STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055262	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lomita Post-Acute Care Center	1955 Lomita Blvd Lomita, CA 90717

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure two of four sampled residents (Resident 25 and Resident 35) were free from unnecessary psychotropic medications (any drug that affects brain activity related to mental processes and behavior) by failing to:1. Ensure an appropriate diagnosis and evaluation was conducted for Resident 35 before starting the treatment with Seroquel ([generic name - quetiapine] a medication used to treat schizophrenia [a mental illness that is characterized by disturbances in thought], bipolar disorder [sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs] and as an adjunct treatment option for depression (a serious mood disorder causing persistent sadness and loss of interest, affecting thoughts, feelings, and daily activities). 2.Ensure Resident 25 who was taking Lexapro (antidepressant - medicine used to treat depression) had a diagnosis of depression (serious mood disorder causing persistent sadness, loss of interest in activities which affects daily life) and was evaluated by a psychiatrist(medical doctor who specializes in mental health, diagnosing and treating mental, emotional, and behavioral disorders) for the use of Lexapro after admission to the facility on [DATE]. These failures had the potential to put Resident 25 and Resident 35 at risk for adverse consequences (unintended, harmful events attributed to the use of medication) from the use of unnecessary psychotropic drug for an extended period, which could result in impairment or decline in the resident's mental, physical condition, functional, and psychosocial status. Findings: 1. During a review of Resident 35's admission Record (a document containing demographic and diagnostic information), dated 12/10/2025, the admission record indicated Resident 35 was admitted to the facility on [DATE] with diagnoses that included but not limited to unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, with other behavioral disturbance and history of falling. During a review of Resident 35's History and Physical (H&P), dated 12/1/2025 and 12/9/2025, the H&P indicated Resident 35 with an assessment for dementia, unable to give history mostly nonverbal baseline, on Seroquel at bedtime. The H&P did not indicate any diagnosis of psychiatric (mental) or mood disorders. During a review of Resident 35's Minimum Data Set (MDS resident assessment tool), dated 11/17/2025, the MDS indicated Resident 35's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was severely impaired. The MDS indicated Resident 35 needed moderate assistance from the facility staff for activities of daily living (ADLs) such as eating, dependent on the facility staff for oral hygiene, toileting hygiene, upper and lower body dressing, putting on or taking off footwear, personal hygiene, and not attempted to shower due to medical condition or safety concerns. The MDS indicated Non-Alzheimer's Dementia as one of (continued on next page)

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the diagnoses for Resident 35. The MDS did not indicate any diagnoses for psychiatric disorders such as schizophrenia, bipolar disorder or depression. During a review of Resident 35's Order Summary Report (a document containing a summary of all active physician orders), dated 12/10/2025 and 12/1/2025, the Order Summary Report indicated but not limited to the following physician orders: Monitor episodes of psychotic behavior (adverse event behavior) behavior (quetiapine) every shift, order date 11/14/2025, start date 11/14/2025 Quetiapine Fumarate oral tablet 25 mg, give 1 tablet by mouth at bedtime for psychosis (involves a loss of contact with reality) manifested by (m/b) agitation, order date 11/21/2025, start date 11/21/2025 During a review of Resident 35's Medication Administration Record ([MAR] a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 12/1/2025 to 12/10/2025, the MAR indicated quetiapine fumarate 25 mg oral tablet was documented give one tablet by mouth at bedtime for psychosis m/b agitation as administered nine times from 12/1/2025 to 12/9/2025 at 9:00 p.m. During a review of Resident 35's MAR, dated 11/1/2025 to 11/30/2025, the MAR indicated quetiapine fumarate 25 mg oral tablet was documented give two tablets by mouth at bedtime for dementia with psychosis m/b agitation as administered six times. During a concurrent interview and record review on 12/11/2025 at 10:40 a.m. with Registered Nurse Supervisor (RNS) 1, the order details for Resident 35's quetiapine, care plan, diagnoses and other chart details were reviewed. The order details dated 12/11/2025 indicated, Quetiapine Fumarate Oral Tablet 25 MG (Quetiapine Fumarate), give 1 tablet by mouth at bedtime for psychosis m/b agitation. RNS 1 stated Resident 35 did not have a specific diagnosis for quetiapine use, except that she had a diagnosis of dementia psychosis. RNS 1 stated there was a psychotropic evaluation on 11/14/2025, which did not indicate any assessment or notes, except that Resident 35 was on quetiapine 50 mg and family did not have issues. RNS 1 stated there were no specific behaviors being monitored or documented due to psychosis such as getting out of bed unassisted. RNS 1 stated the facility did not follow the Care Plan, dated 11/25/2025 that indicated, Focus: antipsychotic medication use related to (quetiapine) dementia with psychosis m/b agitation; Interventions: Elderly patients with dementia-related psychosis treated with antipsychotic (a type of medication prescribed to treat mental health problem) drugs are at an increased risk of death. Quetiapine is not approved for the treatment of patients with dementia-related psychosis. Document episodes of behavior. During an interview on 12/11/2025 at 2:15 p.m. with the Director of Nursing (DON), the DON stated Resident 35 was placed on Seroquel for psychosis manifested by agitation. The DON stated there should have been a diagnosis based on an evaluation by a psychiatrist (medical doctor specializing in mental health, qualified to diagnose, treat, and prevent mental, emotional, and behavioral disorders). The DON stated the diagnosis needed additional information besides just psychosis and agitation. The DON stated that the facility would ask residents and/or their families about the medications they were taking and the reasons for use, then compare this information with hospital orders. She stated that hospital records only listed a diagnosis of dementia, while Seroquel (quetiapine) was prescribed for psychosis. The DON stated that the care plan indicated quetiapine should not be used in elderly patients with dementia due to an increased risk of death. She stated that Seroquel was unnecessary (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	without a proper psychiatric evaluation, as its use could increase mortality risk in elderly residents such as Resident 35. The DON further stated that Resident 35 could experience altered mental function and other unintended side effects. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medications, dated 5/2007, the P&P indicated, The Licensed Nurses (LN) shall review the classification of the drug, the appropriateness of the diagnosis, its indication, behavior monitors and related adverse side effects prior to verification of admission orders with the Attending Physician. The P&P indicated, The Social Services (SSD) and/or nursing designee will be responsible for initiating the resident's individualized, person-centered psychosocial plan of care, based on their comprehensive initial admission assessment. Upon initial comprehensive assessment, the SSD designee shall review new admissions for any psychiatric, mood or behavior disorders, mental and psychosocial difficulties, and/or. orders. The facility's Interdisciplinary Team (IDT) will review to ensure: a. Psychotropic medication was prescribed to treat a specific diagnosed condition, as documented in the clinical record; b.g. Review of plan of care shows individualized, person-centered care approaches to manage behavior with non-pharmacological interventions; h appropriate. During a review of the facility's P&P titled, Resident Assessments, dated 11/2016, the P&P indicated, It is the policy of this facility that resident will be assessed, and the findings documented in their clinical health record. These will be comprehensive, accurate. conducted initially and periodically as part of . functional and health status, and strengths and needs will be identified. The P&P indicated, An accurate Comprehensive Assessment will be made.include at least the following: Mood and behavior patterns, Psychological well-being. 2.During a review of Resident 25's admission Record, the admission Record indicated Resident 25 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease(a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), delirium(a serious disturbance in a person's mental abilities that results in a decreased awareness of one's environment and confused thinking), and unspecified psychosis. The admission Record indicated no diagnosis of depression. During a review of Resident 25's MDS dated [DATE], the MDS indicated Resident 25 had severely impaired cognitive skills and required substantial/maximal assistance (helper does more than half the effort to complete the activity) with transfer from bed to chair and bed mobility. The MDS indicated Resident 25 was on anti-depressant, but no diagnosis of depression was documented. During a review of Resident 25's Order Summary Report dated 11/25/2025, the Order Summary Report indicated an order of Escitalopram Oxalate 5 milligrams (mgs. - unit of measurement) one tablet by mouth one time a day for depression manifested by little interest in doing things. During a review of Resident 25's Care Plan titled, Antidepressant medication use related to depression manifested by little interest in doing things, initiated on 12/10/2025. The Care Plan goal indicated the resident will be free from discomfort and adverse reactions (a harmful, unintended response to a medicine). The Care Plan indicated interventions including giving antidepressant as ordered by the physician and monitoring/ documenting side effects and effectiveness. During a concurrent interview and record review on 12/10/ 2025, at 1:06 p.m. with the Minimum Data Set Coordinator (MDSC), Resident 25's MDS dated [DATE], progress notes, and history and physical (H&P) from the general acute hospital (GACH) dated 11/15/ 2025, were reviewed. The MDSC stated (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that Resident 25 was receiving Lexapro from the GACH, but she did not see a diagnosis of depression in the H&P during her assessment. MDSC stated that the MDS dated 11/30/ 2025, did not include a depression diagnosis, although she coded antidepressant use in the MDS because the resident was receiving the medication. The MDSC stated there was no evidence of a psychiatric consultation for the resident while receiving psychotropic medications. She added that the licensed nurse should have clarified the diagnosis for Lexapro use with the Resident 25's physician at admission. The MDSC stated that without a proper diagnosis and indication for use, the resident could experience adverse effects from the medication. During an interview on 12/11/2025, at 12:47 p.m. with the Director of Nursing (DON), the DON stated that when a resident was admitted on psychotropic medications from the GACH and those medications were continued in the facility, the resident should be evaluated by a psychiatrist. The DON stated confirming a proper diagnosis and indication for Lexapro ensures the medication was appropriate for the resident's condition and that the resident receives proper treatment. The DON stated psychotropic medications can induce psychosis and may cause side effects such as drowsiness, dry mouth, and rash. The DON stated that these medications can be unnecessary if not clinically indicated for the resident's diagnosis. During a review of facility's P&P titled, Chemical Restraints and Psychotropic Medication Management, dated 4/2025, the P&P indicated psychotropic medicines are administered only to treat the resident's medical symptoms and the decision to prescribe, continue to prescribe and administer medications are based on the comprehensive assessment of the resident. The P&P indicated the specific condition requiring the use of psychotropic medication is diagnosed and documented in the clinical record.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to provide services to improve or maintain range of motion ([ROM] full movement potential of a joint) for two of eight sampled residents (Residents 52 and 65) with ROM concerns by failing to: 1. Objectively measure Resident 65's limited finger ROM of the left hand during the Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Evaluation, dated 3/25/2025.2. Provide ROM exercises to Resident 65's right knee during a Restorative Nursing Aide (RNA, nursing aide program that helps residents maintain any progress made after therapy intervention to maintain their function) session in accordance with physician's orders.3. Provide RNA ROM exercises to Resident 65's both arms and both legs, three (3) times a week, and apply a splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) to Resident 65's left hand for two (2) to four (4) hours, 4 times a week in accordance with physician's orders.4. Provide RNA ROM exercises to Resident 52's both arms and both legs, 3 times a week in accordance with physician's orders.These failures had the potential for Resident 52 and Resident 65 to experience a further decline in ROM resulting in contracture (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) development and have a decline in physical functioning, mobility (ability to move), and activities of daily living (ADL, basic activities such as eating, dressing, toileting). Findings:A. During a review of Resident 65's admission Record, the admission Record indicated the facility admitted Resident 65 on 11/7/2019 with diagnoses including a left-hand contracture, left hemiplegia (weakness to one side of the body), and chronic obstructive pulmonary disease (lung disease that causes obstruction of airflow and can limit normal breathing).During a review of Resident 65's Minimum Data Set (MDS, resident assessment tool), dated 9/5/2025, the MDS indicated Resident 65 had severe cognitive (mental action or process of acquiring knowledge and understanding) impairment. The MDS indicated Resident 65 required substantial/maximal assistance (helper does more than half the effort) in oral and personal hygiene, setup or clean-up assistance (helper sets up or cleans up and resident completes the activity) with eating, and was dependent (helper does all the effort) in toileting hygiene, bathing, dressing, and rolling to both sides. During a review of Resident 65's Order Summary Report, the Order Summary Report indicated a physician order, dated 6/20/2024, for RNA to provide active assistive ROM ([AAROM] movement at a given joint with a person's own effort and assistance from an external force or another person) exercises to Resident 65's right arm, 3 times a week.During a review of Resident 65's Order Summary Report, the Order Summary Report indicated a physician order, dated 6/20/2024, for RNA to provide passive ROM (PROM, movement at a given joint with full assistance from another person) exercises to Resident 65's left arm, 3 times a week.During a review of Resident 65's Order Summary Report, the Order Summary Report indicated a physician order, dated 8/2/2024, for RNA to provide PROM exercises to Resident 65's both legs, 3 times a week. During a review of Resident 65's OT Evaluation, dated 3/25/2025, the OT Evaluation indicated Resident 65's ROM of the left hand was impaired. The OT Evaluation indicated Resident 65's ROM of the left thumb, index finger (pointer finger), middle finger, ring finger, and little finger were impaired.During a review of Resident 65's Order Summary Report, the Order Summary Report indicated a physician order, dated 3/25/2025, for RNA to apply a splint to Resident 65's left wrist for 2 to 4 hours, 4 times a week.During a review of Resident 65's June 2025 RNA flowsheet (daily record of RNA services provided for each month), the RNA flowsheet indicated for the RNA to provide the following interventions for Resident 65: 1) AAROM exercises to Resident 65's right arm, 3 times a week 2) PROM exercises to Resident 65's both legs and left arm, 3 times a week and 3) application of a resting hand splint (RHS, splint secured from the hand to the forearm to position the hand in a functional position) to Resident 65's left hand for 2 to 4 hours, 4 times a week. The squares on the RNA flowsheet were blank on the following days: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/1/2025, 6/4/2025 to 6/17/2025, 6/20/2025 to 6/22/2025, 6/28/2025 to 6/30/2025.During a review of Resident 65's July 2025 RNA flowsheet, the RNA flowsheet indicated for the RNA to provide the following interventions for Resident 65: 1) AAROM exercises to Resident 65's right arm, 3 times a week 2) PROM exercises to Resident 65's both legs and left arm, 3 times a week and 3) application of a RHS to Resident 65's left hand for 2 to 4 hours, 4 times a week. The squares on the RNA flowsheet were blank on the following days: 7/2/2025, 7/3/2025, 7/5/2025, 7/6/2025, 7/11/2025 to 7/13/2025, 7/19/2025 to 7/21/2025, and 7/23/2025 to 7/27/2025.During a review of Resident 65's August 2025 RNA flowsheet, the RNA flowsheet indicated for the RNA to provide the following interventions for Resident 65: 1) AAROM exercises to Resident 65's right arm, 3 times a week 2) PROM exercises to Resident 65's both legs and left arm, 3 times a week and 3) application of a RHS to Resident 65's left hand for 2 to 4 hours, 4 times a week. The squares on the RNA flowsheet were blank on the following days: 8/1/2025 to 8/5/2025, 8/8/2025 to 8/10/2025, 8/12/2025, 8/14/2025 to 8/17/2025, 8/22/2025 to 8/24/2025, 8/26/2025, 8/27/2025, and 8/29/2025 to 8/31/2025. 1. During an observation of an RNA session on 12/10/2025 at 10:51 am in Resident 65's room, Resident 65 was lying in bed. Resident 65's left arm was resting by her side with the left elbow straight, the forearm rotated downwards, the wrist fully bent downwards, and the hand in a fist. Restorative Nursing Aide 1 (RNA 1) assisted with AAROM exercises to Resident 65's left shoulder and left elbow. RNA 1 tried to open Resident 65's left hand by straightening the fingers but was unable. Resident 65 yelled, not my hand! and requested RNA stop the ROM exercises because it was ticklish and painful. RNA 1 applied a splint to Resident 65's left arm which extended from Resident 65's forearm to the palm of the hand. During a concurrent record review and interview on 12/11/2025 at 10:23 am with the Director of Rehabilitation (DOR), the DOR reviewed Resident 65's therapy notes. The DOR stated PTs and OTs used goniometers (instrument used for the precise measurement of angles) to measure joint mobility to objectively (unbiased, based on facts) determine a resident's baseline ROM and detect changes in joint ROM. The DOR reviewed Resident 65's OT Evaluation, 3/25/2025, and confirmed Resident 65's ROM of the left hand was impaired. The DOR stated Occupational Therapist 1 (OT 1) completed Resident 65's OT Evaluation and did not use a goniometer to measure the joints of Resident 65's fingers on the left hand but should have because Resident 65 had ROM limitations. The DOR stated Resident 65's baseline ROM of the fingers of the left hand were not determined because the ROM limitations were not measured with a goniometer. The DOR stated lack of objective ROM measurements had the potential to negatively impact the staff's ability to detect changes such as improvements or declines in Resident 65's ROM. During a concurrent record review and interview on 12/11/2025 at 1:19 pm with OT 1, OT 1 reviewed Resident 65's therapy notes. OT 1 stated Physical Therapists ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) and OTs used goniometers to measure joint mobility to objectively determine a resident's baseline ROM and detect changes in joint ROM. OT 1 reviewed Resident 65's OT Evaluation, 3/25/2025, and confirmed Resident 65's ROM of the left hand was impaired. OT 1 stated she did not use a goniometer to measure the joints of Resident 65's fingers on the left hand but should have because Resident 65 had ROM limitations. OT 1 stated it was important to objectively measure joint limitations using a goniometer on the OT Evaluation to establish a ROM baseline as it affected staff's ability to monitor for changes in ROM.During an interview on 12/11/2025 at 2:51 pm with the Director of Nursing (DON), the DON stated the facility provided RNA and Rehabilitation (Rehab) services to maintain, improve, and prevent declines in ROM for the residents in the facility. The DON stated the facility monitored changes in ROM by joint mobility assessments (JMA, a brief assessment of a resident's ROM in both arms and both legs), report from Rehab and/or nursing, and observations during RNA sessions and daily care. The DON stated it was important for staff to objectively measure ROM during ROM evaluations to ensure staff could identify if the treatment and services provided were effective or needed adjustments. The DON stated the lack of objective ROM measurements for joints with limited ROM resulted in a lack of baseline assessments and inability to monitor for (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	changes in ROM which could result in a functional decline. 