STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055259	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monrovia Post Acute	1220 E. Huntington Drive Duarte, CA 91010

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a clean, safe, sanitary, and homelike environment when:a. There was black substance on the caulk (a flexible sealing material used to fill gaps, cracks, and joints to prevent air, water, dust, and contaminants from passing through) in two of two showers (Shower 1 and Shower 2) located inside one of two facility shower rooms.b. The cove base (a type of vinyl and or rubber trim that's applied to the edges of a floor to help create a smooth transition between the floor and the wall) in the shared bathrooms of three of three sampled resident rooms (Rooms 1, 31 and 35) and the wall close to the bathroom door inside room [ROOM NUMBER] was loose and had a gap from the wall. Additionally, there was an insect found in the gap between the cove base and the wall close to the bathroom door inside room [ROOM NUMBER].c. The door trim, located outside the bathroom door in one of one sampled room (Resident 36, Resident 75, and Resident 12's room), was loose and had a gap from the door frame.d. A foul odor was detected in one of one multi-resident room (Resident 54, Resident 48, and Resident 7's room). These failures had the potential for residents and employees to be exposed to dirt, mold, drywall dust, and disease-carrying insects which could lead to a decline in residents' health. These failures also had the potential for residents and employees to sustain an injury from tripping on loose cove base and had the potential to cause discomfort among all residents inside the room and affect the residents' physical and psychosocial wellbeing.Findings: a. During a concurrent observation and interview on 4/23/2026 at 8:46 AM with the Maintenance Director, there was black substance on the silicone caulk on two corners of Shower 2. Maintenance Director (MD) was able to scrape off the black substance using the tip of the flathead screwdriver. When asked if the back substance was mold, the MD did not answer. The MD stated mold could be black, beige and brown in color. The MD answered yes when asked if mold could grow in a moist environment. During a concurrent observation and interview on 4/23/2026 at 8:50 AM, there was black substance on the silicone caulk on one corner of Shower 1. The MD attempted to scrape off the black substance, and some of the black substance came off. The MD stated the black substance that did not come off would be (caulking) glue. b. During an observation with the Director of Staff Development (DSD) on 4/23/2026 at 8:28 AM, approximately 3 inches of the cove base inside the shared bathroom in room [ROOM NUMBER] (shared with room [ROOM NUMBER]) was loose and had a gap off from the wall. During an interview on 4/23/2026 at 8:30 AM, the DSD stated we need to repair any areas that are broken or loose to provide a safe and homelike environment for all residents at the facility. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/23/2026 at 8:31 AM with the DSD, the cove base inside the shared bathroom in room [ROOM NUMBER] (shared with room [ROOM NUMBER]) was loose and had a gap from the wall. During an observation and interview on 4/23/2026 8:54 AM with the MD, the cove base on the wall close to the bathroom door inside room [ROOM NUMBER] was loose and had a gap. There were chunks of drywall in between the gaps. There was a light colored, shrimplike small insect approximately 0.5 centimeters in length found inside the gap. The MD stated the insect looked like a cricket. The MD answered yes when asked if insects, like cockroaches could hide behind the gaps. The MD stated MD would close the gaps with glue. c. During a concurrent observation and interview on 04/23/2026 at 8:38 AM with the MD, approximately 7 inches of the door trim leading to the shared bathroom in Resident 36, Resident 75, and Resident 12's room was loose and had a gap from the door frame. The MD answered yes when asked if the loose trim would put the residents and staff at risk for tripping on the loose door trim. d. During a review of Resident 54's admission Record (AR), the AR indicated the facility originally admitted Resident 54 on 3/10/2026 with diagnoses including unilateral primary osteoarthritis of the right hip (a progressive disorder of the joints, caused by a gradual loss of cartilage, that primarily affects one side of the body, often involving a single joint) and spinal stenosis (narrowing of the spinal canal), lumbar region (lower back) without neurogenic claudication (compression of the nerves in the lower spine leading to leg pain). During a review of Resident 54's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 3/11/2026, the H&P indicated Resident 54 had the capacity to understand and make decisions. During a review of Resident 54's Minimum Data Set (MDS- a resident assessment tool), dated 3/17/2026, the MDS indicated Resident 54's cognitive (the ability to think and process information) skills for daily decision making were intact. The MDS indicated Resident 54 required supervision or touching assistance with eating, oral hygiene, and upper body dressing and required partial/moderate assistance with toileting, showering, lower body dressing and personal hygiene. During a concurrent observation and interview on 4/21/2026 at 11:20 AM with Resident 54 in Resident 54, Resident 48, and Resident 7's room, a foul odor was detected. Resident 54 stated there had been a foul odor in Resident 54's room for a week. Resident 54 stated Resident 54 had notified staff many times about the foul odor. During a concurrent observation and interview on 4/23/2026 at 12:09 PM in Resident 54, 48, and 7's room with Certified Nursing Assistant (CNA) 1, CNA 1 stated there was a foul smell detected in Resident 54, 48, and 7's room. CNA 1 stated the odor smelled like body odor. During a concurrent observation and interview on 4/23/2026 at 3:40 PM in Resident 54, 48, and 7's room with CNA 2, CNA 2 stated there was a foul smell which smelt like feces coming from Resident 54, 48, and 7's room. CNA 2 stated Resident 54 had complained to CNA 2 many times about a foul odor in Resident 54, 48, and 7's room. During an interview on 4/24/2026 at 11:26 AM with Registered Nurse (RN) 1, RN 1 stated there should not be a foul odor in the residents' rooms (in general). RN 1 stated it was the policy of the facility to (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ensure the residents' rooms (in general) were clean and did not have a foul odor. During a review of the facility's Policy and Procedure (P&P) titled, Homelike Environment, revised February 2021, the P&P's policy statement indicated, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The P&P's policy interpretation and implementation indicated, Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include clean, sanitary and orderly environment; pleasant, neutral scents.