medications Assessment, which evaluates the resident's: cognitive function, physical ability, medication knowledge, compliance history, knowledge of proper storage and safety, and knowledge of administration of each route.- A written physician's order is required before a resident begins self-administration- The licensed nurse will inspect the contents of the medication containers for evidence that the resident may not be able to self-administer medications (i.e. non-drug items stored in pill containers, different medications mixed together, medications which have expired or appear to be deteriorating.- Any concerns will be communicated to the physician and IDT immediately.- All self-administered medications must have complete pharmacy labels or intact, readable labels if they are over the counter medications. On [DATE] at 0955 hours, during the initial tour of the facility, Resident 104 was observed in bed with a loose medication tablet and a white unlabeled medication bottle on his bedside table. Resident 104 stated the medications in the bottle were his supplements which was brought in by his wife. Resident 104 stated he administered the supplements himself. Medical record review for Resident 104 was initiated on [DATE]. Resident 104 was admitted to the facility on [DATE]. Review of Resident 104's H&P examination dated [DATE], showed the resident had no capacity to understand and make decisions due to cognitive impairment. Review of Resident 104's Order Summary Report for [DATE] failed to show a physician's order to self-administer the medications. Further review of Resident 104's medical record failed to show an assessment was conducted to determine if Resident 104 was safe to self-administer the medications. On [DATE] at 1004 hours, an observation of Resident 104 and concurrent interview was conducted with LVN 3. Resident 104 was observed in bed with the bedside table positioned across his bed. The resident's bedside table was observed with a loose medication tablet and a white unlabeled medication bottle. LVN 3 stated the loose medication tablet on the resident's bedside table looked like one of Resident 104's supplements that his wife provided and the facility dispensed. However, LVN 3 stated she did not know where the medication tablet came from. LVN 3 stated she did not know what medications were in the white unlabeled medication bottle. On [DATE] at 1010 hours, a follow up interview was conducted with LVN 3. LVN 3 stated she did not know what medications were in the white unlabeled medication bottle or where it came from. LVN 3 stated she was in the resident's room earlier to administer Resident 104's medication and did not question the medication bottle on Resident 104's bedside table. On [DATE] at 1015, an observation of Resident 104 and concurrent interview was conducted with the DON. The DON stated sometimes the resident's wife brought in the supplements for Resident 104 without notifying the facility staff. The DON stated the facility had several discussions with the wife to stop bringing in the supplements for the resident. The DON was observed opening the white unlabeled medication bottle and was unable to verify the contents of the bottle. The DON stated there was a risk of the unknown medication tablets interacting with the medications the facility was administering to the resident. The DON verified the above findings.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **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 individualized and ongoing activity program to meet the needs and interests of one of one final sampled resident (Resident 20) reviewed for activities. * The facility failed to provide an ongoing activity program for Resident 20 in accordance with the comprehensive assessment, interests, and physical, mental, and psychosocial well-being to ensure the resident maintained their highest mental, physical, and psychosocial well-being. This failure had the potential for the resident to experience feelings of social isolation.Findings: Review of the facility's P&P titled Activities Program dated 5/22/25, showed the facility provides an Activity Program designed to meet the needs, interests, and preferences of each resident. The facility will be staffed and equipped to encourage the participation of each resident, to fully stimulate and support physical and mental capabilities, and to enable the resident to maintain the highest attainable social, physical and emotional functioning. On 1/6/26 at 8030 hours, during the initial tour to the facility. Resident 20 was in his room and was asked if he was attending the facility's recreational activities. Resident 20 stated It is a joke, one to two times a week they play music. I went there sometimes but not my music. They don't have what I like. Resident 20 further stated the activity staff did not go to his room. Resident 20 had the Activities Calendar affixed to his room wall. Resident 20 stated maybe they're just satisfying the state guidelines, they put that up. Medical record review for Resident 20 was initiated on 1/8/26. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's H&P examination dated 9/25/25, showed Resident 20 could make his own decisions. Review of Resident 20's Activity Evaluation dated 9/25/25, showed Resident 20's activity preferences were as follows: fishing and playing golf, listening to pop, country, and rock and roll, prefer to watch news sports weather talk shows, some game shows like Trivia, Jeopardy, Who wants to be a Millionaire, and comedy movies, reads non-fiction, fiction, and biology books. Review of Resident 20's Quarterly Activity Progress Note dated 12/26/25, showed the Activities Department would encourage/assist/remind Resident 20 to join/participate to the group activity of interest, provide contact room rounds to offer activity material, and socialization as needed or as tolerated. Review of Resident 20's Activities Look Back Report from November to January 8, 2026, showed the following documentation:- on 11/18/25: active 1:1 (one staff to one resident) participation - books /reading materials, education/current topics/ trivia;- on 11/29/25: passive 1:1 participation- books /reading materials;- on 12/9/25: passive 1:1 participation- education/current topics/ trivia;- on 12/13/25: active1:1 participation- books /reading materials;- on 12/27/25: active1:1 participation- books /reading materials; and- on1/3/26: active1:1 participation- books / reading materials, education/current topics/ trivia. On 1/8/26 at 943 hours, an interview and concurrent medical record review was conducted with the Activity Director. The Activity Director stated Resident 20 hardly came to activities and was visited three times a week by the activity staff. Review of Resident 20's Activity Look Back Report was conducted with the Activity Director, which showed Resident 20 had activity staff visits and participated six times from 11/18/25 through 1/3/26, with no documentation of refusals. The Activity Director stated she was not checking the activity staff to make sure the room visits were being done. When asked if the activity staff knew Resident 20's plan of care were, the Activity Director stated, I'm hoping they do. On 1/8/26 at 1000 hours, an interview and concurrent medical record review was conducted with Activity Assistant 1. Activity Assistant 1 stated she conducted the room visits for the residents using the following schedule:- on Mondays and Tuesdays: the residents in Nursing Stations 1 and 2;- on Tuesdays: the residents in Nursing Station 3;- on Wednesdays: the residents in Nursing Stations 1 and 2; and- on Thursdays: the residents in Nursing Station 3.Review of the Activity Look back Report with Activity Assistant 1 showed Resident 20 was visited and participated six times from 11/18/25 through 1/3/26. Activity Assistant 1 verified the above findings and stated the room visits for Resident 20 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have been two to three times a week. Activity Assistant 1 stated she was not sure what had happened.