2. During an observation of an RNA session on 12/10/2025 at 10:51 am in Resident 65's room, Resident 65 was lying in bed. Resident 65's left arm was resting by her side with the left elbow straight, the forearm rotated downwards, the wrist fully bent, and the hand in a fist. Restorative Nursing Aide 1 (RNA 1) assisted with AAROM exercises to Resident 65's left arm, applied a left wrist splint, and assisted with AAROM to Resident 65's right arm. Resident 65's both legs were fully straight at both hips and both knees and the toes of both feet were pointing downwards. RNA 1 assisted with PROM exercises to Resident 65's right hip and right ankle. Resident 65 stated both of her legs felt very stiff. RNA 1 did not assist with PROM exercises to Resident 65's right knee. RNA 1 moved to the right side of the bed and assisted Resident 65 with PROM exercises to Resident 65's left hip, left knee, and left ankle. During an interview on 12/10/2025 at 11:10 am with RNA 1, RNA 1 confirmed Resident 65 had RNA orders for PROM exercises to Resident 65's both legs which meant assisting Resident 65 with ROM exercises to the entire leg, including the hips, knees, and ankles. RNA 1 confirmed she did not assist with ROM exercises to Resident 65's right knee as ordered because she forgot. RNA 1 stated Resident 65 required encouragement and assistance with ROM exercises to both arms and both legs because Resident 65's joints were very stiff, and she required total assistance for mobility. RNA 1 stated she should have assisted Resident 65 with right knee ROM exercises as ordered but did not. RNA 1 stated Resident 65 could have a decline in ROM if RNA exercises were not provided as ordered.\During an interview on 12/11/2025 at 10:23 am with the DOR, the DOR stated the purpose of the RNA program was to maintain and improve a resident's functional level and ROM. The DOR stated Rehab determined the types of exercises RNAs were to perform when creating an RNA program. The DOR stated if an RNA order was written for ROM exercises to both legs, it was expected the RNA provides ROM to the entire leg, which included the hips, knees, and ankles. The DOR stated if RNA did not provide RNA services as ordered, it could potentially result in a decline in ROM and contracture development.During an interview on 12/11/2025 at 2:51 pm with the DON, the DON it was important for RNA to provide exercises as ordered to ensure the residents in the facility maintained their level of function and to prevent potential declines in mobility and contracture development. 3. During a concurrent observation and interview on 12/10/2025 at 11:28 am with Resident 65, Resident 65 was lying in bed. Resident 65's left arm was fully straight at the elbow, the wrist bent downwards, and the fingers were bent into a fist. Resident 65 was wearing a splint that extended from Resident 65's forearm to the palm of the hand. Resident 65's both legs were fully straight at both hips and both knees with the toes of both feet pointing downwards. Resident 65 stated her entire body, including her arms and legs, felt very stiff and needed assistance with exercises and mobility since she was bedridden. Resident 65 stated staff did not regularly assist with exercises and left wrist splint application.During a concurrent record review and interview on 12/10/2025 at 5:21 pm with the Director of Staff Development (DSD), the DSD stated she supervised the RNAs. The DSD stated the purpose of the RNA program was to ensure the residents in the facility received exercises to prevent joint stiffness and contractures. The DSD reviewed Resident 65's June 2025, July 2025, and August 2025 RNA flowsheets and physician's orders. The DSD confirmed Resident 65 had physician's orders for RNA to provide AAROM exercises to Resident 65's right arm, 3 times a week, PROM exercises to Resident 65's both legs and left arm, 3 times a week, and apply a RHS to Resident 65's left hand for 2 to 4 hours, 4 times a week. The DSD stated a blank square on the RNA flowsheet indicated Resident 65 was not seen for RNA treatment that day. The DSD confirmed Resident 65 missed five (5) RNA sessions for ROM exercises to both arms and both legs and eight (8) RNA sessions for left RHS application in the month of June 2025. The DSD confirmed Resident 65 missed 2 RNA sessions for ROM exercises to both arms and both legs and application of the left RHS application in the month of July 2025. The DSD confirmed Resident 65 missed 3 RNA sessions for ROM exercises to both arms and both legs and six (6) RNA sessions for left RHS application for the month of August 2025. The DSD stated Residents 65 did not receive RNA treatments as ordered by the physician. The DSD stated (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	it was important for RNA to provide services as prescribed by the physician because missed treatments could place residents at risk for a functional decline in ROM, ADLs, and contracture development. During an interview on 12/11/2025 at 2:51 pm with the DON, the DON stated the purpose of the RNA program was to ensure the residents in the facility maintained their level of function and to prevent any functional declines. The DON stated missed RNA treatments could potentially cause a resident to have a functional decline and develop contractures. B. During a review of Resident 52's admission Record, the admission Record indicated the facility admitted Resident 52 on 12/19/2022 with diagnoses including left hemiplegia and hemiparesis (inability to move one side of the body) following a cerebral infarction (stroke, blockage of the flow of blood brain, causing or resulting in brain tissue death) and dysphagia (difficulty swallowing).During a review of Resident 52's Order Summary Report, the Order Summary Report indicated two physician orders, dated 5/20/2024, for: 1) RNA to provide AAROM exercises to Resident 52's both legs, 3 times a week and 2) RNA to provide AAROM exercises to Resident 52's both arms, 3 times a week.During a review of Resident 52's June 2025 RNA flowsheet, the RNA flowsheet indicated for the RNA to provide AAROM to Resident 52's both arms and both legs, 3 times a week. The squares on the RNA flowsheet were blank on the following days: 6/1/2025, 6/4/2025 to 6/17/2025, 6/20/2025 to 6/22/2025, 6/28/2025 to 6/30/2025.During a review of Resident 52's July 2025 RNA flowsheet, the RNA flowsheet indicated for the RNA to provide AAROM to Resident 52's both arms and both legs, 3 times a week. The squares on the RNA flowsheet were blank on the following days: 7/3/2025, 7/5/2025, 7/6/2025, 7/11/2025 to 7/13/2025, 7/19/2025 to 7/21/2025, and 7/23/2025 to 7/27/2025. During a review of Resident 52's August 2025 RNA flowsheet, the RNA flowsheet indicated for the RNA to provide AAROM to Resident 52's both arms and both legs, 3 times a week. The squares on the RNA flowsheet were blank on the following days: 8/1/2025 to 8/10/2025, 8/16/2025, 8/17/2025, 8/19/2025, 8/22/2025, 8/24/2025, 8/26/2025, 8/27/2025, and 8/29/2025 to 8/31/2025.4.During a concurrent observation and interview on 12/9/2025 at 1:30 pm with Resident 52 in Resident 52's room, Resident 52 was sitting in a wheelchair watching television. Resident 52 stated staff did not assist with ROM exercises. Resident 52 raised the left arm to shoulder height. Resident 52 minimally lifted the left leg off the wheelchair leg rest, was unable to fully straighten the left knee, and moved the left ankle up and down minimally. During a concurrent record review and interview on 12/10/2025 at 5:21 pm with the DSD, the DSD stated she supervised the RNAs. The DSD stated the purpose of the RNA program was to ensure the residents in the facility received exercises to prevent joint stiffness and contractures. The DSD reviewed Resident 52's June 2025, July 2025, and August 2025 RNA flowsheets and physician's orders. The DSD confirmed Resident 52 had physician's orders for RNA to provide AAROM exercises to Resident 65's both arms and both legs, 3 times a week. The DSD stated a blank square on the RNA flowsheet indicated Resident 52 was not seen for RNA treatment that day. The DSD confirmed Resident 52 missed RNA sessions for AAROM for both arms and both legs 5 times in the month of June 2025, 2 times in the month of July 2025, and 4 times in the month of August 2025. The DSD stated Residents 52 did not receive RNA treatments as ordered by the physician. The DSD stated it was important for RNA to provide services as prescribed by the physician because missed treatments could place residents at risk for a functional decline in ROM, ADLs, and contracture development. During an interview on 6/13/2024 at 1:55 p.m., the DON stated the purpose of the RNA program was to maintain and/or improve a resident's current level of function and prevent declines in ROM and functional mobility. The DON stated missed RNA treatments could potentially cause a resident to experience a decline in overall function and mobility. During a review of the facility's policy and procedure (P/P) titled, ROM and Contracture Prevention, revised 5/2019, the P/P indicated the facility would ensure that management of resident joint mobility was provided by an interdisciplinary team approach of assessment, care planning, and preventative or rehabilitative measures. The P/P indicated it was the policy of the facility to ensure that residents received services, care, and equipment to ensure that every resident maintained and/or improved to his or her highest level of (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ROM and mobility unless clinically unavoidable. The P/P indicated all residents would have a comprehensive baseline assessment performed to identify contracture problems or a predisposition. The P/P indicated an interdisciplinary care plan was developed to maintain or increase joint mobility and the implementation of the program was to be carried out by the appropriate personnel in skilled rehab, routine therapy, restorative nursing or Certified Nursing Assistant staff. The P/P indicated the appropriate documentation was completed to address goals of the program and resident tolerance to the program. During a review of the facility's undated P/P titled, Restorative Program, the P/P indicated the Restorative Program was designed to restore or maintain a resident's mobility skills to maximum independence and safety and to prevent loss of function in existing functional abilities. The P/P indicated the Restorative Program reduced the risk for decline in ADLs, maintained existing mobility and ROM, and worked in conjunction with the therapy department. The P/P indicated residents required a physician's order for participation in the restorative program and the appropriate exercises would be ordered by the physician and determined with the assistance of nursing.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5% (percent) during medication pass, affecting four of five sampled residents (Residents 11, 29, 18 and 35) by failing to:1. Administer Resident 11's ferrous sulfate (a medication used to treat low levels of iron) within one hour of its prescribed time as per facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2019.2. Administer Resident 29's ferrous sulfate within one hour of its prescribed time as per facility's P&P titled, Administering Medications, dated 4/2019.3. Ensure Resident 18's lidocaine patch (a medication in the form of a patch used to treat inflammation and pain) was dated with the date of application and removed after 12 hours of application, in accordance with manufacturer specifications.4. Ensure the facility's licensed nurse did not crush and mix Resident 35's acetaminophen (a medication used to treat fever and pain) and aspirin (a medication used to prevent blood clots) together prior to medication administration, as per facility's P&P titled, PH 1 Medication Administration, undated. These deficient practices of medication error rate of 16.67% exceeded the five (5) percent threshold, increased the risk of anemia, local site reactions such as skin irritation, redness, and burning, drug interactions (occur when two or more drugs taken simultaneously affect each other's actions in the body) or intolerability to one or more medications without possibly knowing which medication caused intolerability, for Residents 11, 18, 29 and 35.Findings:1. During a review of Resident 11's admission Record (a document containing demographic and diagnostic information), dated 12/9/2025, the admission Record indicated Resident 11 was admitted to the facility on [DATE] with diagnosis that included but not limited to unspecified anemia (a condition where the body does not have enough healthy red blood cells).During a review of Resident 11's History and Physical (H&P), undated, the H&P indicated Resident 11 had the capacity to understand and make decisions.During a review of Resident 11's Minimum Data Set (MDS -resident assessment tool), dated 9/29/2025, the MDS indicated Resident 11's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was moderately impaired. The MDS indicated Resident 11 needed setup or clean-up assistance from the facility staff in performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, oral hygiene and upper body dressing, and supervision assistance for toileting hygiene, showering, lower body dressing, putting on/taking off footwear and personal hygiene. During a concurrent observation and interview on 12/9/2025 at 9:37 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 prepared and administered the following four oral medications to Resident 11. LVN 2 checked Resident 11's blood pressure and heart rate, and stated Resident 11's BP was 136/74 millimeters of mercury (mm/HG- unit of pressure) and heart rate (HR) was 82 beats per minute.a. One tablet of ferrous sulfate 325 milligrams ([mg] a unit of measurement for mass)b. One tablet of vitamin D (a vitamin supplement used to treat low levels of vitamin D) 25 micrograms ([mcg] a unit of measurement for mass)c. One tablet of metoprolol succinate (a medication used to treat high blood pressure and heart problems) extended release (ER - a medication formulation that is designed to release its active ingredient slowly over a prolonged period) 25 mgd. One tablet of multivitamins with minerals (a vitamin supplement used to treat low levels of vitamins and minerals)During a medication reconciliation review on 12/9/2025 at 11:52 a.m., Resident 11's Order Summary Report (a document containing a summary of all active physician orders) dated 12/9/2025 was reviewed. The Order Summary report and order details indicated the following physician order was scheduled to be administered daily at 7:15 a.m.: Ferrous Sulfate tablet 325 mg (65 elemental iron), give 1 tablet by mouth two times a day for anemia, order date 3/25/2025, start date 3/26/2025The order summary report indicated the following medications to be administered at 9:00 a.m.: Cholecalciferol (vitamin D) tablet 1000 units (a unit of measurement for mass) (25 mcg), give 1 tablet by mouth one time a day for nutritional supplement, order date (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/28/2025, start date 7/29/2025 Metoprolol Succinate ER tablet extended release 24-hour 25 mg, give 1 tablet by mouth one time a day for hypertension (high blood pressure) hold if systolic blood pressure ([SBP] the blood pressure reading measuring the force of blood against artery walls when the heart contracts (beats) to pump blood out) below 110 mmHg or HR below 60, order date 3/25/2025, start date 3/26/2025. Multivitamin-minerals oral tablet, give 1 tablet by mouth in the morning for supplement, order date 3/25/2025, start date 3/26/2025. During a concurrent interview and record review on 12/9/2025 at 12:15 p.m. with LVN 2, the electronic medication administration record (eMAR) for Resident 11's ferrous sulfate 325 mg dated 12/9/2025 was reviewed. The eMAR indicated that ferrous sulfate 325 mg (65 mg elemental iron) was scheduled to be administered on 12/9/2025 at 7:15 a.m. and it was administered on 12/9/2025 at 10:00 a.m. LVN 2 stated the ferrous sulfate was supposed to be administered at 7:15 a.m. and it was administered late on 12/9/2025 at 10:00 a.m. LVN 2 stated ferrous sulfate should have been given with breakfast at 7:15 a.m. for better absorption and administering it late could cause low hemoglobin ([Hgb] an iron-containing protein in red blood cells that carries oxygen from the lungs to the body's tissues and brings carbon dioxide back) levels for Resident 11. 