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Residents 3 and 14) received nursing care and services in accordance with professional standards of practice.For Resident 3 the facility failed to ensure the physician notification was completed and act upon a change in condition (CIC) when Resident 3 experienced the following: On 4/2/2026 Resident 3's sodium level (Normal sodium levels = 135 to 145 milliequivalent per liter (meq/L)) was 131 meq/L (low).Resident 3's level of consciousness was altered and Resident 3 was lethargic (consists of severe drowsiness in which the patient can be aroused by moderate stimuli and then drift back to sleep). This deficient practice led to a delay in Resident 3's care and treatment for the low sodium and Resident 3's change in the level of consciousness and the potential to result in a physical decline to Resident 3. For Resident 14, Licensed Vocational Nurse (LVN) 6 failed to ensure a physician's order was followed for the administration of Milk of Magnesium (medication used to relieve constipation) 2400 milligram (mg, unit of measurement)/10 milliliter (mL-a metric unit of volume) to give 30 mL by mouth one time a day for bowel management (structured program designed to help individuals control their bowels, achieve daily bowel movements, and prevents long standing constipation).This deficient practice had the potential to result in medication underdosing leading to constipation affecting Resident 14's physical well-being.Findings:A. During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 5/8/2024 with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning) and chronic kidney disease (condition characterized by a gradual loss of kidney function over time).During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 1/21/2026, the MDS indicated Resident 3 had severe cognitive (ability to think and make decisions) deficit and Resident 3 was dependent with all activities of daily living.1. During an interview on 4/21/2026 at 12:08 PM, Resident 3's Family Member 2 (FM 2) stated Resident 3 had been sleeping a lot for 3 weeks. FM 2 stated Resident 3 was probably tired because Resident 3 was [AGE] years of age. During a review of Resident 3's Lab Results Report, dated 3/26/2026, the result indicated Resident 3's sodium level was 126 meq/L.During a review of Resident 3's CIC Evaluation dated 3/26/2026, the CIC indicated a low sodium level of 126 with clinician recommendation to administer sodium chloride via gastrostomy tube (GT - a feeding tube inserted through the abdomen directly into the stomach), for 5 days and to repeat Basic Metabolic Panel (BMP, blood test) on 4/2/2026.During a review of Resident 3's Lab Results Report, dated 4/2/2026, the result indicated a sodium level of 131 meq/L.During a review of Resident 3's CICs and Nurse's Progress Notes, dated April 2026, there was no documented evidence indicating Resident 3's physician (Medical Doctor, MD 1) was notified of the laboratory result dated 4/2/2026.During a concurrent record review and interview on 4/23/2026 at 10:45 AM with the Assistant Director of Nursing (ADON), Resident 3's sodium level lab result, dated 4/2/2026, Resident 3's CICs and Progress Notes dated April 2026 were reviewed. The ADON stated the timeframe for notifying a physician of a CIC was immediately or within the shift [of the CIC]. The ADON stated a low sodium level could lead to dizziness, mentation changes, and tiredness. The ADON stated there was no CIC evaluation on 4/2/2026 and the Progress Notes dated 4/8/2026 indicated MD 1 was notified of Registered Dietitian's recommendation for water flush due to low sodium. The ADON stated a sodium level of 131 meq/L was low and MD 1 needed to be notified immediately or within the same day of the laboratory test result. The ADON stated the ADON stated if a CIC evaluation was initiated on 4/2/2026, the evaluation would ensure monitoring of Resident 3's change in condition.2. During an observation on 4/23/2026, Resident 3 was sleeping during the following times: at 8:45 AM, at 11 AM, and at 1:10 PM.During an interview on 4/23/2026 at 2:53 PM, Certified Nursing Assistant (CNA) 3 stated Resident 3 was able to eat, walk, talk, and yell often. CNA 3 stated Resident 3 was now mostly (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sleeping starting on Monday 4/20/2026. CNA 3 stated Resident 3 would open Resident 3's eyes when being repositioned and today Resident 3 asked for water but coughed when drinking. CNA 3 stated CNA 3 reported to Licensed Vocational Nurse (LVN) 1 that Resident 3 was sleeping a lot.During an interview on 4/23/2026 at 2:57 PM with LVN 1, LVN 1 stated Resident 3 had been sleepy for a few days but Resident 3 woke up when someone talked to the resident. LVN 1 stated LVN 1 did not complete a change in condition because Resident 3 could be awakened.During an interview on 4/23/2026 at 3:17 PM, LVN 2 stated lethargy meant the resident (in general) would be unable to wake up right away, unable to answer right away, and waking up the resident would take time. LVN 2 stated Resident 3 was usually sleeping when LVN 2 started LVN 2's shift but Resident 3 usually opened Resident 3's eyes when LVN 2 talked to Resident 3. LVN 2 stated Resident 3's level of consciousness before was Resident 3 was awake and alert and yelled almost every minute.During an observation on 4/23/2026 at 3:25 PM, Restorative Nursing Assistant (RNA, specialized rehabilitative care provided by nurse assistants with extra training to help residents regain or maintain mobility, strength, and independence in activities of daily living) 1 attempted to wake up Resident 3 by calling resident's name three times, Resident 3 remained asleep with eyes closed. RNA 1 shook Resident 3's bilateral shoulder once, then twice and Resident 3 opened resident's eyes on the third try. RNA 1 informed Resident 3 the RNA 1 would be providing exercises, then Resident 3 closed Resident 3's eyes and fell back asleep. During this observation, Registered Nurse Supervisor 1 (RNS 1) was present at Resident 3's bedside.During an interview on 4/23/2026 at 3:44 PM, RNS 1 stated RNS 1 assessed Resident 3 when staff reported any changes to RNS 1. RNS 1 stated when a resident (in general) had increased sleepiness and was hard to wake up, RNS 1 checked for infections, aspiration pneumonia, or urinary tract infections (UTI - an infection in the bladder/urinary tract), and notified the physician to get physician orders for the resident. RNS 1 stated RNS 1 did not receive a report from any staff regarding any incidents for Resident 3. RNS 1 stated FM 2 was always present at Resident 3's bedside and did not report any changes to RNS 1. RNS 1 answered yes when asked are the licensed nurses and certified nursing assistants responsible for identifying changes in condition.During an interview on 4/23/2026 at 4:30PM, the Director of Nursing (DON) stated when determining a change in condition related to increased sleepiness, the DON investigated first why the resident (in general) was sleeping during the day and find out if the resident was awake during the night, find out if there was any medication changes, and look into the resident's co-morbidities. The DON stated if these were not the reasons [root cause], the DON notified the physician for the resident to be assessed and the facility receive physician orders for laboratory work-up to find the source of a possible infection or abnormal laboratory results.During an observation on 4/24/2026 Resident 3 was asleep during the following times: at 8:45 AM, at 9:55 AM, and at 11:27 AM.During an interview on 4/24/2026 at 11 AM, Resident 3's roommate stated Resident 3 used to scream day and night but Resident 3 sleeps all the time now for the past 3-4 months. During a review of Resident 3's Care Plan (CP) titled Episode of Hyponatremia initiated on 3/26/2026, the CP's interventions indicated to monitor for signs and symptoms such as confusion, lethargy, headache, nausea and vomiting.During a review of Resident 3's CP titled Potential for Complications, signs and symptoms related to Chronic Kidney Disease the CP's interventions indicated to monitor and report changes in mental status such as lethargy, tiredness, fatigue, tremors, and seizures.During a review of an undated article from the National Library of Medicine, National Institutes of health (NIH), titled Level of Consciousness-Clinical Methods, the article indicated the normal state of consciousness comprises either the state of wakefulness, awareness, or alertness in which most human beings function while not asleep or one of the recognized stages of normal sleep from which the person can be readily awakened. The article indicated the different altered states of consciousness are: clouding of consciousness, confusional state, delirium, lethargy, obtundation, stupor, dementia, hypersomnia, vegetative state, akinetic mutism, locked-in syndrome, coma, and