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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, and medical record review, the facility failed to ensure one final sampled resident (Resident 116) and one nonsampled resident (Resident 120) reviewed for the accident hazards were provided the necessary care and services. * The facility failed to ensure CNA 1 remained awake while providing supervision for Residents 116 and 120, who were on high observation alert due to falls. This failure posed a risk for the residents to sustain further falls and/or injuries.Findings: On 1/8/26 at 0518 hours, during a tour of the facility, an observation of CNA 1 was conducted inside Residents 116 and 120's room. Upon entering the residents' room, CNA 1 was observed with her head down on the nightstand next to Resident 120 (bed A). The privacy curtain was closed with no visual of Resident 116 (Bed B). The surveyor knocked on the wall in attempt to wake CNA 1 but was not successful. Resident 120 was observed awake and moving around in bed and Resident 116 appeared to be sleeping. The surveyor then contacted RN 1 to wake up CNA 1. RN 1 entered the residents' room and tapped CNA 1 on the arm. CNA 1 sat up but did not turn around. RN 1 then tapped CNA 1 on the arm again and CNA 1 stood up to speak with the surveyor as RN 1 exited the residents' room. On 1/8/26 at 0520 hours, an interview was conducted with CNA 1. CNA 1 stated she was asleep. CNA 1 stated she was assigned to provide supervision for Residents 116 and 120 because they were trying to get out of bed unassisted. CNA 1 also stated she was unable to maintain a visual of Resident 116 with the privacy curtain closed. On 1/8/26 at 0541 hours, an interview was conducted with RN 1. RN 1 stated the facility staff assigned to provide supervision for the residents should be sitting by the residents' closet where they would have visual of both residents, or have the privacy curtain open if they chose to sit at the table. RN 1 also stated the facility staff assigned to provide supervision for the residents were not supposed to be sleeping while watching the residents. a. Medical record review for Resident 116 was initiated on 1/8/26. Resident 116 was admitted to the facility on [DATE]. Review of Resident 116's H&P examination dated 1/1/26, showed Resident 116 had the capacity to understand and make decisions. The H&P also showed the physician advised to send Resident 116 to the emergency room for evaluation of fall on 12/31/25. b. Medical record review for Resident 120 was initiated on 1/8/26. Resident 120 was admitted to the facility on [DATE]. Review of Resident 120's H&P examination dated 1/1/26, showed Resident 120 was able to make their own decisions. The H&P also showed the resident had a fall on 1/1/26 at 0400 hours. On 1/9/26 at 1254 hours, an interview was conducted with the DON. The DON stated Residents 116 and 120 had physician's orders for high observation because they were new residents in the facility and both residents fell on the day they were admitted to the facility. The DON stated when the facility staff were assigned to watch two residents on high observation, the facility staff could sit wherever they wanted, as long as they could visually see both residents. The DON stated the facility staff should not be sitting at the nightstand if they could not see both the residents. The DON also stated the facility staff should never be sleeping in the residents' room and it was a safety issue for the residents for the facility staff to be sleeping. On 1/9/26 at 1445 hours, an interview was conducted with the Administrator. The Administrator stated Residents 116 and 120 were on high observation because they both fell the day they were admitted to the facility. The Administrator stated the facility staff assigned for high observation should be doing frequent checks of the residents they were assigned to and should never be sleeping.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids 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 obtain the appropriate admission PICC line measurements for one of one final sampled resident (Resident 119) reviewed for the central lines (a long, flexible tube inserted into a large vein in the neck, chest, arm, or groin, ending near the heart, to provide long-term access for delivering fluids, nutrition, and medications). * The facility failed to ensure Resident 119's arm circumference and the PICC line's external catheter were measured upon the resident's admission to the facility. This failure had the potential to delay identifying potential complications of the central line. Findings: Medical record review for Resident 199 was initiated on 1/6/16. Resident 119 was admitted to the facility on [DATE]. Review of Resident 119's IV Administration Record for December 2025 showed a physician's order dated 12/19/25, to measure the resident's arm circumference and PICC lie external catheter lumens every week. The record showed a box for the measurements to be completed on 12/19/25 (the resident's admission date), which was not completed. Further review of Resident 119's medical record failed to show the resident's arm circumference and external catheter length measurements were completed upon the resident's admission to the facility. On 1/8/26 at 0909 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 stated the arm circumferences and PICC line external catheter lengths measurements were obtained for all the newly admitted residents with PICC lines upon their admission to the facility, and weekly thereafter. RN 3 further stated the changes in the measurements would help identify central line catheter issues, like tubing migration. RN 2 verified Resident 119's medical record failed to show the admission PICC line arm circumference and external catheter length measurements were obtained.