2. During a review of Resident 29's admission Record, dated 12/9/2025, the admission Record indicated Resident 29 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to unspecified anemia. During a review of Resident 29's MDS, dated [DATE], the MDS indicated Resident 29's cognition was moderately impaired. The MDS indicated Resident 29 needed setup or clean-up assistance from the facility staff in performing ADLs such as eating and personal hygiene, supervision assistance for oral hygiene, maximal assistance for upper body dressing and dependent on facility staff for toileting hygiene, showering, lower body dressing and putting on or taking off footwear. During a concurrent observation and interview on 12/9/2025 at 10:07 a.m., LVN 2 prepared and administered the following 11 oral medications to Resident 29. LVN 2 stated Resident 29's BP was 148/88 mmHg and HR was 86.a. One tablet of ferrous sulfate 325 mg (elemental iron 65 mg)b. One tablet of aspirin (a medication used to prevent blood clots) 81 mg enteric coatedc. One capsule of docusate sodium (a medication used to treat constipation) 100 mgd. One tablet of cranberry 450 mge. One tablet of multivitaminf. One and one-half tablet (15 mg) of baclofen (a medication used to treat spasms) 10 mgg. One tablet of clonidine (a medication used to treat high blood pressure) 0.1 mg, hold if SBP less than 110 mmHgh. One tablet of furosemide (a medication used to remove excessive fluid from body and treat high blood pressure) 20 mg, hold if SBP less than 110 mmHgi. One tablet of amlodipine (a medication used to treat high blood pressure and heart problems) 10 mg, hold if SBP less than 110 mmHgj. One tablet of metoprolol tartrate (a medication used to treat high blood pressure and heart problems), hold if SBP less than 110 mmHg or HR less than 60k. One spray of fluticasone (a medication used to treat symptoms of allergy) intranasally in both nostrils 50 mcg per actuation (ACT - spray) During a medication reconciliation review on 12/9/2025 at 11:52 a.m., Resident 29's Order Summary Report, dated 12/9/2025 was reviewed. The Order Summary report and order details indicated the following physician order was scheduled to be administered daily at 7:15 a.m.: Ferrous sulfate tablet 325 mg (65 mg elemental iron), give 1 tablet by mouth two times a day for supplementation, give with breakfast and dinner, order date 2/16/2025, start date 2/16/2025 Amlodipine besylate tablet 10 mg, give 1 tablet by mouth one time a day related to essential hypertension, hold SBP less than 110, order date 2/16/2025, start date 2/17/2025 Aspirin enteric coated (EC) tablet delayed release 81 mg, give 1 tablet by mouth one time a day for deep venous thrombosis (DVT - a serious condition where blood clot forms in the deep vein usually in the legs) prevention, order date 2/16/2025, start date 2/17/2025 Baclofen oral tablet 15 mg, give 1 tablet by mouth four times a day for muscle spasms, order date 2/16/2025, start date 2/16/2025 Clonidine hydrochloride (HCl) oral tablet 0.1 mg, give 1 tablet by mouth three times a day related to essential (primary) hypertension, hold if SBP <110 mmHg or HR <60, order date 2/16/2025, start date 2/16/2025 Cranberry oral tablet 400 mg, give 1 tablet by mouth one time a day for supplement, order date 11/6/2025, start date 11/7/2025 Cranberry oral (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tablet 450 mg, give 1 tablet by mouth one time a day for supplement, order date 12/9/2025, start date 12/10/2025 Cranberry oral tablet 450 mg, give 1 tablet by mouth one time only for supplement for 1 day, one time (x1) now, order date 12/9/2025, start date 12/9/2025, end date 12/10/2025 Docusate sodium oral capsule 100 mg, give 1 capsule by mouth one time a day for bowel management, hold if loose stool, order date 2/16/2025, start date 2/17/2025 Fluticasone propionate nasal suspension 50 mcg per actuation, 1 spray in both nostrils one time a day for allergy, ?shake well before use', order date 2/16/2025, start date 2/17/2025 Furosemide oral tablet 20 mg, give 1 tablet by mouth one time a day related to essential (primary) hypertension, hold for SBP <110, order date 2/16/2025, start date 2/17/2025 Metoprolol tartrate oral tablet 50 mg, give 1 tablet by mouth one time a day related to essential (primary) hypertension, hold if SBP <110, HR <60, order date 2/16/2025, start date 2/17/2025 Multiple Vitamin tablet, give 1 tablet by mouth one time a day for supplementation, order date 2/16/2025, start date 2/17/2025 During a concurrent interview and record review on 12/9/2025 at 12:26 p.m. with LVN 2, the electronic medication administration record (eMAR) for Resident 29's ferrous sulfate 325 mg dated 12/9/2025 was reviewed. The eMAR indicated that ferrous sulfate 325 mg (65 mg elemental iron) was scheduled to be administered on 12/9/2025 at 7:15 a.m. and it was administered on 12/9/2025 at 10:38 a.m. LVN 2 stated the ferrous sulfate was supposed to be administered at 7:15 a.m. and it was administered late on 12/9/2025 at 10:38 a.m. LVN 2 stated ferrous sulfate should have been given with breakfast at 7:15 a.m. LVN 2 stated she would check with the physician if the order could be changed to a later time because they are not able to keep up with 7:15 a.m. time. LVN 2 stated Resident 29 was at risk of not being treated for anemia as prescribed. During an interview on 12/10/2025 at 5:13 p.m. with the Director of Nursing (DON), the DON stated the physician changed Resident 11 and Resident 29's ferrous sulfate's scheduled time to 9:00 a.m. The DON stated Residents 11 and 29 received ferrous sulfate late when they were administered at 10:00 a.m. and 10:38 a.m. respectively, for scheduled administration at 7:15 a.m. The DON stated there was a risk for Residents 11 and 29 to feel more weak and fatigued due to low levels of iron and hemoglobin. 3. During a review of Resident 18's admission Record, dated 12/10/2025, the admission Record indicated Resident 18 was admitted to the facility on [DATE] with diagnoses that included but not limited to pain in left knee and bilateral (affecting both sides) primary osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of knee. During a review of Resident 18's MDS, dated [DATE], the MDS indicated, Resident 18's cognition (mental action or process of acquiring knowledge and understanding through thought and senses) was moderately impaired. The MDS indicated Resident 18 needed setup or clean-up assistance from the facility staff in performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, oral hygiene, upper body dressing, putting on/taking off footwear and personal hygiene, maximal assistance for lower body dressing, dependent on facility staff for toileting hygiene, and not attempted due to environmental limitations for showering. During a concurrent observation and interview on 12/10/2025 at 9:28 a.m., LVN 1 prepared the following six medications to be administered to Resident 18. LVN 1 checked BP on 12/10/2025 at 9:28 a.m. without surveyor observation and stated Resident 18's BP was 124/67 mmHg and HR was 75. LVN 1 rechecked BP in surveyor's presence on 12/10/2025 at 9:38 a.m. and stated Resident 18's BP was 119/60 mmHg and HR was 75.a. One patch of lidocaine (a medication in patch form used to treat pain) 5% patch (removed from package) to be applied to left knee, to be removed per scheduleb. One drop of Artificial Tears (a medication used to treat dryness and itching in eyes) eye drops into each eyec. One tablet of sacubitril-valsartan (a combination of two medications used to treat high blood pressure and heart problems) 24-26 mg, hold if SBP <110 mmHg and/or HR <60d. One tablet of amlodipine 2.5 mg, hold if SBP <110 mmHge. One tablet of metoprolol succinate ER 25 mg, hold if SBP <110 mmHg and/or HR <60f. One tablet of aspirin 81 mg enteric coatedDuring a concurrent observation and interview on 12/10/2025 at 9:30 a.m. in Resident 18's room with LVN 1, there was a white patch applied on Resident 18's left knee with no date or time on the patch. LVN 1 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated although the lidocaine patch on Resident 18's left knee did not have a date when it was applied, she remembered that the patch was from the previous day, 12/9/2025 because she placed it on Resident 18's left knee on 12/9/2025. During a medication reconciliation review on 12/10/2025 at 12:14 p.m., Resident 18's Order Summary Report, dated 12/10/2025 was reviewed. The Order Summary report indicated but not limited to the following physician orders: Lidoderm External Patch 5% (lidocaine), apply to left knee topically in the morning for pain management and remove per schedule, order date 11/21/2025, start date 11/22/2025 Lidocaine External Cream 5% (lidocaine), apply to right knee topically in the morning for pain management, order date 11/21/2025, start date 11/22/2025 Amlodipine besylate oral tablet 2.5 mg, give 1 tablet by mouth one time a day for hypertension, hold for SBP <110, order date 11/7/2025, start date 11/8/2025 Artificial Tears solution 0.4% (Hypromellose), instill 1 drop in both eyes two times a day for dry eyes on both eyes, order date 11/7/2025, start date 11/7/2025 Aspirin EC tablet delayed release 81 mg, give 1 tablet by mouth one time a day for cerebrovascular accident (CVA - also known as stroke characterized as a sudden disruption of blood flow to the brain, causing brain cell death and potential damage) prevention, order date 12/3/2025, start date 12/4/2025 Metoprolol succinate ER tablet 24-hour 25 mg, give 1 tablet by mouth one time a day, hold for SBP <110 mmHg and/or HR <60 do not crush or chew, order date 11/7/2025, start date 11/8/2025 Sacubitril-Valsartan oral tablet 24-26 mg, give 1 tablet by mouth one time a day for Congestive Heart Failure (CHF - a medical condition where the heart cannot pump blood effectively, leading to fluid buildup (congestion) in the lungs, legs, and feet), hold if SBP <110 mmHg and/or HR <60, order date 11/7/2025, start date 11/8/2025 During a review of Resident 18's Medication Administration Record ([MAR] a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 12/1/2025 to 12/10/2025, the MAR indicated check marks documented for the following order:Lidoderm External Patch 5% (Lidocaine) Apply to left knee topically in the morning for pain management and remove per schedule, order date 11/21/2025 12:48 p.m., remove patch daily at 8:59 a.m. and for apply patch daily at 9:00 a.m.During a concurrent interview and record review on 12/10/2025 at 1:55 p.m. with LVN 1, the pharmacy label on lidocaine 5% patches and the lidocaine patch 5% manufacturer package label were reviewed. LVN 1 stated, the manufacturer package label indicated, Apply the prescribed number of patches, only once for up to 12 hours within a 24-hour period. Remove patches if irritation occurs. The pharmacy label indicated, Lidocaine 5% patch, apply to left knee topically in the morning for pain management, and remove per schedule. LVN 1 stated it was important to write the date on lidocaine patch when it was applied on Resident 18's left knee to ensure licensed nurses were aware of the date when the patch was applied. LVN 1 stated that there should have been a drug free period and lidocaine patch should have been taken off during 3 p.m. to 11 p.m. shift. LVN 1 stated by not removing the lidocaine patch after 12 hours, it placed Resident 18 at risk of skin breakdown. During an interview on 12/10/2025 at 5:27 p.m. with the Director of Nursing (DON), the DON stated that licensed nurses should have verified the lidocaine patch order and labeled the patch with the date of application. The DON stated labeling was essential to ensure timely removal, as the lidocaine patch should only remain in place for 12 hours per manufacturer instructions. The DON stated that the order should include the patch strength, time of application, and time of removal after 12 hours. The DON stated the nurse should not have observed the patch still applied on the resident's affected area the following morning during medication pass. The DON stated leaving the patch on for an extended period could cause local reactions such as itchiness and burning, and potentially lead to systemic side effects from lidocaine. 4. During a review of Resident 35's admission Record, dated 12/10/2025, the admission Record indicated Resident 35 was admitted to the facility on [DATE] with diagnoses that included but not limited to displaced fracture (broken bone) of base of neck of right femur, subsequent encounter for closed fracture with routine healing, and unilateral primary osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of right knee, left hip and right hip.During a review of Resident 35's MDS, dated [DATE], the MDS indicated Resident 35's cognition was severely impaired. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDS indicated Resident 35 needed moderate assistance from the facility staff for ADLs such as eating, dependent on the facility staff for oral hygiene, toileting hygiene, upper and lower body dressing, putting on or taking off footwear, personal hygiene, and not attempted to shower due to medical condition or safety concerns.During a concurrent observation and interview on 12/10/2025 at 9:58 a.m. with LVN 1, LVN 1 prepared the following five medications to be administered to Resident 35.a. Two tablets of acetaminophen 325 mgb. One tablet of zinc 50 mgc. One tablet of aspirin 81 mg chewable tabletd. One tablet of vitamin C (a vitamin used to treat low level of vitamin C) 500 mge. One tablet of docusate sodium 100 mgLVN 1 then crushed two tablets of acetaminophen and one tablet of aspirin together in the same clear bag using the crushing device. LVN 1 stated she crushed acetaminophen and aspirin together, and planned to crush one tablet of zinc, one tablet of vitamin C and one tablet of docusate sodium together. LVN 1 stated she thought it would be okay to crush the medications together and crush the vitamins and supplements together. LVN 1 stated she thought she could crush the medications together until she was questioned by the surveyor. LVN 1 then discarded the powder of the mixture of acetaminophen and aspirin. LVN 1 then took out two new tablets of acetaminophen and one new tablet of aspirin, crushed them individually, and then crushed zinc, vitamin C and docusate sodium individually to be administered with apple sauce. During a medication reconciliation review on 12/10/2025 at 12:14 p.m., Resident 35's Order Summary Report, dated 12/10/2025, the Order Summary report indicated, but not limited to the following physician orders: Diet - Consistent Carbohydrate Diet (CCHO diet) Puree - Level 4 texture. Thin liquids level 0 consistency. For speech therapy (ST licensed professional aimed in the prevention, assessment, and treatment of speech, language, communicative, and swallowing disorders) treatment and recommendation for dysphagia (difficulty swallowing food or liquids), order date 12/3/2025, start date 12/3/2025 Acetaminophen tablet 325 mg, give 2 tablets by mouth every 4 hours as needed for pain level 1-3 (total 650 mg) not to exceed (NTE) 3-gram acetaminophen (APAP) 3-gram ([gm] a unit of measurement of mass) APAP in 24 hours from all sources, order date 11/15/2025, start date 11/15/2025 Acetaminophen tablet 325 mg, give 2 tablets by mouth two times a day for pain management, NTW 4 gm/24 hours, order date 12/5/2025, start date 12/5/2025 Ascorbic Acid tablet 500 mg, give 1 tablet by mouth one time a day for skin management for 30 days, order date 11/21/2025, start date 11/26/2025, end date 12/26/2025 Aspirin EC tablet delayed release 81 mg, give 1 tablet by mouth one time a day for CVA prophylaxis (PPX), order date 11/14/2025, start date 11/15/2025 Docusate Sodium oral tablet 100 mg, give 1 tablet by mouth two times a day for bowel care, hold if loose stools, order date 11/14/2025, start date 11/15/2025 Zinc Sulfate capsule 220 (50 Zn) mg, give 1 capsule by mouth one time a day for skin management for 21 days, order date 11/21/2025, start date 11/26/2025, end date 12/17/2025 During an interview on December 10, 2025, at 2:12 p.m. with LVN 1, LVN 1 stated Resident 35 was on a pureed diet and had a risk for aspiration or choking; therefore, it was acceptable to crush her medications. LVN 1 stated the importance of crushing medications individually rather than mixing them together to prevent chemical reactions, gastrointestinal upset, and potential drug-drug interactions. She stated administering crushed medications separately would help identify a specific medication if the resident refused to take it or did not tolerate it. During an interview on 12/10/2025, at 5:13 p.m. with the Director of Nursing (DON), the DON stated licensed nurses complete a nursing pharmacy skills competency assessment, which includes a teaching point emphasizing that medications should be crushed and administered separately with applesauce. The DON stated that medications should not be mixed together to avoid potential drug-drug interactions. The DON stated keeping medications separate ensures that, in the event of a spill, the nurse can identify which medication was lost. Additionally, if a resident refuses or does not tolerate a medication, the nurse can determine which specific medication was involved. According to the manufacturer's labeling for lidocaine patch 5%, the labeling indicated, apply Lidoderm ([generic name: lidocaine) to intact skin to cover the most painful area. Apply the prescribed number of patches (maximum of 3), only once for up to 12 hours within a 24-hour period.During a review of the (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).During a review of the P&P titled, PH 1 Medication Administration, undated, the P&P indicated, Important Points to Remember - If you are crushing multiple meds for a resident who is by mouth (PO) and has difficulty swallowing, then you must crush each med separately and administer each one separately. Never mix together. Also be sure to rinse all cups so not residual remains. Get order to add applesauce if needed.During a review of the facility's P&P titled, Transdermal Drug Delivery System (Patch) Application, undated, the P&P indicated, To administer medication through the skin for continuous absorption while the patch is in place, through proper placement of the patch and care of the application sites. Procedures: A. Identify the location on the body for patch placement; B. Remove old patch from body; C. Cleanse area of old patch with alcohol wipe; D. Remove new patch from package and envelope; E. Label patch with date and nurse's initials.H. Document.During a review of the facility's P&P, titled Physician Orders, dated 5/2007, the P&P indicated, Orders for medications must include: A. Name and strength of the drug; B. Quantity or specific duration of therapy; C. Dosage and frequency of administration; D. Route of administration if other than oral; and E. Reason or problem for which given.During a review of the facility's P&P titled, Guidelines for Medication Administration, undated, the P&P indicated, observe the five rights of administering medication. The right Resident/Patient, the right drug, the right dose, the right time, the right route.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled residents for unnecessary medications review (Resident 3) was free from significant medication errors, by failing to follow parameters for pain level and ensuring hydrocodone (a controlled substance or also known as an opioid [medications that the use and possession of are controlled by the federal government] a medication used to treat pain) in combination with acetaminophen (APAP - a medication used to treat fever and pain) and morphine (a controlled substance or also known as an opioid used to treat severe pain) were only administered to Resident 3 for the prescribed pain score parameters, affecting one of five sampled residents for unnecessary medications review. This deficient practice had the potential to result in excessive sedation (the process of calming or relaxing a person, often by administering medication), opioid overdose, respiratory depression, hospitalization and death.Findings:During a review of Resident 3's admission Record (a document containing demographic and diagnostic information), dated 12/11/2025, the admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses that included but not limited to nondisplaced longitudinal fracture (broken bone) of left patella - subsequent encounter for closed fracture with routine healing, fracture of superior rim of right pubis - subsequent encounter for fracture with routine healing, other specified fracture of right pubis - subsequent encounter for fracture with routine healing and chronic pain syndrome (long-lasting pain [over 3-6 month] from an injury or condition). During a review of Resident 3's Minimum Data Set ([MDS] a resident assessment tool) dated 3/29/2025, the MDS indicated, Resident 3's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was severely impaired. The MDS indicated, Resident 3 needed setup or clean-up assistance for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, oral hygiene and personal hygiene, moderate assistance for upper body dressing and maximal assistance for toileting hygiene, showering, lower body dressing and putting on/taking off footwear. During a review of Resident 3's list of active medications on 12/10/2025, the order details and Order Summary Report (a document containing a summary of all active physician orders) were reviewed. The Order Summary Report, dated 12/1/2025 indicated but not limited to the following physician orders: Monitor pain level using the following scale: 0 = No pain, 1-3 = Mild, 4-6 = Moderate, 7-10 = Severe, every shift, order date 10/29/2025, start date 10/29/2025. Hydrocodone-Acetaminophen Oral Tablet 10-325 milligram ([mg] a unit of measurement for mass), give 1 tablet by mouth every 6 hours as needed for moderate pain, order date 10/29/2025, start date 10/29/2025. Morphine Sulfate oral solution 20 mg/5 milliliters ([mL] a unit of measurement for volume), give 1 mL by mouth every 4 hours as needed for severe pain, give 1 mL for a total of 5 mg every 4 hours as needed, order date 11/3/2025, start date 11/3/2025. During a review of Resident 3's Medication Administration Record ([MAR] a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 12/1/2025 to 12/10/2025, the document indicated the following:1. Hydrocodone-Acetaminophen 10-325 mg - give one tablet by mouth every 6 hours as needed for moderate pain, was documented as administered three times outside of the prescribed parameters for moderate pain, pain level 4-6 by two different licensed nurses:1a. Hydrocodone-APAP 10-325 mg administered on 12/7/2025 at 9:56 a.m. for pain level of 7.1b. Hydrocodone-APAP 10-325 mg administered on 12/7/2025 at 4:42 p.m. for pain level of 8. 1c. Hydrocodone-APAP 10-325 mg administered on 12/8/2025 at 6:27 p.m. for pain level of 8. 2. Morphine Sulfate Oral Solution 20 mg/5 mL - give 1 mL by mouth every 4 hours as needed for severe pain, was documented as administered three times outside of the prescribed parameters for severe pain, pain level 7-10:2a. Morphine Sulfate 20 mg/5 mL administered on 12/3/2025 at 10:00 a.m. for pain level of 6.2b. Morphine Sulfate 20 mg/5 mL administered on 12/4/2025 at 1:00 p.m. for pain level of 6. 