brain death. The article indicated the following definition;Clouding of consciousness is a very mild form of altered mental status in which the patient (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	has inattention and reduced wakefulness.Confusional state is a more profound deficit that includes disorientation, bewilderment, and difficulty following commands.Lethargy consists of severe drowsiness in which the patient can be aroused by moderate stimuli and then drift back to sleep.Coma is a state of unarousable unresponsiveness.During a review of the facility's Policy and Procedure (P&P) titled Acute Condition Changes - Clinical Protocol, dated March 2018, the P&P indicated direct care staff, including nursing assistants will be trained in recognizing subtle but significant changes in the resident (for example, a decrease in food intake, increased agitation, changes in skin color or condition) and how to communicate these changes to the Nurse. Nursing Assistants are encouraged to use the Stop and Watch Early Warning Tool to communicate subtle changes in the resident to the Nurse. The P&P indicated the nurse shall assess and document/report the following baseline information such as. level of consciousness, onset, duration, severity, recent labs.B. During a review of Resident 14's admission Record (AR), the AR indicated the facility admitted Resident 14 on 7/26/2020 and re-admitted the resident on 9/6/2025, with diagnoses including Gastro-Esophageal Reflux Disease (GERD-when stomach acid flow back into the esophagus [the tube from the mouth to the stomach], causing burning in the chest and irritation), irritable bowel syndrome (IBS-a condition where the intestines are overly sensitive and don't move normally, causing abdominal pain, bloating, and changes in bowel habits [diarrhea, constipation, or both] without visible damage to the digestive tract), dysphagia (difficulty swallowing), and ileus (a condition where the intestines temporarily stop moving, so food and gas can't pass normally).During a review of Resident 14's MDS, dated [DATE], the MDS indicated Resident 14's cognition (the ability to think and process information) was moderately intact. The MDS indicated Resident 14 required substantial/maximal assistance (helper does more than half the effort) with activities of daily living (ADL-term used in healthcare that refers to self-care activities) and mobility was not attempted due to medical condition or safety concerns.During a review of Resident 14's Order Summary (OS), dated 3/18/2026, the (OS) indicated:Milk of Magnesium 2400 mg/10 mL, give 30 mL by mouth one time a day for bowel management.During a review of Resident 14's Medication Administration Record (MAR), dated 4/2026, the MAR indicated to administer the following medications at 9 AM:Milk of Magnesium 2400 mg/10 mL give 30 mL by mouth one time a day.Risperidone (used to treat mood or behavior conditions such as agitation or psychosis (mental health symptom characterized by disconnection from reality) 0.5 mg, give 1 tablet by mouth two times a day.Oxybutynin Chloride (used to treat overactive bladder [hollow muscular organ at the base of the pelvis [basin-shaped bony structure located at the base of the spine] acts as a reservoir for urine] by reducing urinary urgency and frequency) 5 mg, 1 tablet by mouth three times a day.Dicyclomine Hydrochloride (used to relieve stomach cramps and bowel spasms) 10 mg, 1 capsule by mouth three times a day.Sertraline (used to treat depression and anxiety) 50 mg, give 1 tablet by mouth every day.During a medication pass observation on 4/23/2025 at 8:36 AM, Licensed Vocational Nurse (LVN) 6 prepared the following medications for Resident 14: Risperidone, Oxybutynin Chloride, Dicyclomine Hydrochloride, Sertraline, and Milk of Magnesium. LVN 6 obtained the stock bottle of Milk of Magnesium with a concentration of 1200 mg/15 mL and poured 30 mL into a medication cup. LVN 6 stated she was done preparing the medication and was ready to administer it to Resident 14.During an interview and concurrent record review on 4/23/2026 at 8:45 AM with LVN 6, LVN 6 stated the physician's order indicated Milk of Magnesium 2400 mg/10 mL, give 30 mL, which equalled a total dose of 7,200 mg. LVN 6 stated the stock bottle available for Milk of Magnesium had a concentration of 1200 mg/15 mL, and administering 30 mL from that concentration provided [Resident 14] a total dose of 2,400 mg. LVN 6 stated LVN 6 prepared to administer 30 mL of Milk of Magnesium based solely on the volume listed in physician's order [30 mL], without accounting for the difference in concentration [in the bottle], resulting in a significantly lower dose than prescribed. LVN 6 further stated that she should have verified that the concentration of the medication matched the physician's order to ensure the correct dose was administered. LVN 6 stated that failing to verify the correct concentration could have resulted in underdosing Resident 14, leading (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to ineffective treatment, unresolved constipation, and result in complications or discomfort to Resident 14.During an interview and concurrent record review on 4/23/2026 at 10:38 AM, with the Assistant Director of Nursing (ADON), the ADON stated nurses are expected to cross-check each medication order against the medication label and concentration prior to administration. The ADON stated if anything appeared incorrect or unclear, the nurse should stop and verify the order with the physician and/or contact the pharmacy to obtain the correct concentration or clarify the order. The ADON stated in this situation, the nurse should have recognized the concentration discrepancy and either requested a corrected order or obtained the appropriate formulation. The ADON further stated that these practices are essential to ensure resident safety and ensure medications are administered accurately according to the physician's order.During a review of the facility's Policy and Procedure (P&P) titled, Administering Medications, dated 4/2019, the P&P indicated: Medications are administered in a safe and timely manner, and as prescribed. The P&P indicated medications are administered in accordance with prescriber orders, including any required time frame. The P&P indicated the individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a safe and appropriate discharge for one of one sampled resident (Resident 80) who discharged against medical advice (AMA- when a resident chooses to leave the facility before the physician recommends discharge).This failure had the potential to result in Resident 80 being discharged without necessary instructions, services, or follow-up care, placing the resident at risk for adverse health outcomes, including worsening conditions, medication mismanagement, or rehospitalization.Findings:During a review of Resident 80's admission Record (AR), the AR indicated the facility originally admitted Resident 80 on 2/2/2026 and readmitted the resident on 2/17/2026 with diagnoses including fusion of spine (a surgery where doctors permanently join two or more bones in the spine so they heal into one solid piece) lumbar region (the lower part of the back, just above the hips and below the ribs), need for assistance with personal care, and repeated falls.During a review of Resident 80's Discharge Planning Review (DPR), dated 2/3/2026, the DPR record indicated Resident 80 was expected to be discharged to the community and discharge was determined to be feasible. The DPR indicated the Social Services Director (SSD) would assist Resident 80 with placement and Resident 80 would go to an assisted living facility if willing. The DPR's care plan interventions indicated establishing a pre-discharge plan, arranging community resources, and providing written instructions to ensure continuity of care post-discharge. During a review of Resident 80's Minimum Data Set (MDS - a resident assessment