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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 interview, medical record review, and facility P&P review, the facility failed to provide the appropriate pain management for one of one final sampled resident (Resident 11) reviewed for pain management. * The facility failed to accurately record Resident 11's highest pain level for the shift, as well as document the nonpharmacological interventions (NPI) implemented prior to administering the PRN (as needed) pain medication. These failures put the resident at risk of their pain level not being documented accurately and receiving unnecessary pain medication without the NPI in place. Findings: Medical record review for Resident 11 was initiated on 1/6/26. Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's Order Summary Report showed a physician's order dated 10/2/25, showed to monitor the resident's pain level every shift (on a scale of 0-10, with 0 being no pain, and 8-10 being sever pain) and document the NPI provided. Review of Resident 11's MAR for January 2026 showed the following:- On 1/1/26, during the day shift, the resident's pain level was documented as 0, and NA was entered for the NPI. However, two tablets of the Percocet (a controlled pain medication) 5-325 mg medication was administered at 1122 hours, for a pain level of 8. - On 1/1/26, during the evening shift, the resident's pain level was documented as 0. However, two tablets of the Percocet 5-325 mg medication was administered at 1530 hours, for a pain level of 8. - On 1/2/26 day shift, the resident's pain level was documented as 0, and NA was entered for the NPI. However, two tablets of the Percocet 5-325 mg medication were administered at 1002 hours, for a pain level of 8, and at 1422 hours, for a pain level of 9. - On 1/2/26 evening shift, the resident's pain level was documented as 0, and NA was entered for the NPI. However, two tablets of the Percocet 5-325 mg medication were administered at 1830 hours, for a pain level of 9. - On 1/2/26, during the night shift, the resident's pain level was documented as 0, and NA was entered for the NPI. However, two tablets of the Percocet 5-325 mg medication were administered on 1/3/26 at 0630 hours, for a pain level of 8. - On 1/3/26 during the day shift, the resident's pain level was documented as 0, and NA was entered for the NPI. However, two tablets of the Percocet 5-325 mg medication were administered at 1038 hours, for a pain level of 8, and at 1440 hours, for a pain level of 9. - On 1/3/26, during the evening shift, the resident's pain level was documented as 0, and NA was entered for the NPI. However, two tablets of the Percocet 5-325 mg medication were administered at 1840 and 2240 hours, for a pain level of 9. - On 1/4/26, during the day shift, the resident's pain level was documented as 0, and NA was entered for the NPI. However, two tablets of the Percocet 5-325 mg medication were administered at 1030 hours, for a pain level of 7, and at 1444 hours, for a pain level of 9. - On 1/4/26, during the evening shift, the resident's pain level was documented as 0, and NA was entered for the NPI. However, two tablets of the Percocet 5-325 mg medication were administered at 1845 hours, for a pain level of 9. - On 1/4/26, during the night shift, the resident's pain level was documented as 0, and NA was entered for the NPI. However, two tablets of the Percocet 5-325 mg medication were administered on 1/5/26 at 0526 hours, for a pain level of 8. - On 1/5/26, during the day shift, the resident's pain level was documented as 0, and NA was entered for the NPI. However, two tablets of the Percocet 5-325 mg medication were administered at 0957 hours, for a pain level of 8. - On 1/5/26, during the evening shift, the resident's pain level was documented as 0, and NA was entered for the NPI. However, two tablets of the Percocet 5-325 mg medication were administered at 1730 and 2130 hours, for pain levels of 8. - On 1/5/26, during the night shift, the resident's pain level was documented as 0, and NA was entered for the NPI. However, two tablets of the Percocet 5-325 mg medication were administered on 1/6/26 at 0530 hours, for a pain level of 8. - On 1/6/26, during the evening shift, the resident's pain level was documented as 0, and NA was entered for the NPI. However, two tablets of the Percocet 5-325 mg medication were administered at 1838 hours, for a pain level of 7. - On 1/6/26, during the night shift, the resident's pain level was documented as 0, and NA was entered for the NPI. However, two tablets of the Percocet 5-325 mg medication were (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered on 1/7/26 at 0417 hours, for a pain level of 8. On 1/7/26 at 1159 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated for the pain and NPI documentation in the resident's MAR for each shift, the licensed nurses should document the highest pain level for the entire shift, as well as all the NPI implemented prior to administering the pain medication. The DON verified the above shifts with a 0 pain level documented and the NA for the NPI were incorrect and should have reflected the resident's highest pain level. The DON also verified there was no documentation to show the NPIs were implemented prior to administering the PRN pain medication (except for 1/2/26, during the evening shift).