2c. Morphine Sulfate 20 mg/5 mL (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered on 12/10/2025 at 10:00 a.m. for pain level of 6. During a review of Resident 3's MAR, dated 11/1/2025 to 11/30/2025, the document indicated the following:1. Hydrocodone-Acetaminophen 10-325 mg - give 1 tablet by mouth every 6 hours as needed for moderate pain, was documented as administered seven times outside of the prescribed parameters for moderate pain, pain level 4-6 by four different licensed nurses:1a. Hydrocodone-APAP 10-325 mg administered on 11/8/2025 at 9:12 a.m. for pain level of 7.1b. Hydrocodone-APAP 10-325 mg administered on 11/9/2025 at 10:13 a.m. for pain level of 8.1c. Hydrocodone-APAP 10-325 mg administered on 11/9/2025 at 5:37 p.m. for pain level of 8.1d. Hydrocodone-APAP 10-325 mg administered on 11/15/2025 at 9:50 a.m. for pain level of 7.1e. Hydrocodone-APAP 10-325 mg administered on 11/17/2025 at 8:30 a.m. for pain level of 7.1f. Hydrocodone-APAP 10-325 mg administered on 11/22/2025 at 4:43 p.m. for pain level of 7.1g. Hydrocodone-APAP 10-325 mg administered on 11/23/2025 at 8:24 a.m. for pain level of 7. 2. Morphine Sulfate Oral Solution 20 mg/5 mL - give 1 mL by mouth every 4 hours as needed for severe pain, was documented as administered nine times outside of the prescribed parameters for severe pain, pain level 7-10 by two different licensed nurses:2a. Morphine Sulfate 20 mg/5 mL administered on 11/3/2025 at 10:00 a.m. for pain level of 6.2b. Morphine Sulfate 20 mg/5 mL administered on 11/4/2025 at 9:24 a.m. for pain level of 6.2c. Morphine Sulfate 20 mg/5 mL administered on 11/5/2025 at 8:30 a.m. for pain level of 6.2d. Morphine Sulfate 20 mg/5 mL administered on 11/6/2025 at 9:00 a.m. for pain level of 6.2e. Morphine Sulfate 20 mg/5 mL administered on 11/7/2025 at 11:00 a.m. for pain level of 6.2f. Morphine Sulfate 20 mg/5 mL administered on 11/11/2025 at 1:00 p.m. for pain level of 6.2g. Morphine Sulfate 20 mg/5 mL administered on 11/12/2025 at 1:00 p.m. for pain level of 6.2h. Morphine Sulfate 20 mg/5 mL administered on 11/13/2025 at 10:58 a.m. for pain level of 6.2i. Morphine Sulfate 20 mg/5 mL administered on 11/14/2025 at 1:40 p.m. for pain level of 6. During an interview on 12/10/2025 at 5:43 p.m. with the Director of Nursing (DON), the DON stated each instruction as needed for moderate pain and as needed for severe pain should have the level of pain or a pain scale so the licensed nursing staff could determine which medication was correct for the resident's pain level. The DON stated the resident could be placed at increased risk for drowsiness, sedation, respiratory depression, hospitalization and even death when both medications were administered inaccurately and/or given for the same pain level. During a concurrent interview and record review on 12/11/2025 at 11:54 a.m. with the Licensed Vocational Nurse (LVN) 2, the active physician orders for Resident 3's hydrocodone-APAP and morphine sulfate, and MAR for December 2025 were reviewed. The MAR for 12/8/2025 indicated Resident 3 received hydrocodone-APAP for pain level of 8. LVN 2 stated the hydrocodone-APAP should not have been given for pain level of 8 because that would be scored as severe pain (8-10) and morphine sulfate should have been given. LVN 2 stated the DON revised Resident 3's physician orders for hydrocodone-APAP and morphine sulfate to include the moderate pain scale for hydrocodone/APAP and severe pain scale for morphine sulfate. LVN 2 stated the facility should have notified the doctor and clarified the orders that did not specify pain level. LVN 2 stated the resident was not receiving the right medication for pain management because she was getting two medications, both opioids which would increase the risk for overdose. LVN 2 stated there should have been assessment and administration of meds for pain appropriately. LVN 2 stated Resident 3 could experience opioid overdose that would be characterized with symptoms of weakness, sleepiness, nausea, vomiting, decreased appetite, low blood pressure, abnormal heart rate, chest pain, hospitalization and death. During an interview on 12/11/2025 at 1:38 p.m. with the DON, the DON stated she added the pain scale on Resident 3's hydrocodone-APAP and morphine sulfate orders, to indicate moderate pain scale as 4-6 and severe pain scale as 7-10. The DON stated these orders originally did not have a numeric pain scale. The DON stated it was important to have the pain scale because it was important to determine the correct medication based on a specific level of pain. The DON stated for an elderly resident receiving both hydrocodone-APAP and morphine sulfate without a proper pain scale, there would be an increased risk for side effects of drowsiness, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	respiratory depression, nausea, vomiting, hospitalization, respiratory depression, opioid overdose, hospitalization and death. During a review of the facility's policy and procedure (P&P) titled, Pain Recognition and Management, dated 5/2007, the P&P indicated, It is the policy of this to ensure that pian management is provided to residents who require such services, consistent with professional standards of practice, comprehensive and routine assessments, person-centered care plan and the residents' goals and preferences. During a review of the facility's 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, If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified.the person preparing or administering the medication will contact the prescriber, the resident's Attending Physician or the facility's Medical Director to discuss the concerns.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure that food was properly labeled, monitored, and handled in a sanitary manner, to ensure that dietary staff had effective systems and oversight to safely perform assigned duties, creating the potential for food contamination (when food becomes unsafe or spoiled by harmful substances) and adverse resident outcomes by failing to: 1. Properly label and date food items.2. Monitor and document cold storage temperatures. 3. Monitor and document sanitation and equipment temperatures.4. Ensure the ice machine had a monitoring log for sanitation. These failures placed residents at risk for expired, spoiled contaminated food, foodborne illness (illness cause by food contaminated with bacteria, viruses, parasites, or toxins), bacterial contamination (food, multiplied to unsafe levels), infection, hospitalization, and decline in overall health status. Findings:During a concurrent observation and interview on 12/8/2025 at 8:35 a.m. with [NAME] (CK) 1, the following was observed in refrigerator #1, there were multiple food items including tomatoes, celery, and bell peppers that were observed stored in the refrigerator without labels or dates. In refrigerator #2, there were multiple unlabeled food items were observed, including butter, milk, eggs, cheese, and tortillas. In the freezer, tilapia, ground beef, turkey, and pork were observed without labels or dates. In the dry storage area, two loaves of bread and a container of mayonnaise were observed unlabeled. CK 1 stated he was unable to explain why the food items were not labeled or dated. CK 1 stated that all food items should be labeled and dated according to the facility policy. CK 1 stated that labeling is required to ensure proper rotation of food items, prevent the use of expired products, and maintain food safety. CK 1 stated that when food items are not labeled, staff are unable to determine how long the items have been stored, which could result in serving expired or contaminated food and may lead to foodborne illness.During a concurrent observation and interview on 12/8/2025 at 9:00 a.m. with [NAME] (CK) 1, an observation of the interior bin door of the ice machine, the interior bin door surface was wiped with a white paper towel, which revealed black residue resembling dirt or dust. CK 1 stated that the dietary staff are responsible for cleaning the ice machine monthly and the Plant Supervisor (PS) is responsible for servicing and cleaning the ice machine every three months. CK 1 stated that the ice machine should be kept clean to prevent contamination of ice used by the residents. CK 1 stated if the ice machine is not properly cleaned and maintained, there is a risk of bacterial growth or contamination, which could result in residents consuming contaminated ice, potentially leading to foodborne illness or adverse health outcomes. During a concurrent observation and interview on 12/8/2025 at 9:15 a.m. with [NAME] (CK) 1 the facility's Cold Storage Temperature Log (used to document the consistent monitoring of temperatures in refrigerators, freezers, and other cold storage units), Quaternary Ammonia (powerful, man-made chemicals used as disinfectants, sanitizers, and preservatives) Log (used to document and monitor the concentration of disinfectants and sanitizers), and Dish Machine Temperature Log (record used to document and verify that the commercial dishwasher is operating correctly and safely) were reviewed and the revealed the following: 1. Refrigerator #1, Refrigerator #2, and the Freezer, there was no documentation on the temperature log for the am shift on December 8th.2. Refrigerator #1, Refrigerator #2, or the Freezer, there was no documentation on the temperature log for the pm shift on December 6th, 7th, and 8th. 3. No documentation for the dishwashing sanitation logs for the am shift on December 7th and December 8th. 4. No documentation for the dishwashing sanitation logs for the pm shift on December 5th, 6th, and 8th. 5. No documentation for the dishwashing temperature logs dinner on December 5th and 6th.6. No documentation for the dishwashing temperature logs dinner on December 7th and for Breakfast and Lunch.7. No documentation for the dishwashing temperature logs for breakfast on December 8th. CK 1 stated that all the logs are required to be completed daily by all staff but was unable to explain why the above entries were missing at the time of review. CK 1 stated that failure to monitor and document (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	temperatures and the Quaternary Ammonium Log could result in staff being unaware of unsafe food temperatures, and improper chemical concentrations for the dish washing machine. CK 1 acknowledged that without proper monitoring and documentation, there is an increased risk of bacterial growth, food contamination, improper sanitization of dishes and equipment. CK 1 stated that the residents would be at risk consuming unsafe food or beverages, which could result in foodborne illness, infection and hospitalization. During a concurrent interview and record review on 12/10/2025 at 2:01 p.m. with the Plant Supervisor (PS), a photograph of a white paper towel with black residue, was reviewed. The PS stated that the black or dark residue could be mold or dirt. The PS stated based on the appearance of the residue on the paper towel, the interior bin door did not appear clean and looked as though it had not been adequately cleaned at that time. The PS stated that he is responsible for performing quarterly maintenance on the ice machine and that the dietary staff are responsible for monthly maintenance. The PS stated that the quarterly cleaning includes emptying the ice machine, taking units apart, cleaning the interior bin door, and descaling (removing hard mineral buildup) per the manufacturer-recommendations. The PS stated that if the ice machine is not cleaned properly, it could cause a potential health risk requiring the residents to be hospitalized .During a concurrent interview and record review on 12/10/2025 at 2:29 p.m. with the Dietary Supervisor (DS), a photograph dated 12/8/2025 of a white paper towel with black residue, was reviewed. The DS stated the residue on the paper towel appeared to be dirty. The DS stated that dietary aides are responsible for routine cleaning and wipe-down of the interior and exterior using sanitizer and paper towels monthly. The DS stated the Plant Supervisor is responsible for quarterly deep cleaning and maintenance of the ice machine. The DS stated the presence of residue inside the ice door bin could pose a risk for contamination. The DS stated that he did not know the facility's policy verbatim, for labeling and dating food items, but acknowledged that all food items are expected to be labeled and dated immediately after opening or preparation. The DS stated that labeling and dating food items are important to ensure proper food rotation, prevent the use of expired food, and maintain food safety. The DS acknowledged that failure to properly label and date food items could result in staff being unable to determine food freshness, which may lead to serving spoiled food or contaminated food, placing residents at risk for foodborne illness. The DS stated that the cooks and dietary aides are responsible for completing the cold storage temperature logs, Quaternary ammonia sanitizer logs, and dish machine temperature logs daily. The DS stated that it is important for these logs to be completed to ensure that food is maintained at safe temperatures and that sanitation processes are effective. The DS stated that unlabeled food, incomplete logs, improper sanitizer monitoring, and ice machine sanitation failures, could result in cross-contamination (the transfer of bacteria, viruses, microorganisms, or other harmful substances from one surface to another through improper or unsanitary equipment, procedures, or products), bacterial growth, residents consuming contaminated food or beverages, illness, and potential hospitalization. The DS stated that he believed that system failures contributed to the identified findings.During a review of the facility's policy and procedure (P&P) titled, Labeling and Dating of Foods, dated 2023, the P&P indicated, All food items in the storeroom, refrigerator, and freezer need to be labeled and dated based on established procedures for either food safety or product rotation (FIFO-First In-First Out). During a review of the facility's policy and procedure (P&P) titled, Dishwashing, [undated], the P&P indicated, A temperature log (and chlorine log for low-temperature machines) will be kept and maintained by the dishwashers to assure that the dish machine is working correctly. This log will be completed each meal prior to anu dishwashing. During a review of the facility's policy and procedure (P&P) titled Ice Machine Cleaning Procedures, dated 2023, the P&P indicated, Clean inside of ice machine with a sanitizing agent per the manufacturer's instructions.Be sure special attention is paid to cleaning the door molding and the lid of the machine.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement proper infection control practices. The facility failed to:1. Ensure Licensed Vocational Nurse (LVN) 1 wash hands before administering Artificial Tears eye drops (a medication used to treat dryness and itchiness in eyes) to Resident 18 during medication pass observation.2.Ensure open trash bags were not left on top of linen hampers.3.Ensure sorting of dirty linens were not performed in the same area where clean clothes were removed from washing machines.4.Ensure non-disposable yellow gown were not left hanging on the wall next to the clean area of the laundry room.These failures had the potential to spread infection and cause cross-contamination (the transfer of bacteria, viruses, microorganisms, or other harmful substances from one surface to another through improper or unsanitary equipment, procedures, or products). Findings: During a review of Resident 18's admission Record, dated 12/10/2025, the admission Record indicated Resident 18 was admitted to the facility on [DATE] with diagnoses including unspecified glaucoma (a group of eye diseases damaging the optic nerves due to increased eye pressure). During a review of Resident 18's Minimum Data Set (MDS – resident assessment tool), dated 11/14/2025, the MDS indicated, Resident 18's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was moderately impaired. The MDS indicated Resident 18 needed setup or clean-up assistance from the facility staff in performing activities of daily living (ADLs – routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, oral hygiene, dressing, etc.) upper body dressing, putting on/taking off footwear and personal hygiene, maximal assistance for lower body dressing, dependent on facility staff for toileting hygiene, and not attempted due to environmental limitations for showering. During a concurrent observation of medication administration and interview on 12/10/2025 at 9:38 a.m. outside of Resident 18's room, Licensed Vocational Nurse (LVN) 1 prepared six medications listed below for Resident 18. 1. One patch of lidocaine (a medication in patch form used to treat pain) 5% patch (removed from package) to be applied to left knee and one patch (not removed from package) of lidocaine 5% patch to be applied to right knee, both to be removed per schedule. 2. One drop of artificial tears eye drops in both eyes. 3. One tablet of sacubitril-valsartan (a medication used to treat high blood pressure and heart conditions) 24-26 milligram ([mg] a unit of measurement for mass), hold if systolic blood pressure ([SBP] blood pressure reading measuring the force on artery walls when heart pushes out blood) less than (<) 110, and or heart rate (HR) <60. 4. One tablet of amlodipine (a medication used to treat high blood pressure and heart conditions) 2.5 mg, hold for SBP < 110. 5. One tablet of metoprolol succinate extended release ([ER] a medication formulation designed to gradually release its active ingredient into the body over a prolonged period) 25 mg, hold if SBP <110 and/or HR <60. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	machines. 4. During a concurrent observation and interview on 12/10/2025 at 8:26 a.m. with Laundry Aide (LA) 1, a non-disposable, reusable isolation gown (a medical garment made from durable materials designed to be laundered, sterilized, and reused) was observed hanging on the wall next to the clean area where clothes from the dryers were folded. LA 1 stated the gown was clean and would be used to sort dirty clothes and linens. During an interview on 12/10/2025 at 8:30 a.m. with the Maintenance Supervisor (MS), the MS stated that staff should not place open trash bags on top of linen hampers due to the risk of cross-contamination and infection control concerns. The MS stated that staff sorts dirty clothes in the same area where the washing machines are located. During an interview on 12/11/2025 at 12:12 p.m. with the Infection Prevention Nurse (IPN), the IPN stated open trash bags should be properly sealed and not left on top of hampers, as this practice can lead to cross-contamination. The IPN stated LA 1 should not have hung a non-disposable gown on the wall near the clean laundry area, as this also poses a cross-contamination risk. The IPN stated staff have consistently used the same area across the washing machines for sorting dirty clothes. The IPN stated laundry staff should sort dirty clothes and linens in the designated dirty area of the laundry, rather than in the same location where clean clothes are removed after washing, to prevent cross-contamination. During an interview on 12/11/2025 at 1:03 p.m. with the Director of Nursing (DON), the DON stated that staff should have sealed and disposed of open garbage bags in hampers or bins, rather than leaving them on top of hampers, to prevent cross-contamination. The DON stated non-disposable gowns should not be hung on the wall adjacent to the clean laundry area, as this practice increases the risk of cross-contamination and spread of infection. The DON stated sorting dirty clothes and linens in the same room where clean items are washed poses a potential risk for cross-contamination, which could lead to the spread of infection. During a review of facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, dated 4/2025, the P&P indicated The facility will use effective methods for the safe storage, transport and disposal garbage in consistent with the applicable local, state and federal requirements for disposal. The P&P indicated the staff will prevent the spread of infection thru handling, storing, processing and transporting linens. During a review of facility's P&P titled, Personal Protective Equipment-Using Gowns, revised 9/2010, the P&P indicated Reusable gowns should be laundered after each use and gowns are used only once and should be discarded into appropriate receptacle.