tool), dated 2/10/2026, the MDS indicated Resident 80's cognition (the ability to think and process information) was intact. The MDS indicated Resident 80 required setup or clean-up assistance (helper sets up or cleans up) with activities of daily living (ADL, term used in healthcare that refers to self-care activities).During a review of the Physician's Discharge Summary (PDS), discharge date [DATE], the PDS indicated Resident 80 was discharged AMA.During a review of the Release of Responsibility for Discharge Against Medical Advice (RRDAMA), dated 2/23/2026, the RRDAMA indicated Resident 80 acknowledged being informed of the advisability of risk, inherent in and the probable consequences of leaving the facility against medical advice and/or without a physician's discharge order. The RRDAMA indicated Resident 80 assumed all responsibility for the care and custody of himself or of the risks of leaving prior to physician-recommended discharge and assumed responsibility for the decision to leave. During an interview and concurrent record review on 4/23/2026 at 2:22 PM with the Assistant Director of Nursing (ADON), Resident 80's Progress Note (PN)- Discharge summary, dated [DATE], were reviewed with the ADON, the PN indicated Resident 80 was informed of the risks and benefits of leaving the facility, with emphasis on the need for continued care related to Resident 80's recent cervical (neck) and lumbar spine fusion. The PN indicated accommodations such as transportation and medications would not be allowed. The PN indicated Resident 80 verbalized understanding. The ADON stated there was no documented evidence in Resident 80's medical record indicating the facility offered, attempted, or provided discharge planning instructions, education, or coordination of care prior to the AMA discharge. The ADON stated discharge planning was necessary to ensure Resident 80 received instructions, services, and follow-up care upon leaving the facility. The ADON stated without this, Resident 80 was at risk for worsening conditions, lack of services, medication mismanagement, and potential rehospitalization. The ADON stated that if the facility had offered, attempted, and documented discharge planning and coordination in good faith, it would have demonstrated efforts were made. The ADON acknowledged that while the resident may have refused, the attempt should have been [made and] documented in the medical record.During a review of the facility's Policy and Procedure (P&P) titled, Discharging a Resident Against Medical Advice, revision dated 7/2025, the P&P indicated residents are discharged in the safest and most appropriate manner possible. The P&P indicated prior to discharge, the (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following information is clearly documented in the resident's medical record:a.Facility staff, providers, and physician attempts to address or correct factors that have led to the request for discharge (e.g., dissatisfaction with care, financial concerns, dependent care, etc.)b.All information provided to the resident or representative regarding the clinical risks of discontinuing care at the facility, and why it is in the best interest of the resident to stay at the facility and complete the plan of care.c.Any information provided by the resident or representative regarding the setting and care-giving arrangements made for the resident after discharge.The P&P indicated if a resident or representative requests to be discharged to a setting that does not appear to meet the resident's post-discharge needs, or appears unsafe, the staff and physician will:1.Discuss with the resident and/or representative (and document) the implications and/or risks of being discharged to a location not equipped to meet the resident's needs and attempt to ascertain why the resident or representative is choosing that location.2.Discuss with the resident and/or representative (and document) other, more suitable locations equipped to meet the needs of the resident.3.Document if, despite being offered other options that could meet the resident's needs, the resident and/or representative refused the more appropriate settings.The P&P indicated otherwise, the facility will provide a Notice of Discharge, discharge orientation, and a detailed Discharge Summary (including referrals for continued care) .before the resident leaves the facility.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an accurate comprehensive assessment for one of one sampled resident (Resident 46) when Resident 46's Minimum Data Set (MDS - a resident assessment tool) did not indicate Resident 46 had loosely fitting dentures. This failure had the potential to result in Resident 46's individualized needs not being met and had the potential to result in an increased risk of weight loss or malnutrition.Findings:During a review of Resident 46's admission Record (AR), the AR indicated the facility originally admitted Resident 46 on 3/15/2026 with diagnoses including urinary tract infection (an infection that affects any part of the urinary system including the kidneys, ureters, bladder, and urethra) and sepsis (the body's extreme, lifeˆthreatening response to an infection that can lead to organ damage or failure).During a review of Resident 46"s Nursing Progress Note, dated 3/15/2026, the progress note indicated, per [Emergency Contact (EC)] [Resident 46] has loose fitting dentures on the bottom and missing teeth to the top dentures that prevents [Resident 46] from being able to chew effectively.During a review of Resident 46's History and Physical (H&P), dated 3/18/2026, the H&P indicated Resident 46 had the capacity to understand and make decisions.During a review of Resident 46's MDS, dated [DATE], the MDS indicated Resident 46's cognitive (the ability to think and process information) skills for daily decision making were moderately impaired (makes poor decisions requiring cues or supervision). The MDS indicated Resident 46 required partial to moderate assistance with eating, oral and personal hygiene, and upper body dressing, required substantial to maximal assistance with toileting, and lower body dressing and was dependent on showering.During an interview on 4/21/2026 at 11:06 AM with Resident 46, Resident 46 stated Resident 46 had not had dentures for one month and one week. Resident 46 stated the Dentist had told Resident 46 that Resident 46 needed new dentures.During an interview on 4/22/2026 at 1:57 PM with the Social Service Director (SSD), the SSD stated Resident 46 had dentures but they did not fit Resident 46.During a concurrent interview and record review on 4/23/2026 at 11:01 AM with the Minimum Data Set Nurse (MDSN), Resident 46's MDS, dated [DATE] was reviewed. The MDS indicated Resident 46 did not have any broken or loosely fitting full or partial denture. The MDSN stated Resident 46's MDS was incorrect. The MDSN stated it was important to have the correct information in the MDS to ensure the facility could identify Resident 46's needs.During a review of the facility's Policy and Procedure (P&P) titled, Comprehensive Assessments, revised October 2023, the P&P's policy statement indicated, Comprehensive MDS assessments are conducted to assist in developing person-centered care plans. The P&P's policy interpretation and implementation indicated, The facility conducts comprehensive, accurate, standardized, reproducible assessments of each resident's functional capacity using the Resident Assessment Instrument specified by CMS.