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **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 there was adequate staffing for the 2300 to 0700 hours shift to meet the physical and psychosocial needs for two of 19 final sampled residents (Residents 20 and 118) and two nonsampled residents (Residents 43 and 81). * The facility failed to ensure Resident 20's call light was answered in a timely manner for assistance in toileting and transfers to and from the bed between the hours of 0200 - 0500 hours on 1/4 and 1/5/26. * The facility failed to ensure Residents 43 and 81 received timely staff assistance during the 2300-0700 hours shift. * The facility failed to timely answer Resident 118's call light to address her toileting needs without the resident experiencing distress over the staff's response time. These failures had the potential for the residents to not be provided with care consistent with professional standards of practice and care as outlined in their person-centered plans of care.Findings: Review of the facility's P&P titled Nursing Department- Staffing, Scheduling and Posting dated July 2018 showed the facility was to ensure adequate number of nursing personnel are available to meet resident needs. The facility will employ Nursing staff that will be on duty in at least the number and with the qualifications required to provide necessary nursing services for residents admitted for care. In staffing an adequate number of Nursing Service personnel, scheduling will be done as needed to meet the residents' needs, and such information will be posted as required. 1.a. On 1/6/26 at 0845 hours, an observation and concurrent interview was conducted with Resident 81. Resident 81 was lying in his bed with a feeding tube connected to his abdomen. Resident 81 stated he was dependent on staff assistance and had a concern with facility staffing during the night shift. Resident 81 stated he did not get the assistance he needed timely during the night shift. Resident 81 stated he was admitted to the facility at around 1900 hours on 12/31/25. The assigned CNA put him on the bed and covered him with the blanket the resident got from the acute care hospital and left. Resident 81 further stated he did not remember getting assistance until the next morning on 1/1/26. Resident 81 stated he remembered pressing the call button multiple times but did not remember getting assistance that night. Resident 81 further stated on 1/4/26 at around 2000 hours, the assigned CNA assisted the resident to change his incontinence brief. Resident 81 stated after around 30 minutes, he needed to be changed again and pressed the call button to ask for staff assistance. Resident 81 stated he did not get any assistance until midnight, almost three hours after he needed assistance. Resident 81 stated he did not feel good to have to wait for the staff for a long time to change his wet incontinence brief. Resident 81 further stated he knew he waited three hours because he looked at the clock so he knew how long he waited. Medical record review for Resident 81 was initiated on 1/6/26. Resident 81 was admitted to the facility on [DATE]. Review of Resident 81's MDS assessment dated [DATE], showed Resident 81 was cognitively intact and required staff assistance for his activities of daily living. Review of Resident 81's H&P examination dated 1/1/26, showed Resident 81 could make his needs known and could make his own decisions. b. On 1/6/26 at 1012 hours, an observation and concurrent interview was conducted with Resident 43. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 43 was lying in her bed. Resident 43 stated the facility did not have enough staff during the 2300-0700 hours shift. Resident 43 stated she had to wait more than an hour to get assistance at night. Resident 43 stated she remembered an incident when she had to wait for more than 25 minutes to get her colostomy bag changed. Resident 43 stated she remembered because her colostomy bag was full and it was hurting her when she was waiting for the staff to help her. Resident 43 stated she knew she waited more than 25 minutes for assistance because she looked at the clock in front of her. Medical record review for Resident 43 was initiated on 1/6/26. Resident 43 was admitted to the facility on [DATE]. Review of Resident 43's Order Summary Report showed an order dated 12/26/24, to provide colostomy care every shift. Review of Resident 43's H&P examination dated 6/11/25, showed Resident 43 had the capacity to understand and make medical decisions. Review of Resident 43's MDS assessment dated [DATE], showed Resident 43 was cognitively intact and dependent on facility staff for her activities of daily living. On 1/9/26 at 1142 hours, the Administrator and the DON were informed and acknowledged the above findings. 2.a. Review of the facility's P&P titled Communication- Call system dated 11/1/12, showed the purpose of the call system is to provide a mechanism for residents to promptly communicate with Nursing Staff. The Nursing Staff will answer the call bells promptly, in a courteous manner. Medical record review for Resident 118 was initiated on 1/6/25. Resident 118 was admitted to the facility on [DATE]. Review of Resident 118's Order Summary Report showed a physician's order dated 1/6/25, to monitor for sign and/or symptoms of urinary retention for 72 hours status post indwelling urinary catheter removal. Review of Resident 118's H&P dated 12/26/25, showed the resident had the capacity to understand and make medical decisions. On 1/7/26 at 0947 hours, an interview was conducted with Resident 118. Resident 118 stated after her indwelling urinary catheter was removed yesterday morning, she had a hard time voiding. Resident 118 further stated she now has a hard time getting used to holding in her urine. Resident 118 stated when she has the urge to void, she needs to rush to the toilet. On 1/8/26 at 0511 hours, an interview was conducted with CNA 2. CNA 2 stated she had 18 residents to care for that night. CNA 2 stated about half of her residents did not sleep all night, and many were incontinent and need assistance toileting. CNA 2 stated the residents complain about the call light response time, but some residents were time consuming and she gets overwhelmed. On 1/8/26 at 0521 hours, an interview was conducted with RN 1. RN 1 stated they did get resident complaints during the 2300-0700 hours shift. RN 1 stated the facility currently has five CNAs and two 1:1 sitters (staff assigned to a specific resident for direct supervision) for 88 residents. When asked if (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the nurses help answer call lights, RN 1 replied the LVNs were pretty busy. RN 1 stated the facility has 88 residents for two LVNs and tries to provide assistance with answering the call lights. RN 1 stated he did rounds and on his last round he answered two call lights while the assigned CNA was busy with another resident. On 1/8/26 at 0542 hours, an observation and concurrent interview was conducted with Resident 118. Resident 118 was awake watching TV in her bed. Resident 118 stated she dreads having to go to the bathroom because she was afraid she was going to have an episode of incontinence and will need to wait 15-20 minutes for the staff to respond to her call light and assist her with toileting. Resident 118 stated the staff just could not get to her timely. b. On 1/6/26 at 0830 hours, during the initial tour of the facility, Resident 20 stated the call light response was not answered timely. Resident 20 stated he went to the bathroom, used the call light for assistance and the staff did not show up. Resident 20 stated he self-transferred and went to bed. Resident 20 further stated there was only one CNA to help the residents because the other one was on break. Medical record review for Resident 20 was initiated on 1/8/26. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's H&P examination dated 9/25/25, showed Resident 20 could make his needs known and could make his own decisions. On 1/8/26 at 0615 hours, an interview was conducted with CNA 4. CNA 4 stated Resident 20 asked for assistance in toileting one to four times during the shift. Resident 20 was assisted to the shower chair to the toilet and transferred back to the bed. CNA 4 was informed Resident 20 stated he was calling and no one came after 30 minutes, so he self-transferred to the wheelchair then to the bathroom and back to the bed. CNA 4 stated they were not aware of this and the resident did not say anything. On 1/8/26 at 0700 hours, an interview was conducted with CNA 5. CNA 5 stated they usually did not wait to answer the call lights because the sound was annoying. CNA 5 stated they checked the resident to see if the call light was on. On 1/9/25 at 1520 hours, the Administrator was informed of the above findings.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure medications were available, administered, and accounted for appropriately for one of five final sampled residents reviewed for unnecessary medication (Resident 116) and for one of two IV E-kit medication kits. * Resident 116's insulin was not available to be administered as ordered. * The facility failed to ensure the IV E-kit in Medication Room A was replaced timely. * The facility failed to ensure the IV E-kit pharmacy log in Medication Room A was accurately completed when accessed by RN 1. These failures resulted in medication not being available to be administered to the residents as well as inaccurate accounting of the emergency medication supply. Findings: 1. Review of the facility's P&P titled Provider Pharmacy Requirements revised January 2025 showed the pharmacy will provide timely services 24 hours a day, seven days a week. All new medication orders will be available for administration on the day they are ordered. Medical record review for Resident 116 was initiated on 1/6/26. Resident 116 was admitted to the facility on [DATE]. Review of Resident 116's Order Summary Report showed a physician's order dated 12/31/25, for Novolog to be administered subcutaneously before meals and at bedtime per the sliding scale (a dose based on the resident blood sugar level). Review of Resident 116's MAR for January 2026 showed on 1/1/26 at 0630 hours, Resident 116's blood sugar was 200 mg/dl. The entry was coded with a 9 for other/see progress notes. Review of Resident 116's Progress Note dated 12/31/25 at 1954 hours, showed the resident was admitted at 1841 hours. Review of Resident 116's Orders – Administration Progress Note dated 1/1/26 at 0646 hours, showed the Novolog insulin medication (antidiabetic) was pending delivery (more than 11 hours after the resident was admitted). On 1/7/26 at 1535 hours, an observation of the facility's Refrigerated E-kit showed the E-kit included Novolin R insulin and Humalog insulin (antidiabetic medication). On 1/8/26 at 1423 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated for new admissions, medications should be delivered by the pharmacy within four to six hours, and the E-kits may be utilized as well. The DON reviewed Resident 116's medical records and verified the Novolog insulin medication should have been available to be administered on 1/1/25 for the 0630 dose. The DON stated even though Resident 116's ordered insulin was not available in the E-kits, the nurse should have contacted the physician for a temporary physician's order for one of the available insulins until the supply was delivered by the pharmacy. 2. Review of the facility's P&P titled Medication Ordering and Receiving from Pharmacy revised January 2025 showed the following: - an emergency supply of medications including emergency drugs, antibiotics, controlled substances, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and products for infusion is provided in sealed containers in compliance with state regulations - when an emergency dose of a medication is needed, the nurse unlocks the container and removes the required medication. After removing the medication, complete the emergency e-kit slip and re-seal the emergency supply. - if exchanging kits, the used sealed kits are replaced with the new sealed kits within 72 hours of opening. On 1/8/26 at 0810 hours, an inspection of Medication Room A, interview, and concurrent facility document review was conducted with RN 2. Review of the E-kit log book showed the IV E-kit was accessed on 1/2/26, and was replaced by pharmacy on 1/6/26. On 1/8/26 at 0825 hours, an interview was conducted with the Administrator. The Administrator stated the IV E-kit was replaced on 1/6/26, because she personally called the pharmacy to replace it on 1/6/26. The Administrator stated the policy to replace E-kits was 72 hours and verified the E-kit dated 1/6/26, should have been replaced. 3. On 1/8/26 at 0810 hours, an inspection of Medication Room A's IV E-kit, interview, and concurrent facility document review was conducted with RN 2. The E-kit had a yellow lock. RN 2 stated a yellow lock indicated the E-kit had been accessed and needed a replacement. Review of the E-kit log book showed the E-kit was accessed on 1/2/26, but was replaced on 1/6/26. There were no additional entries in the Pharmacy Log inside of the E-kit or in the E-kit log book to show the E-kit was accessed after 1/6/26. RN 2 stated the IV E-kit must have been accessed after it was replaced on 1/6/26, because it had a yellow lock. RN 2 stated she did not know what happened. RN 2 spoke to RN 1 and determined RN 1 accessed the IV E-kit on the previous shift but did not complete the IV E-kit pharmacy log. On 1/8/26 at 0918 hours, an interview was conducted with RN 1. RN 1 stated he accessed the IV E-kit in Medication Room A to start an IV infusion on a new admission. RN 1 stated he was aware of the policy to fill out the pharmacy log when he accessed the E-kit but forgot. On 1/9/26 at 1254 hours, an interview was conducted with the DON. The DON verified the above findings.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility P&P review, and facility document review, the facility failed to ensure the menu was followed for two nonsampled residents. * The menu spreadsheet was not followed for Resident 62's CCHO (Consistent Carbohydrate Diet/Controlled Carbohydrate) diet. * Resident 68 did not receive a salad listed on the lunch menu. These failures posed the risk for the residents who received food prepared in the kitchen to not have their nutritional needs met.Findings: Review of the facility's document titled Diet Type Report dated 1/6/26, showed 77 out of 85 residents received food from the kitchen. Review of the facility's P&P titled Therapeutic Diets dated 6/1/2014, showed therapeutic diets are diets that deviate from the regular diet and require a physician order. Per the physician order, therapeutic diets are planned, prepared and served in consultation with the dietitian. Therapeutic diets are reflected on the menu extension. Review of the facility's document titled Winter Menus dated 1/7/26, showed the residents on a CCHO and renal diet are to receive oven crisp fish with tartar sauce, salt free french fries, ketchup, seasonal carrots, apple hill cake 2 x 2 1/2, and milk. Further review of the document showed residents on a CCHO diet were not to receive a wheat roll. Review of Resident 62's Diet Ticket dated 1/7/26, showed Resident 62 was to receive a renal, CCHO, regular texture diet. The Diet Ticket further showed Resident 62 disliked cold cereal and fish. During the tray line observation and concurrent interview with the DSS on 1/7/26 at 1225 hours, the dietary staff set up the tray for Resident 62's lunch. The tray had seasoned carrots, chicken, brown rice, apple hill cake 2 x 2 1/2, milk and wheat rolls. The DSS stated the tray was ready to be served to the resident. The DSS then verified the above tray to be served to Resident 62. The DSS was observed checking the winter menus and verified Resident 62 was on CCHO diet. The DSS verified Resident 62 should not have wheat rolls per the winter menus. Medical record review for Resident 62 was initiated on 1/7/26. Resident 62 was admitted to the facility on [DATE]. Review of Resident 62's H&P examination dated 1/5/25, showed Resident 62 had diagnoses including Type II Diabetes. On 1/9/26 at 1142 hours, the Administrator and the DON were informed and acknowledged the above findings. 