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to honor a resident right by not obtaining a signed informed consent (a process where a person willingly agrees to a treatment) by the resident and/or resident representative prior to the administration of the influenza vaccine, in accordance with facility policy and resident rights requirements, for one of three residents (Resident 31). This failure placed Resident 31 at risk for receiving medical treatment without consent, violation of resident autonomy (the ability to make your own free, independent choices) and decision-making rights. Findings: During a review of Resident 31's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (progressive disease that makes it hard to breathe), atrial fibrillation (irregular heartbeat), and dementia (loss of memory, language, problem-solving and other thinking abilities). During a review of Resident 31's History and Physical (H&P) dated 8/25/2025, the H&P indicated Resident 31 had fluctuating capacity to make decisions. During a review of Resident 31's Minimum Data Set ([MDS]resident assessment tool) dated 10/22/2025, the MDS indicated Resident 31 had moderate cognitive impairment (problems with memory and thinking and required Partial/moderate assistance (helper does less than half the effort) for toileting hygiene, shower/bathing and personal hygiene. During a concurrent interview and record review on 12/11/2025 at 7:38 a.m. with the Infection Preventionist (IP), Resident 31's Influenza Immunization Consent Forms, dated August 13,2025 and August 26, 2025, was reviewed. The consent form dated August 13, 2025, indicated there was no resident or resident representative signature indicating consent for the influenza vaccine. Resident 31's Informed Consent for Influenza Vaccine Immunization dated August 26, 2025, was reviewed, the consent form indicated that the Resident Representative declined the influenza vaccine at that time. Further review of the Resident 31's Immunization Record indicated that the influenza vaccine was administered on October 2, 2025, despite the documented refusal and absence of a signed consent form. The IP stated the consent should have been obtained prior to the administration of any immunization and acknowledged that the facility's process requires staff to notify the resident representative, obtain documented consent or refusal, and ensure the consent form is signed and documented in the Electrical Health Record (EHR- collection of a resident's health information that is stored electronically) before vaccination is administered. The IP confirmed the documentation did not reflect a signed consent, nor did it reflect that the representative was contacted prior to admistering the vaccination on October 2, 2025. The IP stated that failure to obtain proper consent before administering a vaccine could result in violating resident rights and administering treatment without authorization. The IP stated administering a vaccine against the representative's documented wishes could lead to serious adverse reactions, allergic responses, or other medical complications, and does not align with regulatory requirements for resident autonomy and informed consent. During a concurrent interview and record review on 12/11/2025 at 11:50 a.m. with the Case Manager (CM), Resident 31's Immunization Consent Forms dated August 13, 2025, and August 26, 2025, was reviewed. The immunization consent forms indicated the absence of Resident 31's signature or the resident representative's signature. The CM stated she witnessed the consent form on August 13, 2025, despite the absence of a resident or resident representative signature. Further review of Resident 31's record revealed that the resident representative was not contacted until August 26, 2025, and that the resident representative declined the influenza vaccination. The CM stated vaccinations should not be administered without verified consent from the resident or the resident's legal representative, as required by facility policy and resident rights regulations. The CM stated that administering a vaccine could result in violation of resident rights, administration of treatment against the resident's or representative's wishes, and could lead to adverse reactions, and legal liability for the facility. During a concurrent interview and record review on 12/11/2025 at 2:35 (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	p.m. with the Director of Nursing (DON), Resident 31's Influenza Consent, dated October 2025 was reviewed. The Influenza Consent indicated, there was no education provided to the resident or the resident representative prior to the administration of the influenza vaccine. The DON acknowledged that there was no education regarding the risks, benefits, or purpose of the influenza vaccination was provided to the resident or resident representative prior to administration. The DON stated that administering the vaccination should not have occurred. The DON stated this incident represented a system failure, specifically related to verification of consent prior to vaccine administration, communication with the resident representative, and oversight of the immunization process. The DON stated that administering a vaccine without proper consent could result in violations of resident rights, loss of trust, adverse reactions, and potential legal and regulatory consequences. The DON stated that the failure to obtain a valid consent and provide education prior to administering the influenza vaccination placed Resident 31 at risk for receiving treatment against their wishes or the wishes of their representative, adverse reactions, and a violation of Resident 31's rights. During a review of the facility's policy and procedure (P&P) titled, Immunizations-Residents, [undated], the P&P indicated, Before offering any vaccine and to ensure a resident's right to choose, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization.During a review of the facility's policy and procedure (P&P) titled, Care and Treatment dated 2019, the P&P indicated, The resident and/or resident representative will be given the opportunity to refuse immunizations. If the resident and/or resident representative consented to the vaccine, obtain a physician order for resident.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide and show documentation that an Advanced Directive (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) was discussed with the residents and/or responsible parties and written information was provided for two out of 21 sampled residents (Resident 16, and 54). These deficient practices violated the residents' right to be fully informed of the option to formulate their advance directives and had the potential to cause conflict with the residents' wishes regarding alternatives in the provision of health care and end of life decisions. Findings:A. During a review of Resident 16's admission Record, the admission record indicated the resident was admitted to the facility on [DATE], with diagnoses including Mixed Receptive-Expressive Language Disorder, (a condition affecting both understanding (receptive) and using (expressive) language, dysphagia (difficulty swallowing), and pneumonia (an infection/inflammation in the lungs). During a review of Resident 16's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 10/01/2025, the MDS indicated Resident 16 had severe cognitive impairment (a significant decline in thinking, memory, concentration, and judgment). The MDS indicated Resident 16 needed partial/moderate assistance (helper does less than half the effort) for hygiene and toileting.B. During a review of Resident 54's admission Record, the admission record indicated the resident was admitted to the facility on [DATE], with diagnoses including Chronic Kidney Disease (moderate to severe loss of kidney function), Congestive Heart Failure(the heart's left ventricle weakens, and cannot pump enough oxygen-rich blood out to the body), Atrial Fibrillation, (irregular heartbeat). A review of Resident 54's MDS dated [DATE], the MDS indicated the Resident 54 is cognitively intact (able to make decisions). The MDS indicated Resident 54 needs substantial/maximal assistance (helper does all the effort) with bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing. During a concurrent interview and record review on 12/10/2025 10:40 am with the Social Worker (SW), Resident 16's and Resident 54's medical records (MR) were reviewed. The SW stated the MR indicated there was no written information regarding an Advance Directive was provided to Resident 16 and Resident 54. The SW stated she did not provide Resident 16, Resident 54 or their party responsible parties with written information on how to complete an Advanced Directive. During an interview on 12/11/20256 at 3:16 pm with the Director of Nursing (DON), the DON stated, the facility reviews Advance Directive's with families, and it was important to document in the resident's chart even if resident refused. During review of the facility's revised policy and procedure (P&P) dated 4/2025, titled, Advance Directive and Associated Documentation, the P&P indicated prior to, upon or immediately after admission, a facility staff member shall: 1. Provide resident/family or responsible agent with written information regarding the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives.2. Document in the resident health records that, at the time of admission, the resident and/or resident representative been provided with written information regarding advanced directives.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure that assessment entries on the Minimum Data Set (MDS)-a resident assessment tool) accurately reflected the residents' status at the time of assessment for two of six sampled residents (Resident 25). The facility failed to: 1.Ensure Resident 25 had a documented diagnosis of depression (a serious mood disorder characterized by persistent sadness and loss of interest in activities affecting daily life) when Lexapro (Escitalopram-a prescription medication used to treat depression and anxiety) was administered.This failure resulted in an inaccurate representation of Resident 25's condition during the MDS assessment period and had the potential to impact on the quality and appropriateness of care provided to Resident 25.Findings:During a review of Resident 25's admission Record, the admission Record indicated Resident 25 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease(a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), delirium(a serious disturbance in a person's mental abilities that results in a decreased awareness of one's environment and confused thinking), and unspecified psychosis (involves a loss of contact with reality). During a review of Resident 25's Minimum Data Set (MDS- a resident assessment tool) dated 11/30/2025, the MDS indicated Resident 25 had severely impaired cognitive skills (significant decline in thinking, memory, learning, and decision making) and required substantial/maximal assistance (helper does more than half the effort to complete the activity) with transfer from bed to chair and bed mobility. The MDS indicated Resident 25 was on anti-depressant, but no diagnosis of depression was documented. During a review of Resident 25's Order Summary Report dated 11/25/2025, the Order Summary Report indicated an order of Escitalopram Oxalate 5 milligrams (mgs. - unit of measurement) one tablet by mouth one time a day for depression manifested by little interest in doing things. During a review of Resident 25's Care Plan titled, Antidepressant medication use related to depression manifested by little interest in doing things, initiated on 12/10/2025. The Care Plan goal indicated the resident will be free from discomfort and adverse reactions (a harmful, unintended response to a medicine). The Care Plan indicated interventions including giving antidepressant as ordered by the physician and monitoring/ documenting side effects and effectiveness. During a concurrent interview and record review on 12/10/ 2025, at 1:06 p.m. with the Minimum Data Set Coordinator (MDSC), Resident 25's MDS dated [DATE], progress notes, and history and physical (H&P) from the general acute hospital (GACH) dated 11/15/ 2025, were reviewed. The MDSC stated that Resident 25 was receiving Lexapro from the GACH, but she did not see a diagnosis of depression in the H&P during her assessment. MDSC stated that the MDS dated 11/30/ 2025, did not include a depression diagnosis, although she coded antidepressant use in the MDS because the resident was receiving the medication. The MDSC stated there was no evidence of a psychiatric consultation for the resident while receiving psychotropic medications. She added that the licensed nurse should have clarified the diagnosis for Lexapro use with the Resident 25's physician at admission. MDSC stated accurate assessment was important to ensure resident needs will be met. MDSC stated inaccurate assessment can affect the delivery of care and treatment to Resident 25. During an interview on 12/11/2025, at 12:27 p.m. with the Director of Nursing (DON), the DON stated that proper care cannot be provided if the MDS assessment was inaccurate. The DON stated that an accurate assessment was essential to ensure the appropriate delivery of care and treatment for residents. During a review of facility's policy and procedure (P&P) tiled, Resident Assessment and Associated Process, revised 4/2025, the P&P indicated each resident will be assessed and the findings will be documented in their clinical health record. The P&P indicated these assessments will be comprehensive, accurate, standard, and reproducible assessments which will be conducted initially and periodically.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the care plan intervention for monitoring signs and symptoms of psychosis (a severe mental condition in which thoughts and emotions are so affected that contact with reality is lost) for one of two sampled residents (Resident 25) related to the use of Seroquel (an antipsychotic medication prescribed to treat mental health conditions) by failing to: 1.Document behaviors associated with the use of Seroquel as ordered by the physician. This failure had the potential to prevent staff from determining whether Seroquel was effective in managing Resident 25's psychotic symptoms.Findings:During a review of Resident 25's admission Record, the admission Record indicated Resident 25 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease(a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), delirium(a serious disturbance in a person's mental abilities that results in a decreased awareness of one's environment and confused thinking), and unspecified psychosis (involves a loss of contact with reality). During a review of Resident 25's Minimum Data Set (MDS- a resident assessment tool) dated 11/30/2025, the MDS indicated Resident 25 had severely impaired cognitive skills (significant decline in thinking, memory, learning, and decision making) and required substantial/maximal assistance (helper does more than half the effort to complete the activity) with transfer from bed to chair and bed mobility. The MDS indicated Resident 25 was on anti-depressant, but no diagnosis of depression was documented. The MDS indicated the resident was on anti-psychotic medicine. During a review of Resident 25's Order Summary Report dated 11/25/2025, the Order Summary Report indicated a physician order of Quetiapine (Seroquel) 50 milligrams (mgs- unit of measurement) one tablet by mouth at bedtime for psychosis manifested by restlessness. During a review of Resident 25's Order Summary Report dated 11/25/2025, the Order Summary Report indicated to monitor episodes of psychotic behavior (refers to actions or symptoms associated with psychosis) manifested by restlessness every shift. During a concurrent interview and record review on 12/10/2025 at 10:46 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 25's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 12/2025 was reviewed. The MAR indicated behavioral monitoring for episodes of psychotic behavior such as restlessness were not documented on 12/1/2025 from 3:00 p.m. to 11:00 p.m. shift, 12/5/2025 7:00 a.m. to 3:00 p.m. shift, 12/8/2025 and 12/9/2025 3:00 p.m. to 11:00 p.m. shifts. LVN 2 stated Seroquel was administered to Resident 25 for psychosis manifested by restlessness. LVN 2 stated if licensed nurses should document, and monitor episodes of psychotic behavior to ensure the effectiveness of Seroquel. During a concurrent interview and record review on 12/11/2025 at 11:53 a.m. with LVN 1, Resident 25's Care Plan titled, Anti-psychotic medication use related to psychosis manifested by restlessness, initiated 12/9/2025 with interventions including documenting episodes of behavior. LVN 1 stated it was important to follow the care plan by monitoring Resident 25's behavior related to psychosis. LVN 1 stated that consistently monitoring and documenting behaviors was essential to determine whether Seroquel was effective in managing psychotic symptoms. LVN 1 stated the importance of following the care plan to ensure the resident receives all care and treatment appropriate to their needs. During an interview on 12/11/2025, at 12:47 p.m. with the Director of Nursing (DON), the DON stated that following the resident's care plan was essential to determine whether the interventions related to Seroquel were effective and if the medication was successfully managing behaviors associated with psychosis. During a review of facility's policy and procedure (P&P) titled, Behavioral Assessment, Intervention and Monitoring, revised 3/2019.the P&P indicated the nursing staff will identify, document, and inform the physician about specific details regarding changes in resident's mental status, behavior and cognition. During a review of facility's P&P titled, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Comprehensive Person-Centered Care Planning, reviewed 4/2025, the P&P indicated the facility will develop a comprehensive person-centered care plan for each resident to meet resident's medical, nursing, mental and psychosocial needs.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Resident 18's order for lidocaine patch (a medication in patch form used to treat pain) was implemented according to manufacturer specifications and professional standards of practice. The facility failed to:1.Ensure the lidocaine patch applied to Resident 18's left knee was labeled with the date of application on the day it was applied.2.Ensure the lidocaine patch was removed after 12 hours of application, as required by manufacturer instructions.This deficient practice had the potential to result in adverse consequences such as local site reactions including skin irritation, redness, burning, and itching.Findings:During a review of Resident 18's admission Record (a document containing demographic and diagnostic information), the admission Record indicated Resident 18 was admitted to the facility on [DATE] with diagnoses including pain in left knee and bilateral (affecting both sides) primary osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of knee. During a review of Resident 18's Minimum Data Set (MDS -resident assessment tool), dated 11/14/2025, the MDS indicated, Resident 18's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was moderately impaired. The MDS indicated Resident 18 needed setup or clean-up assistance from the facility staff in performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, oral hygiene, upper body dressing, putting on/taking off footwear and personal hygiene, maximal assistance for lower body dressing, dependent on facility staff for toileting hygiene, and not attempted due to environmental limitations for showering. During an observation on 12/10/2025 at 9:28 a.m., Licensed Vocational Nurse (LVN) 1 prepared a lidocaine 5% patch, among other medications, for administration to Resident 18. LVN 1 removed one lidocaine 5% patch from its package to be applied to the resident's left knee, with instructions for removal per schedule. During a concurrent observation and interview on 12/10/2025 at 9:45 a.m. in Resident 18's room, LVN 1 stated although the lidocaine patch on Resident 18's left knee did not have a date when it was applied; she remembered that the patch was from the previous day, 12/9/2025 because she placed it on Resident 18's left knee on 12/9/2025. During a review of Resident 18's Order Summary Report (a document containing a summary of all active physician orders), dated 12/1/2025 and 12/10/2025, the Order Summary report indicated: Lidocaine External Patch 5% (Lidocaine), apply to left knee topically in the morning for pain management and remove per schedule, order date 11/21/2025, start date 11/22/2025. During a review of Resident 18's Medication Administration Record ([MAR] a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 12/1/2025 to 12/10/2025, the MAR indicated check marks documented for the following order:Lidoderm External Patch 5% (Lidocaine) apply to left knee topically in the morning for pain management and remove per schedule, order date 11/21/2025 12:48 p.m., remove patch daily at 8:59 a.m. and for apply patch daily at 9:00 a.m. During a concurrent interview and record review on 12/10/2025 at 1:55 p.m. with LVN 1, the pharmacy label on lidocaine 5% patches and the lidocaine patch 5% manufacturer package label were reviewed. LVN 1 stated, the manufacturer package label indicated, Apply the prescribed number of patches, only once for up to 12 hours within a 24-hour period. Remove patches if irritation occurs. The pharmacy label indicated, Lidocaine 5% patch, apply to left knee topically in the morning for pain management, and remove per schedule. LVN 1 stated it was important to write the date on lidocaine patch when it was applied on Resident 18's left knee to ensure licensed nurses were aware of the date when the patch was applied. LVN 1 stated there should have been a drug free period and lidocaine patch should have been taken off during 3 p.m. to 11 p.m. shift. LVN 1 stated by not removing the lidocaine patch after 12 hours, it placed Resident 18 at risk of skin breakdown. During an interview on 12/10/2025 at 5:27 p.m. with the Director of Nursing (DON), the DON stated that licensed nurses should have verified the (continued on next page)