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to develop a specific and individualized smoking care plan for one of six sampled residents (Resident 73) to address safe storage and safety when Resident 73 kept their own smoking supplies. This deficient practice had the potential for unsafe smoking practices at the facility.During a review of Resident 73's admission Record (AR), the AR indicated the facility admitted Resident 73 on 5/20/2022, with diagnoses that included hemiplegia and hemiparesis (one-sided weakness and paralysis) affecting the left dominant side and depression (persistent feelings of sadness and worthlessness and a lack of desire to engage in formerly pleasurable activities). During a review of 73's Annual Exam (Amended) History (H&P), dated 11/2/2025, the H&P indicated Resident 73 had the capacity to understand and make decisions. During a review of Resident 73's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/24/2026, the MDS indicated Resident 73 had intact cognition. The MDS indicated Resident 73 required setup or clean-up assistance (helper sets up or cleans up, resident completes the activity. Helper assists only prior to or following the activity) with eating and the resident was independent with oral hygiene, rolling left and right. During an interview on 4/22/2026 at 3:31 PM, the Director of Staff Development (DSD) stated the facility would complete a smoking assessment and a smoking care plan for smokers. The DSD stated the facility would keep the smoking paraphernalia (refers to any equipment and smoking materials) and for those residents who would want to keep their own smoking paraphernalia, there would be an interdisciplinary meeting to assess and discuss safety and to educate the resident. During an interview on 4/22/2026 at 3:44 PM, the Activity Director (AD) stated the Activities Department would provide supervision to smokers because the smoking area was next to the Activity Room. The AD stated Resident 73 was independent and could keep smoking paraphernalia with the resident. The AD stated the AD and activities staff would be able to see any changes in Resident 73's status and would immediately notify the licensed nurses if there would be any change in physical status that would compromise safety. During a concurrent observation and interview on 4/22/2026 at 4:00 PM, there was no cigarette or lighter on the bed or on the table. Resident 73 stated the resident kept own cigarettes and lighter and would store the items inside the drawer. Resident 73 stated the resident was provided education regarding safety including not smoking inside the room or inside the facility and to store the cigarettes and lighter properly and not lying around. During an interview on 4/22/2026 at 4:12 PM, the Director of Nursing (DON) stated Resident 73 was alert and oriented, and the resident was assessed as able to handle smoking materials and could store smoking paraphernalia. During a review of Resident 73's Smoking Risk Evaluation (SRE), dated 4/17/2026, the SRE indicated Resident 73 was a safe smoker, and was capable of smoking without physical assistance but must be supervised per facility policy. During a review of Resident 73's Care Plan, initiated on 1/15/2026, and titled [Resident 73] is a supervised smoker. [Resident 73] is noncompliance in following the smoking schedule, refuses to wear a smoking apron while smoking, and prefers to keep smoking supplies, the Interventions did not indicate the safe storage of smoking paraphernalia and how to monitor for safety when Resident 73 would keep own smoking supplies. During a concurrent review of Resident 73's care plan titled The resident is a supervised smoker and an interview on 4/22/2026 at 4:15 PM, the DON stated that the care plan did not specify the storage of smoking supplies. The DON answered No when asked if the care plan addressed how to ensure safety when residents store their own smoking supplies. During a review of the facility's Policy and Procedure (P&P), titled Care Plans, Comprehensive, dated March 2022, the P&P indicated the interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure appropriate treatment and services were provided to or one (1) of one (1) sampled resident (Resident 44) who was at risk for skin breakdown and pressure injuries (localized damage to the skin and underlying soft tissue, usually occurring over a bony prominence or related to medical devices) to prevent worsening skin integrity by failing to ensure the low Air Loss Mattress's (LALM- an air-filled mattress used to relieve pressure) setting was set according to Resident 44's weight.This failure had the potential to compromise pressure redistribution and increase the risk for skin breakdown and pressure injury development for Resident 44.Findings:During a review of Resident 44's admission Record (AR), the AR indicated the facility admitted Resident 44 on [DATE], and readmitted the resident on [DATE], with diagnoses including muscle wasting and atrophy (shrinking and wasting away of a part of the body, usually a muscle or organ) multiple sites, contracture (when a muscle or joint tightens and gets stuck, limiting movement), and epilepsy (a condition where someone has recurring seizures due to abnormal brain activity).During a review of Resident 44's Care Plan Report (CPR), initiated on [DATE] and revised on [DATE] with a target date of [DATE], the CPR indicated that Resident 44 had a Low Air Loss Mattress (LALM- an air-filled mattress used to relieve pressure) care plan for skin integrity and prevention pressure injury. The CPR interventions indicated:Low air loss set according to residents' weight, comfort, and manufacture settings.Monitor the air pressure settings and functionality of the mattress.During a review of Resident 44's Order Summary Report (OSR), dated [DATE], the OSR indicated Resident 44 had an active order for a LALM every shift for wound management and prevention and to monitor placement and functioning.During a review of Resident 44's Weights and Vitals Summary (WVS), dated [DATE], the WVS indicated Resident 44's most recent weight was 135 lbs. (lbs.-a unit of mass).During a review of Resident 44's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated [DATE], the MDS indicated Resident 44's cognition (the ability to think and process information) was severely impaired. The MDS indicated Resident 44 was dependent (helper does all of the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and mobility was not attempted due to medical conditions or safety concerns.During a review of Resident 44's Braden Scale for Predicting Pressure Sore Risk (BSPPSR-a tool used to assess the likelihood of developing bed sores), dated [DATE], the BSPPSR indicated that Resident 44 was at a very high risk for pressure sore development. During an observation on [DATE] at 09:58 AM, Resident 44's LALM was noted to be set at 350 lbs. the maximum setting, as indicated on the mattress control panel.During a concurrent interview and record review on [DATE] at 10:55 AM, Resident 44's WVS and CPR were reviewed with the Treatment Nurse (TN), The TN stated that Resident 44's LALM was set at the maximum setting of 350 lbs., which was not appropriate for the resident's current weight of 135 lbs. The TN explained that the LALM was intended to prevent and treat pressure ulcers by redistributing pressure and promoting skin integrity; however, when set too high, it reduced the mattress's ability to provide adequate pressure redistribution, airflow, and moisture control, which were essential in the prevention of skin breakdown and pressure injuries. The TN further stated that excessively high setting could have had the opposite effect, and potentially increased pressure could have contributed to skin breakdown damage rather than protection.During a review of the facility's Policy and Procedure (P&P) titled, Prevention of Pressure Ulcers/Injuries, revision dated 7/2017, the P&P indicated to select appropriate support surfaces based on the resident's mobility, continence, skin moisture and perfusion, body size, weight, and overall risk factors.During a review of the manufacturer's operation manual titled Med-Aire Melody Alternating Pressure Low Air Loss Mattress Replacement System, revision dated [DATE], the manufacturer's operation manual indicated to determine the patient's weight and set the control knob to that weight setting on the control unit.