2. Review of the facility's January Menu dated 1/6/26, showed the lunch menu consisted of pork chops with pear sauce, polenta, seasoned broccoli, a green salad with dressing, and a cranberry crunch bar. On 1/6/26 at 1241 hours, an observation and concurrent interview was conducted with Resident 68. Resident 68 was eating his lunch in his room. Resident 68's lunch tray did not include a green salad. Resident 68 stated he was not sure what was on the lunch menu, but would have liked a green salad. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 68's lunch tray ticket did not show the menu items, but did include the resident's dislikes, which did not show salad. CNA 3 came into Resident 68's room and verified there was no green salad on their tray per the menu.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice 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 to provide the necessary care and services to ensure one of one final sampled resident (Resident 100) reviewed for hospice services attained and maintained their highest practicable well-being. * The facility failed to ensure the hospice visit calendar was available in Resident 100's medical record. * The facility failed to integrate Hospice A's plan of care into Resident 100's care and failed to accurately reconcile the physician's orders. These failures posed the risk of the delay in the communication and provision of hospice care between the hospice provider and facility.Findings: Review of the facility's P&P titled Hospice Care of Residents dated 1/1/12, showed if the resident and/or surrogate decision maker decides to utilize hospice care, attending physician will be contacted to make final determination. The hospice and facility will collaborate on a care plan for the residents. Facility and hospice staff will collaborate on a regular basis concerning the residents' care. Review of Hospice A Patient Agreement for Skilled Nursing Inpatient and related Hospice Services dated 9/6/23, under the section Plan of Care showed a written care plan established, maintained, reviewed and modified, if necessary, at intervals established by the interdisciplinary group. A plan of care includes (a) an assessment of each Hospice patient and needs, (b) an identification of the hospice services to be provided in response to assessment, including management of discomfort and symptoms relief, and (c) details concerning the scope and frequency of the Hospice services and facility services needed to meet the patient's and family's needs. The Hospice will develop a coordinated plan of care that is consistent with the state licensure, and Medicare and Medicaid requirements for the provision of Hospice services and is responsive to the unique needs of the Hospice patient who needs who resides in a skilled nursing facility and his/her expressed desire for Hospice care. Further review of the Hospice A Patient Agreement for Skilled Nursing Inpatient and related Hospice Services showed all physician orders communicated to facility on behalf of hospice in connection with the plan of care shall be in writing and signed by the applicable attending physician or hospice physician. Hospice shall maintain all adequate records of all physician orders communicated in connection with the plan of care. Medical record review for Resident 100 was initiated on 1/6/26. Resident 100 was admitted to the facility on [DATE]. Review of Resident 100's Order Summary Report showed the following physician's orders:- dated 5/31/25, to admit the resident to Hospice A under routine level of care.- dated 8/18/25, to administer morphine sulphate (pain medication) oral solution 20 mg per 5 ml to give 0.25 ml (i.e.1 mg) by mouth every two hours as needed for severe pain, and to hold if the respiration rate less than 12 or sedated. b. Review of Resident 100's medical record failed to show the Hospice A calendar for December 2025 and January 2026 to show the schedule when the hospice staff were visiting Resident 100. c. Review of the Resident 100's plan of care failed to show the hospice care plan was incorporated in the facility's plan of care for the resident. d. Review of the Hospice A medication list for Resident 100 showed a physician's order for morphine concentrate 20 mg/ml oral, to administer 5 mg every two hours as needed for shortness of breath and pain. On 1/8/26 at 0837 hours, an interview was conducted with LVN 6. LVN 6 stated Resident 100 was on under hospice care, and the staff from the hospice visited Resident 100. When asked how often the hospice staff visited Resident 100, LVN 6 stated the hospice aid visited twice a week and the skilled nursing visit was once a week. However, LVN 6 did not know the exact days when the hospice staff came to visit Resident 100. On 1/8/26 at 0846 hours, an interview and concurrent medical record review of Resident 100's medical record was conducted with LVN 7. LVN 7 verified the hospice calendar for December 2025 and January 2026 for Resident 100 was not available in the resident's medical record and the facility's care plan did not incorporate the resident's hospice care plan. LVN 7 stated he was unable to locate the hospice care plan in Resident 100's medical record. LVN 7 also verified the physician's order for (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the morphine sulfate medication was not accurately reconciled from the hospice medication list. LVN 7 stated the hospice order was for morphine sulfate 20 mg/mL, and to administer 5 mg (0.25 ml). However, the concentration ordered by the facility was 20 mg per 5 ml, which meant when administering 0.25 ml, the resident would only receive 1 mg instead of 5 mg as ordered. LVN 7 stated this could lead to poor pain control for Resident 100. On 1/9/26 at 1142 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 - Potential for minimal harm Residents Affected - Some	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 provide the necessary transfer/discharge services for one of three residents (Resident 7) reviewed for close records. * The facility failed to notify Resident 7 and/or their representative in writing regarding the transfer and reasons for the transfer, and the facility's bed hold policy when Resident 7 was transferred to the acute care hospital. In addition, the facility failed to send the copy of notice of transfer discharge to Ombudsman (a neutral advocate who investigates and resolves complaints for residents in healthcare settings like long-term care facilities). These failures had the potential for the resident and/or their representative to be unaware about the transfer and reason(s) of transfer, and their rights to request a bed hold and return to the first available bed should the resident's acute care hospital stay exceeded the seven-day bed-hold period.Findings: a. Review of the facility's P&P titled Notice of Transfer/discharge date d October 2017 showed to provide the resident and responsible party with a written notice of transfer/discharge prior to or at the time of discharge/transfer and their appeal right. Before the transfer or discharge occurs, the facility must notify the