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Lomita Post-Acute Care Center	1955 Lomita Blvd Lomita, CA 90717

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lidocaine patch order and labeled the patch with the date of application. The DON stated labeling was essential to ensure timely removal, as the lidocaine patch should only remain in place for 12 hours per manufacturer instructions. The DON stated that the order should include the patch strength, time of application, and time of removal after 12 hours. The DON stated the nurse should not have observed the patch still applied on the resident's affected area the following morning during medication pass. The DON stated leaving the patch on for an extended period could cause local reactions such as itchiness and burning and potentially lead to systemic side effects from lidocaine. According to the manufacturer's labeling for lidocaine patch 5%, the labeling indicated, Apply Lidoderm ([generic name: lidocaine) to intact skin to cover the most painful area. Apply the prescribed number of patches (maximum of 3), only once for up to 12 hours within a 24-hour period. During a review of the facility's policy and procedure (P&P) titled, Transdermal Drug Delivery System (Patch) Application, undated, the P&P indicated, To administer medication through the skin for continuous absorption while the patch is in place, through proper placement of the patch and care of the application sites. Procedures: A. Identify the location on the body for patch placement; B. Remove old patch from body; C. Cleanse area of old patch with alcohol wipe; D. Remove new patch from package and envelope; E. Label patch with date and nurse's initials.H. Document. During a review of the facility's P&P, titled Physician Orders, dated 5/2007, the P&P indicated, Orders for medications must include: A. Name and strength of the drug; B. Quantity or specific duration of therapy; C. Dosage and frequency of administration; D. Route of administration if other than oral; and E. Reason or problem for which given. During a review of the facility's P&P titled, Guidelines for Medication Administration, undated, the P&P indicated, observe the five rights of administering medication. The right Resident/Patient, the right drug, the right dose, the right time, the right route.Cross Reference F761

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one of six sampled residents (Resident 22) received respiratory care (specialized healthcare focused on the treatment, management, and prevention of respiratory disorders) consistent with professional standards of practice by failing to: 1.Ensure Resident 22's nasal cannula (a small plastic tube that fits into the nostrils to provide supplemental oxygen) was labeled and dated. 2.Ensure the prescribed amount of oxygen ordered by the physician was administered to Resident 22. This failure had the potential to place Resident 22 at risk for respiratory infection (an infection affecting the respiratory tract, including the nose, throat, and lungs, caused by viruses or bacteria) and respiratory distress (a condition where the body struggles to breathe effectively). Findings:During a review of Resident 22's admission Record, the admission Record indicated Resident 22 was admitted to the facility on [DATE] with diagnoses including dependence on supplemental oxygen(the body is not getting enough oxygen from the air alone due to heart or lung conditions requiring extra oxygen delivered via device), weakness, and chronic respiratory failure with hypoxia(lungs gradually become unable to get enough oxygen into the blood). During a review of Resident 22's Minimum Data Set (MDS- a resident assessment tool) dated 11/6/2025, the MDS indicated Resident 22 had severe cognitive impairment (significant problems with thinking, memory, judgement, and learning) and required partial/ moderate assistance (helper lifts, holds, or support trunks or limbs but provides less than half the effort) with bed mobility and transfer to and from a bed to a chair. The MDS indicated Resident 22 on continuous oxygen therapy (treatment that provides residents with supplemental oxygen). During a review of Resident 22's Order Summary Report (summary of a resident medical orders, treatments and status) dated 11/3/2025, the Order Summary Report indicated a physician order of continuous oxygen at 2 liters (l-unit of measurement) per minute via nasal cannula /mask to keep oxygen saturation above (O2 sat- a measurement of how much oxygen the blood is carrying as a percentage) 90 percent (%) every shift. During a review of Resident 22's Order Summary Report dated 11/3/2025, the Order Summary Report indicated changing oxygen tubing and humidifier (device that adds moisture (water vapor) to the air) every Monday and on night shift. During a review of Resident 22's Care Plan titled, Has Oxygen Therapy related to chronic respiratory failure with hypoxia, initiated on 11/9/2025 and revised 11/15/2025, the Care Plan goal indicated Resident 22 will not have no signs and symptoms of poor absorption through the review date. The Care plan interventions included monitoring for signs and symptoms of respiratory distress, reporting to the physician as needed, administration of continuous oxygen at 2 L per minute via nasal cannula /mask to keep O2 sat above 90 percent. During a concurrent observation and interview on 12/8/2025 at 9:55 a.m. in Resident 22's room with RN Supervisor (RNS) 1, nasal cannula applied on Resident 22's nostrils had no date label and oxygen flow meter was reading at zero (0). RNS 1 stated the oxygen flowmeter was at zero and nasal cannula was not dated and labeled. Observed RNS1 confirmed the oxygen concentrator (medical device that provides a concentrated source of oxygen) was not functioning well and replaced Resident 22's oxygen concentrator immediately. During an interview on 12/8/2025 at 9:55 a.m. with Resident 22 stated she did not feel any air going through her nostrils via nasal cannula. During an interview on 12/10/2025, at 12:37 p.m. with Certified Nursing Assistant (CNA) 7, CNA 1 she stated that licensed nurses were responsible for ensuring the oxygen concentrator functions properly and the correct amount of oxygen was administered to the resident. CNA 7 explained CNAs check to make sure the nasal cannula was positioned in the resident's nostrils and notify licensed nurses if the oxygen concentrator makes an unusual noise. During a subsequent interview on 12/8/2025, at 4:01 p.m. with RN Supervisor (RNS) 1, RNS 1 stated that licensed nurses were responsible for ensuring residents receive the prescribed amount of oxygen as ordered by the physician. RNS 1 stated nurses should verify that Resident 22 was receiving the correct oxygen flow and that the oxygen concentrator was (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	functioning properly. She added that failure to do so could result in shortness of breath leading to hypoxia. RNS 1 also stated that licensed nurses change the oxygen tubing and nasal cannula weekly to maintain cleanliness and help prevent infection. During an interview on 12/11/2025 at 12:40 p.m. with the Director of Nursing (DON), the DON stated licensed nurses were responsible in ensuring the correct amount of oxygen was administered to the residents and the oxygen concentrator was working properly. The DON stated RNS check residents on oxygen therapy during rounds and as needed. The DON stated the oxygen tubing and nasal cannula should be changed every week and labeled to prevent infection. During a review of facility's policy and procedure(P&P) titled, Use of Oxygen, revised 5/2021, the P&P indicated the oxygen cannula is changed at least every 7 days and tubing, masks and other disposables used for oxygen administration will be dated.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure nursing staff possessed the necessary knowledge and skill set (a collection of abilities, knowledge, personal traits, and expertise developed to perform tasks) for two of seven nursing staff. The facility failed to: 1.Complete and document a performance review for Licensed Vocational Nurse (LVN) 1.2. To follow its policy and procedure titled cardiopulmonary resuscitation ([CPR] an emergency lifesaving procedure performed when breathing or heartbeat stops) dated 6/2025 which indicated for staff to maintain current CPR certification through a provider whose training includes hands-on practice and in-person skills assessment, and specifically stated that online-only certification was not acceptable. These failures had the potential to place residents at risk of not receiving care in a safe and competent manner. The facility could not determine if LVN 1's job performance was adequate and safe to provide resident care, and whether CNA 4 could effectively respond during life-threatening emergencies (situations that could result in death or severe harm if not addressed immediately).Findings:1. During a concurrent interview and record review on [DATE] at 8:15 a.m. with the Director of Staff Development (DSD), the employee file (a folder containing official records such as hire date, performance evaluations, and training records) for LVN 1 was reviewed. The file indicated that no performance evaluation had been conducted for the year 2025. The DSD stated that LVN 1 began employment as a Licensed Vocational Nurse on [DATE]. The DSD stated the Director of Nursing (DON) was responsible for conducting performance evaluations for licensed nurses. During an interview on [DATE] at 10:19 a.m. and 11:47 a.m. with the Director of Nursing (DON), the DON stated performance evaluations should be conducted 90 days after hire for newly hired staff and annually thereafter. The DON stated LVN 1 did not have a performance review for the year 2025. The DON stated performance evaluations were conducted to ensure licensed nurses were providing correct treatments and fulfilling their job responsibilities safely. The DON further stated that evaluations help identify staff strengths and weaknesses and can prevent potential errors in resident care. 2. During a concurrent interview and record review on [DATE] at 3:08 p.m. with the DSD, the employee file for CNA) 4 was reviewed. The file indicated that CNA 4 obtained a Basic Life Support (BLS) certificate online. During a concurrent interview and record review on [DATE] at 3:08 p.m. with the DSD, the facility's policy and procedure (P&P) titled CPR, dated [DATE], was reviewed. The P&P stated staff must maintain current CPR certification through a provider whose training includes hands-on practice and in-person skills assessment. The P&P further indicated that online-only certification is not acceptable. The DSD stated that CNA 4 would not be able to perform efficiently during emergencies if the CPR certification was obtained solely online. During an interview on [DATE] at 2:55 p.m. with RN Supervisor (RNS)1, RNS 1 stated maintaining a valid CPR Certificate is important to ensure the CNA will be able to respond and implement life saving measures during emergencies involving residents in the facility. During a review of facility's Employee Handbook updated [DATE], the Employee Handbook indicated Performance Evaluations identify strengths, areas for improvements and objectives or goals for future work performance. The Employee Handbook indicated the supervisor will complete and conduct performance reviews annually.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure performance evaluations were completed at least once every 12 months for three of five Certified Nursing Assistants (CNAs). This failure had the potential to prevent identification of areas for improvement or weaknesses in the delivery of care and services to residents by CNAs, which could result in unsafe or inadequate care.Findings:During a concurrent interview and record review on 12/11/2025 at 8:15 a.m. with the Director of Staff Development (DSD), the employee files for CNA 3, CNA 4, and CNA 6 were reviewed. The DSD stated that CNA 4 began employment on 3/29/2022 and did not have a performance review for 2025. CNA 3, who started on 8/23/2021, also had no performance review for 2025. CNA 6, who started on 10/12/2022, did not have a performance review for 2025. The DSD stated that failure to conduct performance reviews for CNAs can lead to improper resident care because their performance was not assessed. The DSD stated performance reviews should be conducted to ensure CNAs were proficient in providing care to residents. During an interview on 12/11/2025 at 10:19 a.m. with the Director of Nursing (DON), the DON stated that performance evaluations were conducted after 90 days of employment for newly hired staff and annually thereafter. The DON stated performance reviews were intended to ensure proper care and treatments were provided to residents. During a review of facility's policy and procedure (P&P) titled, Nursing Competency, dated 4/2025, the P&P indicated The facility will have sufficient nursing staff with appropriate skillsets and competencies to ensure safe provision of nursing and related services to the residents. During a review of facility's Employee Handbook updated 9/1/2021, the Employee Handbook indicated Performance Evaluations identify strengths, areas for improvements and objectives or goals for future work performance. The Employee Handbook indicated that the supervisor will complete and conduct performance reviews annually.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide treatment, monitoring, and services for one of five sampled residents reviewed for unnecessary medications (Resident 3) with diagnosis of depression (a mood disorder causing persistent sadness and loss of interest, affecting feelings and thoughts in a person). This deficient practice had the potential to result in suicidal ideation (means thinking about, considering, or planning suicide) and impairment or decline in the resident's mental, physical condition, functional abilities, and psychosocial status.Findings:During a review of Resident 3's admission Record (a document containing demographic and diagnostic information), dated 12/11/2025, the admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnosis that included but not limited to recurrent major depressive disorder (common and serious mood disorder characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in most activities), unspecified. During a review of Resident 3's Minimum Data Set ([MDS] a resident assessment tool) dated 3/29/2025, the MDS indicated, Resident 3's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was severely impaired. The MDS indicated Resident 3 had a diagnosis of depression (mental health disorder characterized by persistent feelings of sadness, hopelessness, and a loss of interest). The MDS indicated, Resident 3 needed setup or clean-up assistance for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, oral hygiene and personal hygiene, moderate assistance for upper body dressing and maximal assistance for toileting hygiene, showering, lower body dressing and putting on/taking off footwear. During a review of Resident 3's History and Physical, dated 10/29/2025, the document did not indicate any diagnosis or treatment of depression. During a review of Resident 3's Order Summary Report, dated 12/1/2025 and 12/11/2025, the Order Summary Report indicated there were no physician orders for treatment or behavioral monitoring for signs and symptoms of depression. During a review of Resident 3's Progress Note, dated 12/9/2025, the Progress Notes did not reflect any diagnosis or treatment related to depression.The facility could not provide psychiatrist (medical doctor who specializes in diagnosing, treating, and preventing mental health disorders) evaluation notes. During an interview on 12/11/2025 at 11:54 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 3 had a diagnosis of major depressive disorder as one of her psychiatric conditions; however, there was no treatment or medication documented in her health record for depression. LVN 2 stated there was a note and order dated 10/29/2025 indicating Resident 3 should be seen by psych, but no evaluation notes were found. LVN 2 stated she could not locate any behavioral monitoring parameters for Resident 3's depression and stated the resident was at risk because she was not monitored or assessed for depressive episodes. During an interview on 12/11/2025 at 1:38 p.m. with the Director of Nursing (DON), the DON stated Resident 3 had a diagnosis of depression. The DON stated a psychological evaluation (PHQ-2) indicated the resident was in the moderate category - moderate for depression. The DON stated the resident should have been seen by a psychiatrist. The DON further stated there was no monitoring for depression-related behaviors such as hopelessness, lack of socialization, and refusal to participate in family activities. The DON stated behavior monitoring for signs and symptoms of depression was important because untreated depression increases the risk for suicidal ideation. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medications, dated 5/2007, the P&P indicated, The Licensed Nurses (LN) shall review the classification of the drug, the appropriateness of the diagnosis, its indication, behavior monitors and related adverse side effects prior to verification of admission orders with the Attending Physician. The P&P indicated, The Social Services (SSD) and/or nursing designee (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	will be responsible for initiating the resident's individualized, person-centered psychosocial plan of care, based on their comprehensive initial admission assessment. Upon initial comprehensive assessment, the SSD designee shall review new admissions for any psychiatric, mood or behavior disorders, mental and psychosocial difficulties, and/or.orders. The facility's Interdisciplinary Team (IDT) will review to ensure: a. Psychotropic medication was prescribed to treat a specific diagnosed condition, as documented in the clinical record; b.g. Review of plan of care shows individualized, person-centered care approaches to manage behavior with non-pharmacological interventions; h appropriate. During a review of the facility's P&P titled, Resident Assessments, dated 11/2016, the P&P indicated, It is the policy of this facility that resident will be assessed, and the findings documented in their clinical health record. These will be comprehensive, accurate.conducted initially and periodically as part of . functional and health status, and strengths and needs will be identified. The P&P indicated, An accurate Comprehensive Assessment will be made. include at least the following: Mood and behavior patterns, Psychological well-being.