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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 record review, the facility failed to implement adequate accident prevention interventions for one (1) of (2) sampled residents (Resident 71) by failing to:A. Ensure Resident 71's bed alarm was properly functioning at the time of the fall on [DATE].B. Ensure adequate supervision was provided at the time of Resident 71's fall on [DATE].These deficient practices resulted in Resident 71 sustaining a fall, placing the Resident 71 at increased risk for injury, including potential fractures, head injury, and decline in overall condition. Findings: During a review of Resident 71's admission Record (AR), the AR indicated the facility admitted Resident 71 on [DATE], and readmitted the resident on [DATE], with diagnoses including history of falling, need for assistance with personal care, and dementia (a progressive state of decline in mental abilities). During a review of Resident 71's Care Plan Report (CPR), initiated on [DATE] and revised on [DATE], the care plan indicated the resident may utilize a bed sensor pad alarm due to a history of repeated falls. The care plan directed staff to monitor the bed alarm for proper functioning and placement every shift. Interventions included:Bed alarm and machine will be checked every shift to ensure proper function. Charge nurse will keep bed alarm monitor machine in hand at all times to properly monitor resident outside visual checks. During a review of Resident 71's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated [DATE], the MDS indicated Resident 71's cognition (the ability to think and process information) was severely impaired. The MDS indicated Resident 71 required substantial/maximum assistance (helper does more than half the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and required substantial/maximum assistance with mobility. During a review of Resident 71's Fall Risk Evaluation (FRE), dated [DATE], the FRE indicated that Resident 71 was assessed as a high fall risk. During a review of Resident 71's Change in Condition Evaluation (COCE) for Resident 71, dated [DATE] at 7:20 PM, the COCE indicated Resident 71 had a status post unwitnessed fall and was found seated on the left side of the bed facing the door. The evaluation indicated no change in mental status, no discoloration or bruising, no skin changes, and no change in range of motion of the upper and lower extremities. The resident reported attempting to go to the bathroom independently, losing balance, and falling. The evaluation indicated the resident was educated to request assistance when needed, and Spanish-speaking staff assisted with translation. During a review of the facility's Employee Timecard Report (ETR), dated [DATE], the ETR indicated that Licensed Vocational Nurse 3 (LVN 3) and LVN 4 were both off the unit for a meal break from 7:05 PM to 7:35 PM, as evidenced by their recorded punch-out time of 7:05 PM and punch-in time of 7:35 PM on the ETR. During a review of the facility's Nursing Staff Assignment and Sign-In Sheet (NSASS), dated [DATE], the NSASS indicated that LVN 3 had an assigned scheduled meal break from 7 PM to 7:30 PM, and LVN 4 had an assigned scheduled meal break from 7:30 PM to 8 PM, as documented on the NSASS. During an interview on [DATE] at 4:20 PM, Certified Nursing Assistant 4 (CNA 4) stated that the typical mid-shift staffing assignment consisted of two charge nurses (LVNs) at station 2 and two licensed nurses at station 1 (one Registered Nurse (RN) and one LVN). CNA 4 stated that due to the unit layout, station 1 did not have visibility of all residents' rooms, and certain areas, including the hallway connecting station 2 to the activities room, as well as Resident 71's room (room [ROOM NUMBER]). CNA 4 stated that these areas could only be monitored from station 2. CNA 4 stated that licensed nurses were expected to coordinate meal breaks (beginning approximately around 7 PM through 8 PM) to ensure coverage of at least one licensed nurse at each station. CNA 4 stated that on [DATE] between 07:15 PM and 07:30 PM, while retrieving ice near station 2, the Dietary Aide (DA) alerted her that Resident 71 had fallen in Resident 71's room and Resident 71 was sitting on the floor. CNA 4 stated that no licensed nurse was present at station 2. Upon entering the room, CNA 4 states she (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed Resident 71 seated on the floor next to the bed and stated that the bed alarm did not activate. CNA 4 stated she directed CNA 5 to notify RN 1 and stated that both LVN 3 and LVN 4 were on their lunch break together at the time. CNA 4 stated this had occurred on prior occasions despite discussions, with both nurses leaving the unit together for extended periods without ensuring coverage. CNA 4 stated that the absence of a licensed nurse at station 2 created a risk for delayed response and compromised resident safety. During an interview on [DATE] at 4:50 PM, with LVN 5, LVN 5 stated that the unit staffing assignment consisted of two licensed nurses at station 1 (one RN and one LVN) and two charge nurses (LVNs) at station 2 this ensured resident safety and timely response to emergencies, with an expectation of continuous coverage at both stations. LVN 5 stated that at least one licensed nurse should always be physically present at each station to respond to emergencies, including contacting physicians and administering medications. LVN 5 acknowledged that LVN 3 and LVN 4 occasionally took their meal breaks together while assigned to station 2 and stated that although in-services had been conducted regarding this expectation, the practice continued to occur. LVN 5 further stated that failure to maintain a licensed nurse at station 2 made it difficult for licensed staff at station 1 to provide adequate coverage due to unit layout and visibility limitations, and that licensed nurses were expected to coordinate meal breaks to ensure continuous coverage at each station. During an interview on [DATE] at 3:37 PM, with RN 1, RN 1 stated that licensed nurses were expected to stagger meal breaks to ensure at least one licensed nurse remained at each station at all times for resident safety, medication administration, and emergency response. RN 1 stated that these measures were in place to prevent incidents such as resident falls and could have prevented the fall involving Resident 71. RN 1 stated that he served as the RN Supervisor on [DATE] from 3 PM to 11 PM and was notified by staff that Resident 71 had fallen. RN 1 stated that upon arrival, LVN 4 was already present, and the resident was found sitting on the floor next to her bed. RN 1 confirmed the resident had a high fall risk and had attempted to ambulate without assistance. RN 1 stated that it was not appropriate for both LVNs assigned to station 2 to take their meal breaks at the same time and confirmed that one licensed nurse should have physically remained at the station. RN 1 stated he was not aware that both LVN 3 and LVN 4 had gone to lunch together, and although LVN 4 reported notifying him of her break, he was not informed both nurses would be off the unit simultaneously. RN 1 stated that the absence of both licensed nurses from station 2 created a safety concern and limited the ability to monitor residents and respond timely, particularly as CNAs may be occupied with