resident and, if known, the responsible party, and ombudsman after transfer and reason for the transfer, and document in the resident's clinical record. Review of the facility's P&P titled Bed Hold dated July 2017 showed the facility notified the resident and/or representative, in writing, of the bed hold, option, anytime the resident is transferred to an acute care hospital or requests therapeutic leave. Closed medical record review for Resident 7 was initiated on 1/8/26. Resident 7 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 7's H&P examination dated 5/15/25, showed Resident 7 had the capacity to understand and make decisions. Review of Resident 7's Physician Order dated 1/2/26, showed to transfer Resident 7 to the acute care hospital for confusion, agitation, tachycardia (high heart rate) and for bed hold for seven days, if admitted . Review of Resident 7's progress notes dated 1/2/26 at 1803 hours, showed Resident 7 was transferred to the acute care hospital and Resident 7 was admitted to the acute care hospital due to acute kidney injury (sudden, rapid loss of kidney function, where the kidneys can't filter waste, leading to buildup in the blood), urinary tract infection (bacterial infection in the urinary system, i.e. kidneys, ureters, bladder and urethra) and sepsis (a life-threatening medical emergency where the body's extreme, overactive response to an infection damages its own tissues, organs, and systems, leading to potential organ failure and death). Review of Resident 7's Notice of Proposed Transfer and discharge date d 1/2/26, showed the transfer location as the acute care hospital and the reason for the transfer was for Resident 7's welfare and Resident 7's needs could not be met in the facility. Under the section for the resident or resident representative signature failed to show any entry. In addition, the Notice of Proposed Transfer and Discharge form did not show if the copy of the form was sent to the Ombudsman. Further review of Resident 7's medical record did not show if a written notice of the transfer/discharge was provided to Resident 7 or their representative when Resident 7 was transferred to the acute care hospital on 1/2/26. In addition, the resident's medical record did not show if the copy of notice of transfer/discharge was sent to the Ombudsman. b. Review of the Resident 7's Bed hold Agreement showed the facility has a bed hold policy and will hold the bed for up to seven days if the resident is transferred to a general acute care hospital or goes on therapeutic leave often of no more than. overnights per calendar days, as long as resident or the representative notifies the facility within 24 hours after transfer leave that they wish to have the facility hold the resident's bed. Resident who are not eligible for Medi-cal/caid are responsible for the cost of the bed hold days not to exceed the patient's daily rate for care. Insurance may or may not cover such charges. You have the options of requesting a bed hold to keep the bed vacant and available for return to the facility. The bed hold begins the day the resident leaves the facility. The bed hold agreement (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	was signed by Resident 7's representative on 9/28/25. Further review of the Bed Hold Agreement did not show if the Bed Hold notice was provided to Resident 7 and/or their representative when Resident 7 was transferred to the acute care hospital on 1/2/26. On 1/9/26 at 1052 hours, an interview and concurrent closed medical record review was conducted with RN 3. RN 3 verified Resident 7 was transferred to the acute care hospital on 1/2/26. RN 3 verified Resident 7's representative was informed regarding the bed hold notice upon the resident's admission to the facility, however, RN 3 was not able to find the documentation to show if the facility's bed hold policy was provided to Resident 7 or their representative in writing when Resident 7 was transferred to the acute care hospital on 1/2/26. RN 3 verified Resident 7's Notice of Proposed Transfer and Discharge form dated 1/2/26 did not have Resident 7's or their representative's signature. RN 3 stated she was not sure how the facility provided the transfer/discharge notices, and the bed hold policies in writing, when the resident was not able to sign the document and the resident representative was not available at the time of the transfer. In addition, RN 3 verified the copy of the Notice of Proposed Transfer and Discharge form for Resident 7 was not sent to the Ombudsman, when he was transferred to the acute care hospital on 1/2/26. On 1/9/26 at 1108 hours, an interview was conducted with the Medical Records Director. The Medical Records Director verified the above findings and stated the facility did not mail the written notice of the transfer/discharge and notice of bed hold to the resident or their representative, when residents were transferred to the acute care hospital. On 1/9/26 at 1142 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 0655 Level of Harm - Potential for minimal harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **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 develop a baseline care plan for one of 19 final sampled residents (Resident 118). * Resident 118's removal of her indwelling urinary catheter (a flexible tube inserted into the bladder to drain urine from the bladder) and interventions in place for monitoring for bladder function were not included in the resident's baseline care plan. This failure had the potential for the resident's plan of care not being communicated to the IDT and a potential delay in identifying a bladder dysfunction. Findings: Review of the facility's P&P titled Comprehensive Person-Centered Care Planning revised 4/24/25, showed the baseline care plan must include the minimum information necessary to properly care for each resident, and should include resident specific health and safety concerns to prevent decline or injury, and identify their needs for assistance with ADL care. Review of the facility's P&P titled Indwelling Catheter - Insertion, Maintenance and Discontinuation of revised 7/22/25, showed after removal of the indwelling urinary catheter, the resident's care plan will be updated as necessary. Medical record review for Resident 118 was initiated on 1/6/25. Resident 118 was admitted to the facility on [DATE]. Review of Resident 118's Order Summary Report showed a physician's order dated 1/6/25, to monitor for the signs and/or symptoms of urinary retention (inability to fully empty the bladder) for 72 hours status post indwelling urinary catheter removal. Review of Resident 118's Baseline Care Plan failed to address the resident's urinary catheter, including when it was removed, and monitoring the resident for urinary retention. On 1/7/26 at 0947 hours, an interview was conducted with Resident 118. Resident 118 stated after her indwelling urinary catheter was removed yesterday morning, she had a hard time voiding. Resident 118 stated she has had a hard time getting used to holding her urine in and when she had the urge to void, she needed to rush to the toilet. On 1/7/26 at 1157 hours, interview and concurrent medical record review was conducted with the DON. The DON reviewed Resident 118's medical record and stated the resident's indwelling urinary catheter was discontinued yesterday morning, and the facility staff were to monitor the resident for bladder retention, like discomfort and distention, for 72 hours. The DON verified the resident's baseline care plan failed to address the resident's indwelling urinary catheter discontinuation and the interventions in place to monitor and assist the resident. The DON stated the resident's baseline care plan should have been updated yesterday, after the indwelling urinary catheter was removed.