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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, and record review, the facility failed to ensure physician orders for medications were complete and accurate per facility policy for two out five sampled residents (resident 11 and 18). The facility failed to: 1. Ensure Resident 18's order for lidocaine patch (a medication in the form of a patch used to treat inflammation and pain) clearly indicated number of patches (dose) to be applied, per facility's policy and procedure (P&P) titled, Physician Orders, dated 5/2007. 2. Ensure Resident 11's order for diclofenac sodium (a medication used to treat inflammation and pain) external gel had a dose, frequency and location for its use, per facility's P&P titled, Physician Orders, dated 5/2007. These deficient practices increased the risk for inappropriate treatments and medication and adverse effects such as local site reactions (skin irritation, redness, burning, and itching). Findings:1. During a review of Resident 18's admission Record (a document containing demographic and diagnostic information), dated 12/10/2025, the admission Record indicated Resident 18 was admitted to the facility on [DATE] with diagnoses that included but not limited to pain in left knee and bilateral (affecting both sides) primary osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of knee. During a review of Resident 18's Minimum Data Set (MDS resident assessment tool), dated 11/14/2025, the MDS indicated, Resident 18's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was moderately impaired. The MDS indicated Resident 18 needed setup or clean-up assistance from the facility staff in performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, oral hygiene, dressing, etc.) upper body dressing, putting on/taking off footwear and personal hygiene, maximal assistance for lower body dressing, dependent on facility staff for toileting hygiene, and not attempted due to environmental limitations for showering. During an observation on 12/10/2025 at 9:28 a.m., Licensed Vocational Nurse (LVN) 1 prepared lidocaine 5% patch amongst other six medications to be administered to Resident 18: a. One patch of lidocaine (a medication in patch form used to treat pain) 5 percent ([%] a measurement of strength or potency of medication) patch (removed from package) to be applied to Resident 18's left knee, to be removed per schedule. During a review of Resident 18's Order Summary Report (a document containing a summary of all active physician orders), dated 12/1/2025 and 12/10/2025, the Order Summary report indicated: Lidocaine External Patch 5% (Lidocaine), apply to left knee topically in the morning for pain management and remove per schedule, order date 11/21/2025, start date 11/22/2025.During an interview on 12/10/2025 at 5:27 p.m. with the Director of Nursing (DON), the DON stated, Lidocaine 5% patch should be entered in two steps, lidocaine patch first, strength, location where patch should be applied, time of application, and removal time after 12 hours. The DON stated the order for Lidocaine 5% patch should have indicated the dose, that is, apply one patch, or apply two patches to ensure the order is specific to prevent medication errors. 2. During a review of Resident 11's admission Record, dated 12/9/2025, the admission Record indicated Resident 11 was admitted to the facility on [DATE] with diagnosis that included but not limited to bilateral primary osteoarthritis of hip. During a review of Resident 11's History and Physical (H&P), undated, the H&P indicated Resident 11 had the capacity to understand and make decisions. During a review of Resident 11's MDS, dated [DATE], the MDS indicated Resident 11's cognition was moderately impaired. The MDS indicated Resident 11 needed setup or clean-up assistance from the facility staff in performing ADLs such as eating, oral hygiene and upper body dressing, and supervision assistance for toileting hygiene, showering, lower body dressing, putting on/taking off footwear and personal hygiene. During a concurrent medication reconciliation after observing medication pass for Resident 11 on 12/9/2025 at 11:52 a.m., the active physician orders were reviewed. The Physician Order for diclofenac gel, dated (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/9/2025, indicated: Diclofenac sodium external gel 1%, Apply to affected area topically as needed for pain, order date 9/19/2025, start date 9/19/2025. During an interview on 12/9/2025 at 12:15 p.m. with LVN 2, LVN 2 stated the diclofenac gel 1% order was missing dose, frequency and location. LVN 2 stated it was important to clarify the order with Resident 11's physician to ensure proper treatment was administered for Resident 11 and resident was not at risk of adverse effects due to overdose and/or untreated pain due to underdosing. During an interview on 12/10/2025 at 5:39 p.m. with the DON, the DON stated there should have been location of affected areas, frequency and dose for diclofenac gel 1%. on 12/9/2025 at 11:52 a.m., The DON stated the gel should be dosed in gram and since there was no dose on the order, the licensed nurse would not know how much to apply which could lead to either applying either too little or too much of the medication. The DON stated there was a risk for burning sensation or rashes if the diclofenac was used too much or pain might not get treated if it was not applied in the correct dose. During a review of the facility's policy and procedure (P&P), titled Physician Orders, dated 5/2007, the P&P indicated, Orders for medications must include: A. Name and strength of the drug; B. Quantity or specific duration of therapy; C. Dosage and frequency of administration; D. Route of administration if other than oral; and E. Reason or problem for which given. During a review of the facility's P&P titled, Guidelines for Medication Administration, undated, the P&P indicated, observe the five rights of administering medication. The right Resident/Patient, the right drug, the right dose, the right time, the right route.Cross Reference F658

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to:1. Ensure Resident 18's lidocaine patch (a medication in the form of a patch used to treat inflammation and pain) applied to Resident 18's left knee was labeled with the date of application on the day it was applied affecting one of five residents observed for medication administration.2. Ensure Resident 38's Fluticasone-Salmeterol (a medication delivered through a device in the form of inhalation powder, used to treat breathing problems) inhaler was removed from Station A and B Medication Cart 1 after being discontinued, and labeled with an open date in accordance with manufacturer's specifications and facility's policy and procedure (P&P), titled PH 1 Medication Administration, undated, affecting one of two medication carts reviewed (Station A B and Medication Cart 1).These deficient practices placed Residents 18 and 38 at risk for adverse events, including local site reactions such as skin irritation, redness, burning, and itching, as well as potential cardiovascular side effects. Additionally, the residents were at risk of receiving a medication that was discontinued, expired, ineffective, or toxic due to improper labeling. Findings:1. During a review of Resident 18's admission Record (a document containing demographic and diagnostic information), dated [DATE], Resident 18 was admitted to the facility on [DATE] with diagnoses that included but not limited to pain in left knee and bilateral (affecting both sides) primary osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of knee. During a review of Resident 18's Minimum Data Set (MDS -resident assessment tool), dated [DATE], the MDS indicated, Resident 18's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was moderately impaired. The MDS indicated Resident 18 needed setup or clean-up assistance from the facility staff in performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, oral hygiene, upper body dressing, putting on/taking off footwear and personal hygiene, maximal assistance for lower body dressing, dependent on facility staff for toileting hygiene, and not attempted due to environmental limitations for showering. During an observation on [DATE] at 9:28 a.m., Licensed Vocational Nurse (LVN) 1 prepared a lidocaine 5% patch along with six other medications for administration to Resident 18.a. One patch of lidocaine (a medication in patch form used to treat pain) 5% patch (removed from package) to be applied to left knee, to be removed per schedule.During a concurrent observation and interview on [DATE] at 9:45 a.m. in Resident 18's room, LVN 1 stated although the lidocaine patch on Resident 18's left knee did not have a date when it was applied; she remembered that the patch was from the previous day,[DATE] because she placed it on Resident 18's left knee on [DATE]. During a review of Resident 18's Order Summary Report (a document containing a summary of all active physician orders), dated [DATE] and [DATE], the order summary report indicated: Lidocaine External Patch 5% (Lidocaine), apply to left knee topically in the morning for pain management and remove per schedule, order date [DATE], start date [DATE]. During a concurrent interview and record review on [DATE] at 1:55 p.m. with LVN 1, the pharmacy label on lidocaine 5% patches and the lidocaine patch 5% manufacturer package label were reviewed. LVN 1 stated, the manufacturer package label indicated, Apply the prescribed number of patches, only once for up to 12 hours within a 24-hour period. Remove patches if irritation occurs. The pharmacy label indicated, Lidocaine 5% patch, apply to left knee topically in the morning for pain management, and remove per schedule. LVN 1 stated that it was important to label the lidocaine patch with the date of application on the day it was applied to Resident 18's left knee to ensure licensed nurses were aware of when the patch was placed. LVN 1 stated that there should have been a drug-free period and that the lidocaine patch should have been removed during the 3 p.m. to 11 p.m. shift. LVN 1 explained that failing to remove the lidocaine patch after 12 hours placed (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 18 at risk for skin breakdown. During an interview on [DATE] at 5:27 p.m. with the Director of Nursing (DON), the DON stated that licensed nurses should have verified the lidocaine patch order and labeled the patch with the date of application. The DON stated labeling was essential to ensure timely removal, as the lidocaine patch should only remain in place for 12 hours per manufacturer instructions. The DON stated that the order should include the patch strength, time of application, and time of removal after 12 hours. The DON stated the nurse should not have observed the patch still applied on the resident's affected area the following morning during medication pass. The DON stated leaving the patch on for an extended period could cause local reactions such as itchiness and burning and potentially lead to systemic side effects from lidocaine. During a review of the facility's P&P titled, Transdermal Drug Delivery System (Patch) Application, undated, the P&P indicated, To administer medication through the skin for continuous absorption while the patch is in place, through proper placement of the patch and care of the application sites. Procedures: A. Identify the location on the body for patch placement; B. Remove old patch from body; C. Cleanse area of old patch with alcohol wipe; D. Remove new patch from package and envelope; E. Label patch with date and nurse's initials.H. Document. 2. During a review of Resident 38's admission Record, dated [DATE], the admission Record indicated Resident 38 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that included but not limited to chronic obstructive pulmonary disease with acute exacerbation (COPD progressive disease that makes it hard to breath). During a review of Resident 38's MDS, dated [DATE], the MDS indicated Resident 38's cognition was intact. The MDS indicated Resident 38 needed setup or clean-up assistance from the facility staff in performing ADLs such as eating, oral hygiene and personal hygiene, partial assistance for showering and upper body dressing, and dependent on facility staff for toileting hygiene, lower body dressing and putting on/taking off footwear. During a concurrent observation and interview on 12/9/ 2025, at 2:55 p.m. with LVN 2 at Station A&B Medication Cart 1, it was observed the following medications were either expired, improperly stored contrary to manufacturer requirements, or lacked an open date as specified by the manufacturer:Fluticasone Propionate - Salmeterol Diskus Inhalation Powder 500 microgram ([mcg] a unit of measurement for mass) - 50 mcg for Resident 38 with no open date.According to the manufacturer's product labeling, fluticasone-salmeterol should be discarded one month after removal from the moisture-protective foil overwrap pouch or after all blisters have been used (when the dose indicator reads 0), whichever comes first. LVN 2 stated there was no active order for Resident 38's fluticasone-salmeterol inhalation powder. During a concurrent interview and record review on [DATE] at 2:55 p.m. with LVN 2, the eMAR (electronic medication administration record) and physician orders were reviewed. LVN 2 stated fluticasone-salmeterol 500 mcg-50 mcg for Resident 38 was discontinued on [DATE] because physician changed the order to a different medication. LVN 2 stated fluticasone-salmeterol should have been removed from the medication cart immediately after it was discontinued and discarded in the medication room. LVN 2 stated that there was a risk the medication could be inadvertently administered to Resident 38, potentially resulting in a medication error, drug-drug interaction, or other adverse effects. During a review of Resident 38's Order Summary Report, dated [DATE] and [DATE], there were no active physician orders for fluticasone-salmeterol 500 mcg-50 mcg diskus inhalation powder.During a review of Resident 38's order for Advair Diskus ([generic name: fluticasone - salmeterol]), dated [DATE], the document indicated the medication was discontinued on [DATE] with the discontinue reason to be continue with Trelegy ([generic name: fluticasone furoate/umeclidinium/vilanterol] a medication used to treat asthma and COPD). During an interview on [DATE] at 5:08 p.m. with the DON, the DON stated the fluticasone-salmeterol inhalation device should have an open date. The DON stated the medication should have been removed from medication cart when it was discontinued. The DON stated there was a risk for the residents to receive an expired medication in error and/or duplicate therapy. The DON stated Resident 38 would be at risk for side effects, breathing problems, abnormal heart rate and possible hospitalization. During a review of the facility's P&P titled, Medication Storage and Labeling, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	undated, the P&P indicated, All drugs will be labeled and stored in a manner consistent with manufacturer's published specifications, federal and state regulations, and to enhance accurate and safe medication administration, by the facility staff. The P&P indicated, Discontinued drug containers shall be marked, or otherwise identified, to indicate that the drug has been discontinued, or shall be stored in a separate location which shall be identified solely for this purpose. Discontinued drugs shall be disposed of within 90 days of the date the drug order was discontinued, unless the drug is reordered within that time. During a review of the facility's P&P titled, PH 1 Medication Administration, undated, the P&P indicated, Inhalers - all inhalers expire 30 days after opening. Advair & Serevent diskus inhalers are required to be dated when opened.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review, the facility failed to ensure dietary staff were competent and able to safely perform assigned job duties, including understanding and accurately following meal tickets (a card for residents' meals) and food service instructions, for two of two dietary staff (Dietary Aide #1 and #2). These failures placed residents at risk for receiving incorrect diets, aspiration (choking), allergic reactions, poor nutritional intake, and compromised resident safety. Findings:During an observation on 12/10/2025 at 12:07 p.m. in the kitchen, Dietary Aide (DA) 2 was observed participating in the tray line (is an assembly-line system in the kitchen where staff quickly prepare and assemble individual resident meal trays) assembly. Dietary Aide 2 appeared to pause prior to assembling trays. DA 2 did not verbally communicate with other staff during the observation regarding clarification of diet orders.During a concurrent observation and interview on 12/10/2025 at 2:15 p.m. with the Dietary Aide (1) and the Dietary Supervisor (DS), DA 1 stated she speaks and reads only a little English. During the interview, the Dietary Supervisor (DS) witnessed an attempt to interview DA 1, who was unable to answer interview questions. The DS stated dietary staff primarily use single-word communication, gestures, and basic phrases to communicate with one another. The DS stated that dietary aides do not have direct resident contact, so their inability to speak English does not impact resident care. The DS stated the dietary staff asks other employees for help and that he shows them tasks visually rather than relying on written instructions. The DS stated that miscommunication could lead to errors in following meal tickets, incorrect food items place on trays, not understanding allergy information, improper use of sanitation chemicals, or failure to follow written procedures, which could result in residents receiving the wrong diet consistency, allergen exposure, or unsafe food handling. During an interview on 12/11/2025 at 8:49 a.m. with Dietary Aide (2), due to DA 2's limited ability to speak and read English, the interpreter line was utilized to conduct the interview. DA 2 stated his primary job duties include assisting with tray line service, reading meal tickets, assembling meal trays according to the posted meal tickets, delivering trays, cleaning the kitchen area and assisting the dietary supervisor or cook. DA 2 stated that he relies on verbal direction, demonstrations, and instructions from supervisory staff when performing tasks. DA 2 stated he does not independently read or interpret meal tickets and instead follows instructions provided by the dietary supervisor or other dietary staff to ensure trays are assembled correctly. DA 2 stated he is responsible for preparing and assembling resident's trays based on written instructions. DA 2 stated that he is required to record temperatures and fill out logs. DA 2 was unable to state what International Dysphagia Diet Standardization Initiative ([IDDSI] a diet prepared to a specific texture so people with swallowing problems can swallow safely) and was unable to independently describe the different diet texture or liquid consistency levels. DA 2 stated he follows directions given by supervisory staff when working the tray line rather than independently interpreting meal tickets. DA 2 stated that he does not know what IDDSI stands for and staff must translate instructions to him. During a review of the facility's policy and procedure (P&P) titled, Job Description Dietary Aide, [undated], the P&P indicated, Must function independently, have flexibility, personal integrity, and the ability to work effectively.