resident care. RN 1 further stated that although the bed alarm was reportedly in place, it would have been difficult to respond without a licensed nurse physically present at the station. During an interview on [DATE] at 4:07 PM, with LVN 3, LVN 3 stated that she worked on [DATE] from 3 PM to 11 PM and was assigned to Cart 2 at Station 2 as the charge nurse, alongside LVN 4, who was assigned to Cart 3 at station 2. LVN 3 confirmed that Resident 71 sustained a fall and stated the resident was a high fall risk, known to be forgetful, and attempted activities without assistance. LVN 3 stated that although Resident 71 was not her specifically assigned resident, she remained responsible for overall supervision of station 2. LVN 3 stated that licensed nurses were expected to coordinate meal breaks to ensure continuous coverage and were responsible for checking bed alarms each shift. LVN 3 acknowledged that on [DATE], she and LVN 4 took their meal break together and did not notify the RN supervisor prior to leaving the station. LVN 3 stated they were notified of the fall by CNA 5 while on break and that LVN 4 responded immediately. LVN 3 stated she was informed the bed alarm did not activate, possibly due to low batteries, and acknowledged that because both LVNs were on break, even if the alarm had activated, it would not have been identified. LVN 3 stated that a licensed nurse should be physically present at the station at all times to ensure resident safety. LVN 3 acknowledged that she did not ensure licensed nurse coverage at station 2 prior to leaving for her meal break with LVN 4. During a telephone interview on [DATE] at 12:16 PM, with LVN 4, LVN 4 stated that she worked on [DATE] from 3 PM to 11PM and confirmed that she took her meal break at the same time as LVN 3. LVN 4 stated that although she reported notifying the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN Supervisor prior to going on break, she did not ensure that a licensed nurse was physically present to cover station 2 during their absence. LVN 4 acknowledged that the absence of licensed nurse coverage at station 2 created a safety concern, as it limited the ability of licensed nurses at station 1 to adequately monitor both stations, particularly during overlapping meal breaks. LVN 4 stated she was notified by staff that Resident 71 had fallen and responded to assess the resident. LVN 4 stated that the resident did not sustain any injuries, a Change in Condition evaluation was completed, the physician was notified, and new orders were obtained to continue monitoring, including neurological checks. During a review of the facility's Policy and Procedure (P&P) titled, Safety and Supervision of Residents, revised 7/2017, the P&P indicated that the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The P&P indicated: The facility individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. Resident supervision is a core component of the system's approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on interview and record review, the facility did not provide needed dental services for one of one sampled resident (Resident 46) when the Social Service Director (SSD) did not follow up with Resident 46's denture needs.This failure resulted in Resident 46 having feelings of abandonment and had the potential to result in Resident 46 experiencing nutritional deficits and psychosocial decline.Findings:During a review of Resident 46's admission Record (AR), the AR indicated the facility originally admitted Resident 46 on 3/15/2026 with diagnoses including urinary tract infection (an infection that affects any part of the urinary system including the kidneys, ureters, bladder, and urethra) and sepsis (the body's extreme, lifeˆthreatening response to an infection that can lead to organ damage or failure).During a review of Resident 46"s Nursing Progress Note, dated 3/15/2026, the progress note indicated, per [RP] [Resident 46] has loose fitting dentures on the bottom and missing teeth to the top dentures that prevents [Resident 46] from being able to chew effectively.During a review of Resident 46's History and Physical (H&P), dated 3/18/2026, the H&P indicated Resident 46 had the capacity to understand and make decisions.During a review of Resident 46's Minimum Data Set (MDS- a resident assessment tool), dated 3/22/2026, the MDS indicated Resident 46's cognitive (the ability to think and process information) skills for daily decision making were moderately impaired (makes poor decisions requiring cues or supervision). The MDS indicated Resident 46 required partial to moderate assistance with eating, oral and personal hygiene, and upper body dressing, required substantial to maximal assistance with toileting, and lower body dressing and was dependent on showering.During an interview on 4/21/2026 at 11:06 AM with Resident 46, Resident 46 stated Resident 46 had not had dentures for one month and one week. Resident 46 stated someone from the Dental Office (DO) had told Resident 46 that Resident 46 needed new dentures.During an interview on 4/23/2026 at 9:45 AM with Resident 46, Resident 46 stated Resident 46 felt abandoned because Resident 46 has been waiting for the dentures to be fixed. Additionally, Resident 46 stated Resident 46 would like to be able to chew food but could not without dentures.During a concurrent record review and telephone interview on 4/23/2026 at 10:06 AM with the Scheduling Coordinator (SC) for the DO, Resident 46's Dental Notes, dated 3/17/2026, 3/25/2026, and 3/31/2026 were reviewed. The SC stated Resident 46's dental notes indicated recommendations were made to follow up with Resident 46 every 3 months, but no recommendations were made regarding dentures.During an interview on 4/23/2026 at 1:41 PM with the Social Services Director (SSD), the SSD stated there was no documentation in Resident 46's medical record regarding the delay of dentures. Additionally, the SSD stated the SSD did not follow up with the DO regarding Resident 46's dentures.During a review of Resident 46's Order Summary Report (OSR), dated 4/24/2026, the OSR indicated Resident 46 could have a dental consultation for evaluation of dentures with an order date of 3/16/2026.During a review of the facility's Policy and Procedure (P&P) titled, Dental Services, revised December 2026, the P&P's policy statement indicated, Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. The P&P's policy interpretation and implementation indicated, If dentures are damaged or lost, residents will be referred for dental services within 7 days. If the referral is not made within 7 days, documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink adequately while awaiting the dental services; and the reason for the delay.During a review of the facility's P&P titled, Resident Rights Policy, revised 4/15/2026, the P&P's policy statement indicated, The facility is committed to promoting and protecting the rights of each resident. All residents shall be treated with dignity, respect, and equality, and shall be free from abuse, neglect, exploitation, discrimination, and unnecessary restraint. The P&P's purpose indicated, To ensure compliance with federal and state regulations and to establish clear expectations for safeguarding resident rights in all aspects of care and services. The P&P's policy guidelines indicated, Residents have the right to receive care in a manner that enhances quality of life.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055259	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monrovia Post Acute	1220 E. Huntington Drive Duarte, CA 91010