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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 and medical record review, the facility failed to ensure for an accurate medical record for one of one final sampled resident (Resident 5) reviewed for dialysis. * Resident 5's blood pressure log inaccurately showed his blood pressure was obtained on his left arm, where the resident had an AV shunt (a surgical connection between an artery and a vein). This failure resulted in inaccurate documentation of the resident's blood pressure measurements site.Findings: Medical record review for Resident 5 was initiated on 1/6/26. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's Order Summary Report showed a physician's order dated 11/28/25, for no blood pressure checks on the resident's left arm AV shunt. Review of Resident 5's Blood Pressure Log showed the following blood pressure readings were obtained from the resident's left arm:- on 12/17/25 at 0722 hours;- on 12/18/25 at 0639 hours;- on 12/25/25 at 0646 hours;- on 12/25/25 at 2152 hours;- on 12/26/25 at 0655 hours;- on 1/1/26 at 0834 hours; and- on 1/5 at 1928 hours. On 1/7/26 at 1149 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated Resident 5 had a left arm AV shunt, and the blood pressures readings should not be checked on the arm with the AV shunt. The DON verified Resident 5's Blood Pressure Log showed the above blood pressure readings were documented as being taken on the left arm. On 1/7/26 at 1415 hours, an interview was conducted with Resident 5. Resident 5 stated the licensed nurses always checked his blood pressure readings on his right arm because his AV shunt was on his left arm.

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F 0847 Level of Harm - Potential for minimal harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and the facility document review, the facility failed to ensure the Arbitration Agreement (an agreement that allows parties to resolve disputes and lawsuits privately rather than going to the court) was explained in a form, manner, and language the residents or their representatives understood for two of three residents (nonsampled Residents 23 and 72) reviewed for the Arbitration Agreement. * The facility allowed Residents 23 and 72 who had no mental capacity to understand and make medical decisions, to enter and sign the Arbitration Agreement. This failure posed the risk for the residents to not have a clear understanding of the arbitration process.Findings: 1. Medical record review for Resident 23 was initiated on 1/9/26. Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's H&P examination dated 11/2/25, showed Resident 23 had no mental capacity to understand and make decisions. Review of Resident MDS dated [DATE], showed Resident 23 had severe cognitive impairment. Review of Resident 23's Arbitration Agreement dated 8/12/25, showed Resident 23's signature. Further review of the Arbitration Agreement showed . by signing this contract you are agreeing to have all claims, including claims other than a claim for medical malpractice, decided by arbitration and you are giving up your right to a jury or court trial and you agree that no party shall adjudicate any claim on a class action basis. 2. Medical record review for Resident 72 was initiated on 1/9/26. Resident 72 was admitted to the facility on [DATE]. Review of Resident 72's H&P examination dated 10/12/25, showed Resident 72 had no capacity to understand and make decisions. Review of Resident 72's Arbitration Agreement dated 10/24/25, showed Resident 72's signature. Further review of the Arbitration Agreement showed . by signing this contract you are agreeing to have any issue of medical malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial. On 1/9/26 at 0953 hours, an interview and concurrent facility document review for Residents 23 and 72 was conducted with the admission Director. The admission Director verified the above findings and stated Residents 23 and 72 had no capacity to understand and make decisions to sign the Arbitration Agreement and the facility staff should have contacted the residents' representatives to explain the Arbitration Agreement for Residents 23 and 72. On 1/9/26 at 1142 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 0865 Level of Harm - Potential for minimal harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and facility document review, the facility failed to implement their QAPI plan and their past Recertification Survey POC for F694. This failure had the potential for ongoing non-compliance and complete data being reviewed by the QAPI committee. Findings: Review of the facility's 2024 Recertification Survey POC accepted by the department on 10/25/24, included the following for F694:- The DON will in-service the RNs on measuring the external PICC line catheters length on admission. - The DON will review residents with PICC lines to ensure RNs are measuring the external catheter length on admission. - The DON will report any findings related to PICC line care to the QA committee monthly for three months. On 1/9/26 at 1545 hours, a review of the facility's QAPI binder was conducted with the Administrator. The facility's QAPI binder failed to show the above POC interventions were completed. The Administrator verified the above findings. Cross reference F694.