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to honor a resident's food preference for one of three sampled residents (Resident 54) by serving beef, despite the resident's stated dislike for it. This failure had the potential to negatively impact Resident 54's dining experience by providing food that did not align with the resident's preferences.Findings:During a review of Resident 54's admission Record, the admission Record indicated Resident 54 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including diabetes mellitus(DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and iron deficiency anemia(condition where the body does not have enough healthy red blood cells due to lack of iron [crucial mineral needed to make hemoglobin which carries oxygen from the lungs to tissues throughout the body). During a review of Resident 54's Minimum Data Set(MDS- a resident assessment tool) dated 11/9/2025 , the MDS indicated Resident 58 had intact cognition(person's mental functions like memory, thinking, judgement and problem solving skills) and required set-up or clean-up assistance (helper sets up or cleans up prior to and after the resident completes the activity) with eating and personal hygiene. During a review of Resident 54's Order Summary Report, the Order Summary Report dated 11/16/2025, the Order Summary Report indicated Resident 58 was on Consistent or Controlled carbohydrate (CCHO - type of diet that helps manage blood sugar by having the same amount of carbohydrates served at each meal) no added salt (NAS) soft and bite sized (diet used for people who struggle with chewing and swallowing) diet. During a review of Resident 54's Social Services Assessment and Evaluation dated 11/18/2025, the Social Services Assessment and Evaluation indicated Resident 58 loved soup and fish and preferred no pork or meat. During an interview on 12/8/2025 at 10:44 a.m. with Resident 54 in resident's room, Resident 54 stated her food always looked like it was mushy and liked to eat fish and scrambled eggs. Resident 54 stated she disliked meat like pork and beef. During a concurrent observation and interview on 12/8/2025 at 1:09 p.m. with Resident 54, lunch tray served consisted of bite size beef, vegetables and mashed potatoes. Resident 54 stated she did not like the food and the meat tasted like beef. During a record review of Resident 54's meal tray card on 12/8/2025 at 1:09 p.m., the meal tray card indicated Resident 54 disliked meat like pork and beef. During an interview on 12/8/2025 at 1:18 p.m. and subsequent interview on 12/11/2025 at 11:17 a.m. with the Dietary Supervisor (DS), the DS stated the meat served on 12/8/2025 for lunch for Resident 54 was beef. The DS stated [NAME] (CK) 1 made a mistake by serving beef instead of turkey during tray line (assembling meal trays for residents). The DS stated Resident 54 will feel upset because her food preferences were not accommodated. The DS stated not getting what the resident wants for food can affect her appetite leading to not meeting resident's nutritional needs. During an interview on 12/11/2025 at 1:33 a.m. with CK 1, CK 1 stated he made Resident 54 a turkey sandwich after learning from DS that beef was served to Resident 54 on 12/8/2025 during lunch time. CK 1 stated Resident 54 would be upset if her food preference was not followed. During an interview on 12/11/2025 at 12:47 p.m. with the Director of Nursing (DON), the DON stated not following and accommodating resident's food preferences can put the resident at risk for loss of appetite and interest in participating activities of daily life (ADL-activities such as bathing, dressing and toileting a person performs daily) and weakness. During a review of facility's policy and procedures(P&P) titled, Resident Food Preferences, revised 7/2017, the P&P indicated Individual food preferences will be assessed upon admission and communicated to the Interdisciplinary Team (IDT- team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care). The P&P indicated the dietician, nursing staff and physician will identify any nutritional issues and dietary recommendations that might conflict with the resident's food preferences.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review, the facility failed to ensure Restorative Nursing Aide (RNA, nursing aide program that helps residents maintain any progress made after therapy intervention to maintain their function) splinting (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) recommendations and interventions were accurately documented for one of eight sampled residents (Resident 65) in the Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Evaluation, RNA care plan, and RNA flowsheets (daily record of RNA services provided for each month). This deficient practice had the potential to negatively impact the provision of necessary care and services, cause miscommunication and confusion among staff, cause a decline in range of motion (ROM, full movement potential of a joint), and result in the inappropriate type of splint being placed on Resident 65's left arm potentially leading to pain, discomfort, skin breakdown (tissue damage caused by friction, shear, moisture, or pressure), joint (where two bones meet) dislocation (an injury where the joint is forced out of the normal position), deformity (malformation), and/or bone fractures (a crack or break in the bone).Findings:During an observation of an RNA session on 12/10/2025 at 10:51 am in Resident 65's room, Resident 65 was lying in bed. Resident 65's left arm was resting by her side with the left elbow straight, the forearm rotated downwards, the wrist fully bent downwards, and the hand in a fist. Restorative Nursing Aide 1 (RNA 1) assisted with AAROM exercises to Resident 65's left shoulder and left elbow. RNA 1 tried to open Resident 65's left hand by straightening the fingers but was unable. Resident 65 yelled, not my hand! and requested RNA stop the ROM exercises because it was ticklish and painful. RNA 1 applied a splint to Resident 65's left arm which extended from Resident 65's forearm to the palm of the hand. Resident 65's fingers of the left hand were not included in the splint. During a review of Resident 65's admission Record, the admission Record indicated the facility admitted Resident 65 on 11/7/2019 with diagnoses including a left-hand contracture, left hemiplegia (weakness to one side of the body), and chronic obstructive pulmonary disease (lung disease that causes obstruction of airflow and can limit normal breathing). During a review of Resident 65's Minimum Data Set (MDS, resident assessment tool), dated 9/5/2025, the MDS indicated Resident 65 had severe cognitive (mental action or process of acquiring knowledge and understanding) impairment. The MDS indicated Resident 65 required substantial/maximal assistance (helper does more than half the effort) in oral and personal hygiene, setup or clean-up assistance (helper sets up or cleans up and resident completes the activity) with eating, and was dependent (helper does all the effort) in toileting hygiene, bathing, dressing, and rolling to both sides. During a review of Resident 65's care plan, the care plan indicated Resident 65 had limited physical mobility due to contractures, history of stroke (blockage of the flow of blood brain, causing or resulting in brain tissue death), and weakness. The care plan indicated a goal to maintain Resident 65's current level of mobility in both arms and both legs and remain free of complications related to immobility including contractures and skin breakdown through the next review date. The care plan interventions included the application of a left RHS for 2 to 4 hours, 4 times a week.During a review of Resident 65's OT Evaluation, dated 3/25/2025, the OT Evaluation indicated Resident 65 was referred for OT services to trial decreasing frequency of Resident 65's left resting hand splint (RHS, splint secured from the hand to the forearm to position the hand in a functional position) from two (2) to four (4) hours a day, 4 times a week. OT Evaluation indicated Resident 65 had ROM impairments in the left hand and a contracture of the left wrist. The OT Evaluation indicated Resident 65's current splint being trialed for tolerance was an RHS. The OT Evaluation indicated the OT recommendation was for a left resting hand/wrist splint. During a review of Resident 65's Order Summary Report, the Order Summary Report indicated a physician order, dated 3/25/2025, for RNA to apply a splint to Resident 65's left wrist for 2 to 4 hours, 4 times a week.During a review of Resident 65's December 2025 RNA (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	flowsheet, the RNA flowsheet indicated for the RNA to apply an RHS to Resident 65's left hand for 2 to 4 hours, 4 times a week. During a concurrent interview and record review on 12/11/2025 at 10:23 am with the Director of Rehabilitation (DOR), the DOR who was a Physical Therapist (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) stated the purpose of splints was to improve or maintain a resident's ROM and prevent contractures. The DOR stated a licensed PT or OT must assess a resident's need for splints if indicated. The DOR stated that after the therapist assessed a resident for the correct type of splint and established the wear tolerance, the therapist transitioned the splinting plan of care to nursing and the RNA program to implement. The DOR stated the licensed therapist or DOR initiated and updated the RNA care plan which in turn generated a task or intervention for the RNAs to follow when providing RNA services. The DOR reviewed and confirmed Resident 65's splinting documentation on the OT Evaluation (dated 3/25/2025), care plan, and December 2025 RNA flowsheet which contained the RNA task intervention were incorrect. The DOR stated Resident 65 was issued a left wrist splint, not an RHS as incorrectly documented on the OT Evaluation, care plan, and RNA task intervention. The DOR stated the OT Evaluation recommendations, care plan, and RNA flowsheet interventions should match but did not. The DOR stated it was important documentation was accurate to ensure the correct splint was being applied to Resident 65's left arm. The DOR stated inaccurate documentation could potentially lead to staff confusion and incorrect splint application. During a concurrent interview and record review on 12/11/2025 at 1:19 pm with Occupational Therapist 1 (OT 1), OT 1 stated licensed therapists determined the type and fit of a resident's splint and transitioned the splinting plan of care to nursing and RNA when appropriate. OT 1 stated an RHS and wrist splint were different types of splints. OT 1 stated an RHS splint was a specific type of splint which immobilized the wrist and fingers of the hand while the wrist splint immobilized the wrist only and did not include the fingers. OT 1 stated she performed Resident 65's OT Evaluation, dated 3/25/2025 and initiated the care plan which automatically generated the RNA task intervention. OT 1 reviewed Resident 65's OT Evaluation, dated 3/25/2025, and stated she incorrectly wrote the type of splint Resident 65 was to wear on the left arm. OT 1 reviewed Resident 65's care plan and December 2025 RNA flowsheet and confirmed she wrote the incorrect type of splint on Resident 65's care plan and RNA task intervention. OT 1 stated she issued and trained RNA in the application of a left wrist splint, not an RHS. OT 1 stated the OT Evaluation splint recommendation, care plan, and RNA task intervention were incorrect and should have indicated for RNA to apply a left wrist splint, not an RHS. OT 1 stated an RHS was an inappropriate type of splint for Resident 65 since Resident 65's fingers on the left hand were too contracted to tolerate splinting. OT 1 stated inaccurate documentation could potentially result in confusion, decline in ROM, pain, discomfort, and incorrect and inappropriate splint application. During a concurrent interview and record review on 12/11/2025 at 2:51 pm with the Director of Nursing (DON), the DON stated the Rehabilitation department assessed for splints and transitioned the splinting plan of care to nursing and RNA to implement when appropriate. The DON stated documentation accuracy was important to ensure the proper care and services were provided to the residents in the facility. The DON reviewed Resident 65's clinical records and confirmed the splinting documentation on the OT Evaluation, care plan, and RNA task interventions did not match but should have to ensure the proper splint was applied to Resident 65's left arm. The DON stated inaccurate splinting documentation could potentially lead to ineffective treatment, the application of the incorrect type of splint, worsening ROM, contractures, and injury.During a review of the facility's Policy and Procedure (P/P) titled ROM and Contracture Prevention, revised 5/2019, the P/P indicated the facility would ensure that the management of resident joint mobility was provided by an interdisciplinary team approach of assessment, care planning, and preventative or rehabilitative services. The P/P indicated appropriate documentation was completed to address goals of the program and resident tolerance to the program.

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	055262	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lomita Post-Acute Care Center	1955 Lomita Blvd Lomita, CA 90717

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain informed consent and involve the resident representative (an individual chosen by the resident to act on their behalf in decision-making and to access medical, social, or other personal information) prior to administering the influenza vaccine for one of three sampled residents (Resident 31). Resident 31 influenza vaccine was administered after the resident representative had declined the vaccine.This failure placed Resident 31 at risk for receiving medical treatment without informed consent, violation of resident rights, adverse reactions or side effects, loss of trust between the facility and the resident's representative, legal and regulatory noncompliance.Findings: During a review of Resident 31's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-progressive disease that makes it hard to breathe), atrial fibrillation (irregular heartbeat), and dementia (loss of memory, language, problem-solving and other thinking abilities). During a review of Resident 31's History and Physical (H& P) dated 8/25/2025, the H&P indicated Resident 31 had fluctuating capacity to make decisions. During a review of Resident 31's Minimum Data Set ([MDS]resident assessment tool) dated 10/22/2025, the MDS indicated Resident 31 had moderate cognitive impairment (problems with memory and thinking) The MDS indicated Resident 31 needs partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for toileting hygiene, shower/bathe self and personal hygiene. During a concurrent interview and record review on 12/11/2025 at 7:38 a.m. with the Infection Preventionist (IP), Resident 31's Influenza, Pneumococcal Immunization Consent Forms, dated 8/13/2025 and 8/26/2025 were reviewed. The consent form dated 8/13/2025 indicated no resident or resident representative signature indicating consent for the influenza vaccine. Resident 31's Informed Consent for the Pneumococcal Vaccine dated 8/16/2025 was reviewed, the consent form indicated that Resident 31's Resident Representative declined the influenza vaccine at that time. Further review of the Resident 31's Immunization Record indicated that the influenza vaccine was administered on 10/2/2025, despite the documented refusal and absence of a signed consent form. The IP stated that a consent should have been obtained prior to the administration of any immunization. The IP stated the facility's process requires that license staff notify the resident representative prior to administering vaccines, provide education regarding the risks/benefits, obtain a documented consent or refusal, ensure that the consent form was signed, and documented in the electrical health record (EHR- collection of a resident's health information that is stored electronically) before vaccinations were administered. The IP stated the documentation did not reflect a signed consent, nor did it reflect that the representative was contacted prior to administering the vaccination on 10/2/2025. The IP stated failure to obtain proper consent before administering a vaccine could result in violating resident rights, administering treatment without authorization, creating distrust with families, and exposing the facility to liability. During a concurrent interview and record review on 12/11/2025 at 11:50 a.m. with the Case Manager (CM), Resident 31's Immunization Consent Forms dated 8/13/2025, and 8/26/2025, were reviewed. The immunization consent forms indicated the absence of Resident 31's signature or the resident representative's signature. The CM stated she witnessed the consent form on 8/13/2025, despite the absence of a resident or resident representative signature. Further review of Resident 31's record indicated the resident representative was not contacted until 8/26/2025, and the resident representative declined the influenza vaccination. The CM stated that vaccinations should not be administered without verified consent from the resident or the resident's legal representative, as required by facility policy and resident rights regulations. The CM stated administering a vaccine could result in violation of resident rights, administration of treatment against the resident's or representative's wishes, and could lead to adverse reactions, legal liability for the facility, loss of (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trust between residents, representatives, and staff. During a concurrent interview and record review on 12/11/2025 at 2:35 p.m. with the Director of Nursing (DON), Resident 31's Immunization Record indicated that the influenza vaccine was administered on 10/2/2025, despite the documented refusal and absence of a signed consent form. The DON stated there was no education regarding the risks, benefits, or purpose of the influenza vaccination was provided to the resident or resident representative prior to administration. The DON stated administering the vaccination should not have occurred. The DON acknowledged that this incident represented a system failure, specifically related to verification of consent prior to vaccine administration, communication with the resident representative, and oversight of the immunization process. The DON stated administering a vaccine without proper consent could result in violations of resident rights, loss of trust, adverse reactions, and potential legal and regulatory consequences. The DON stated that the failure to obtain a valid consent and provide education prior to administering the influenza vaccination placed Resident 31 at risk for receiving treatment against their wishes or the wishes of their representative, adverse reactions, and a violation of Resident 31's rights. During a review of the facility's policy and procedure (P&P) titled, Influenza Vaccine, dated 2012, the P&P indicated, Prior to the vaccination, the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. (See current vaccine information materials.). During a review of the facility's policy and procedure (P&P) titled, Immunizations-Residents, [undated], the P&P indicated, Before offering any vaccine and to ensure a resident's right to choose, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization.

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview and record review, the facility failed to ensure 12 residents' rooms (Rooms 1, 2, 3, 5, 6, 7, 9, 12, 14, and 15) met the requirements of 80 square feet (sq. ft.) for each resident. This deficient practice had the potential to result in inadequate space, provision for resident care and personal property, and privacy for the residents.Findings:During a facility tour and observation on 12/10/2025 at 11:15 am, the residents residing in these rooms were observed with sufficient space to move around freely within the room, and the nursing staff had enough space to provide care. There were no adverse effects noted to the residents' privacy, health, and safety, which could have been compromised by the size of the rooms. During an observation 12/10/2025 at 11:15 p.m., rooms 1, 2, 3, 4, 5, 6, 7, 9, 12, 14, 15, and 17 did not meet the requirement of 80 sq. ft. per resident.During a review of Client Accommodations Analysis form, provided by the facility's Maintenance Supervisor (MS), the Client Accommodation Analysis indicated Rooms 1, 2,3, 5, 6, 7, 9, 12, and 15, were occupied by two residents each. The MS stated the total sq. ft. measurement was between 68.75 square feet to 77.6 square feet per resident. During a review of Room Waiver letter dated 12/12/25 provided by the Administrator (ADM), the ADM indicated, There were no residents who complained of available space in the resident rooms. The waiver request letter indicated there was adequate space for resident care, and the health and safety of residents occupying the rooms are not in jeopardy.