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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 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. Based on observation, interview and record review, the facility failed to ensure two of four kitchen staff (Dietary Supervisor and [NAME] 1) follow the International Dysphagia Diet Standardization Initiative (IDDSI - developed a standard that can be used to describe the characteristics of foods and drinks - from the point of view of a person with swallowing difficulties. To accompany this standard, IDDSI has also developed testing methods to determine if any food or drink conforms to the requirements of the IDDSI Standard) to test pureed food (A diet used in the dietary management of dysphagia with the food texture prepared lump-free, not firm or sticky and holds it shape on a plate. The diet requires no biting or chewing. Any liquids must not separate from the food and the food can fall off a spoon intact. The food is more easily swallowed and prevents aspiration) for 6 residents with orders for pureed - level 4 diet. This deficient practice had the potential for facility to serve pureed food that did not meet the standard characteristics which could potentially put the residents with dysphagia (difficulty swallowing) at risk for choking.Findings:During an observation on 4/23/2026 at 11:35 AM, [NAME] 1 was adding thickener to pureed rice pilaf and performed the spoon test. [NAME] 1 placed less than a spoonful of pureed rice pilaf on to the spoon. when the spoon was tilted, the pureed rice pilaf fell off the spoon right away. During an observation on 4/23/2026 at 11:48 AM, the Kitchen Staff (KS) added pureed food into the blender and blended the pureed pork. [NAME] 1 stated just to make sure there's no lumps on the puree. The KS removed the pureed pork from the blender and [NAME] 1 added the thickener while mixing the pureed food. The Dietary Supervisor performed the spoon test. The DS placed less than a spoonful of pureed pork on the spoon. When the spoon was tilted, the pureed pork easily fell onto the plate below. During an interview on 4/23/2027 at 12:57 PM, [NAME] 1 stated to test pureed food, we would do the spoon test. [NAME] 1 stated, we would check to make sure there were no lumps in the food. [NAME] 1 stated when performing the spoon test, we would tilt the spoon and food should fall off/down. The spoon test would measure the consistency of the pureed food. During a review of the posted IDDSI guidelines for testing Level 4 - Pureed Food and a concurrent interview on 4/23/2026 at 2:46 PM, the guidelines indicated Pureed critical test included two test; Fork Drip Test and the Spoon Tilt Test. The posted guidelines indicated at the bottom Must meet all critical test standards for 30 minutes after serving. The DS stated the [NAME] 1 and the DS only used the Spoon Tilt Test to test pureed food, but they used the Fork Drip Test yesterday. The DS stated the DS was not aware they needed to use both Fork Drip Test and Spoon Tilt Test to test pureed food. The DS checked the posted IDDSI guidelines and verified that the posted IDDSI guidelines indicated food must meet all critical test standards. During a review of the facility's Diet Type Report dated 4/23/2026, the report indicated there were six of 74 residents with orders for Pureed - Level 4 diet. During a review of the IDDSI Framework Testing Methods, the framework indicated it is safest to test pureed food using the IDDSI Fork Drip Test and the IDDSI Spoon Tilt Test. The IDDSI Fork Drip Test indicated the liquid does not dollop or drip continuously through the fork prongs, a small amount may flow through and form a tail below the fork. The IDDSI Spoon Tilt Test indicated sample holds its shape on the spoon and falls off fairly easily if the spoon is tilted or lightly flicked. The sample should not be firm or sticky. During a review of the facility's Policy and Procedure (P&P) titled, Dysphagia Textures - Puree IDDSI Level 4, the P&P indicated puree items may or may not need any thickening agent depending on the food processing tool used and the water content of the food item. Gel or cornstarch or thickeners may be used to reach the required pureed texture. The HPSI recipes primarily incorporate the cornstarch-based thickener products. Follow the IDDSI Framework and suggested testing methods prior to service of pureed products to ensure the pureed products meet the IDDSI standards for pureed foods. The P&P indicated all prepared pureed recipes should be tested prior to service to ensure the texture meets the IDDSI guidelines. They should pass the Fork Drip Test and the Spoon Tilt Test. The P&P indicated We (continued on next page)

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	055259	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monrovia Post Acute	1220 E. Huntington Drive Duarte, CA 91010

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommend using water in the preparation of puree recipes as utilizing water will not alter the nutritional composition. However, broth, milk or juice may also be used.

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	055259	A. Building B. Wing	04/24/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure thawed bacon inside one of two refrigerators (Refrigerator 2) was labeled with a thaw date for dietary staff to follow recommended maximum storage period. This deficient practice had the potential to cause food borne illness that could potentially affect the residents at the facility.Findings:During an observation on 4/21/2026 at 9:10 AM, there were two refrigerators. The second refrigerator had 1 opened box of bacon with a full bag of thawed bacon inside the box. The box had the following information written outside the box: Received date: 4/2/2026, use by date: 7/1/2026, and opened date: 4/6/2026. There was no thawed date indicated or written on the box. During a review of the facility's guidelines posted inside the kitchen and a concurrent interview on 4/21/2026 at 9:16 AM, the posted guidelines indicated thawed bacon had a maximum storage period of one to two weeks. The Dietary Supervisor (DS) stated the kitchen staff would not know if the bacon would meet the recommended maximum storage period of 1-2 weeks since there was no information when the bacon was thawed. The DS stated the importance of following recommended storage guidelines would be to prevent foodborne illness to the residents. During a review of the facility's Policy and Procedure (P&P) titled, Food Receiving and Storage, dated November 2022. The P&P indicated foods shall be received and stored in a manner that complies with safe food handling practices. The P&P indicated Critical Control Point means a specific point, procedure, or step in food preparation and serving process at which control can be exercised to reduce, eliminate, or prevent the possibility of a food safety hazard. Some operational steps that are critical to control in facilities to prevent or eliminate food safety hazards are thawing, cooking, cooling, holding, reheating foods.The P&P indicated refrigerated foods are labeled, dated and monitored so they are used by their use-by' date, frozen or discarded.