STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055288	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Hills Health Care Center	430 N.Glendale Ave Glendale, CA 91206

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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 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 observation, interview, and record review, the facility failed to obtain an informed consent for psychotropic/psychotherapeutic (any drug that affects behavior, mood, thoughts, or perception) drug for one of one sampled resident (Resident 5) who was prescribed Quetiapine (medication used to treat a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions), and Divalproex (medication used to treat mental/mood conditions). This deficient practice had violated Resident 5's rights to be informed when choosing the type of care or treatment to be received, make decisions on alternative measures the resident or responsible party preferred, which can negatively affect Resident 5's quality of life. Findings: A review of the admission record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses that included dementia (a group of related symptoms associated with an ongoing decline of the brain and its abilities), psychotic disorder (affect the mind, where there has been some loss of contact with reality), and mood disorder (a mental health condition that primarily affects your emotional state). A review of Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 5/26/2025, indicated Resident 5's cognitive status (the mental process of thinking and understanding) status was severely impaired. The MDS indicated Resident 5 had symptoms of little interest or pleasure in doing things and feeling down depressed or hopeless. The MDS indicated Resident 5 required Setup and clean-up assistance (helper sets up and cleans up; resident completes activity) with eating, supervision or touching assistance (Helper provides verbal cues and or touching steadying) with personal hygiene, and substantial/maximal assistance (helper does more than half the effort) with toileting, showering and dressing. A review of Resident 5's facility document Physician Order Report, dated 6/1/2025 to 6/30/2025, the Report indicated Physician Orders for the following: a) Quetiapine 25 mg (unit of weight) to give 1 tablet at bedtime for psychotic disorder b) Divalproex 125 mg to give 1 capsule twice a day for mood disorder. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 6/5/2025, at 11:04 AM, with Registered Nurse (RN 1), Resident 5's electronic health records (EHR) 12/7/2023 to 6/5/2025 was reviewed. The EHR did not indicate any informed consents obtained from Resident 5 or Resident 5's Responsible party (RP) by the prescriber for the use of the psychotropic medications Quetiapine and Divalproex. RN 1 stated there was no documentation by the prescriber in Resident 5's EHR indicating that informed consents for quetiapine and Divalproex. During a concurrent interview and record review, on 6/5/2025, at 11:32 AM, with RN 1 and Medical Record Director (MRD) 2, Resident 5's facility document titled Facility Verification of Informed Consent to Psychotherapeutic Drugs, Physical Restraint, and/or Prolonged Use of Device dated 3/25/2025 was reviewed. The document indicated informed consent for Psychotherapeutic Drugs Quetiapine and Divalproex did not have the prescribers' signature. RN 1 stated, when there was no prescriber's signature, the informed consent was not valid. RN 1 stated the informed consents must be completed in the documents' entirety, which included obtaining the prescriber ' s signature. RN 1 stated the informed consent for the use of Resident 5's psychotropic medications indicated that Resident 5 or Resident 5's RP was aware and agreed with the use and the effects of the medications. RN 1 stated, not having an informed consent for psychotropic medications violates resident rights. MRD 2 stated, informed consent for psychotropic medications should be completed with the prescriber's signature upon obtaining consent as per policy. During an interview on 6/5/2025 at 11:57 AM with Director of Nurses (DON), the DON stated, Resident 5 ' s informed consent for psychotropic medications Quetiapine and Divalproex was not complete and not valid, since it was not signed by the prescriber when the consent to use the medications was obtained. The DON stated having the informed consent signed by the prescriber was required since the signature ensured the medications were discussed and explained to the resident or the RP, and concerns and alternatives were addressed. DON stated, not having an informed consent for psychotropic medications violates resident rights. A review of the facility ' s policy and procedure (P&P) titled Health Information/Record Manual under Behavior Drugs/ Psychotropic (undated): a) when a Physician orders use of psychotropic/psychotherapeutic drug, the physician will obtain the informed consent from the resident or resident representative, b) the safety, appropriateness, and effectiveness of psychotropic medications must be reviewed every six (6) months and consents for continued administration renewed, and c) the Physician or Nurse Practitioner will sign the Informed Consent form upon obtaining consent from the resident or their representative. A review of the facility ' s policy and procedure (P&P) titled Resident Rights (undated), indicated: a) the company protects and promote the rights of each resident, b) Residents have freedom of choice to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to company ' s rules and regulations affecting residents conduct and those regulations governing protection of resident health and safety.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a homelike environment for two of two sampled residents (Residents 61 and 42) by failing to ensure: 1. Resident 61 ' s wall clock in the room indicated the accurate time of the day. 2, Resident 42 was provided a wall clock. These deficient practices had the potential to affect the quality of life and cause disorientation for both residents and led to Resident 42's verbalization of feelings of frustration. Findings: 1. A review of Resident 61's admission Record indicated the facility admitted Resident 61 on 5/2/2025 with diagnoses that included dementia (progressive decline in cognitive function, memory, and thinking abilities that can impact daily life), depression (a mental health condition that causes persistent sadness, a loss of interest in activities, and can affect how you think, feel, and act), and muscle wasting and atrophy. A review of Resident 61's Minimum Data Set (MDS - a resident assessment tool), dated 5/1/2025, indicated Resident 61 ' s cognitive status (ability to think and reason) moderately impaired. The MDS indicated Resident 61 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating, oral hygiene, personal hygiene, required partial/moderate assistance (helper does less than half the effort) with toileting and dressing, and required substantial/maximal assistance (helper does more than half the effort) with bathing. 2. A review of Resident 42's admission Record indicated the facility admitted Resident 42 on 5/2/2025 with diagnoses that included dementia, generalized osteoarthritis (the cartilage in several joints is slowly breaking down), and osteoporosis (a condition in which there is a decrease in the amount and thickness of bone tissue). A review of Resident 42's MDS, dated [DATE], indicated Resident 42 ' s cognitive status (ability to think and reason) impaired. The MDS indicated Resident 42 required supervision or touching assistance (Helper provides verbal cues and or touching steadying) with eating, required partial/moderate assistance with personal hygiene, and dependent (helper does all the effort) with toileting, bathing and dressing. During a concurrent observation and interview on 6/3/2025 at 10:05 AM with Infection Preventionist Nurse (IPN) in Resident 61 ' s room, Resident 61 was observed staring at the wall clock that reads 4:55 (shorthand pointed at #4 and long hand pointed at #11). IPN stated, the wall clock reading was inaccurate, it was not 4:55, the appropriate time was 10:05 AM. During a concurrent observation and interview on 6/3/2025 at 10:10 AM with IPN in Resident 42 ' s room, observed the room did not have a wall clock. IPN stated, all room should have a wall clock for residents' orientation of time. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/3/2025 at 10:20 AM with IPN, IPN stated, to ensure a homelike environment for the residents, a wall clock with an accurate time was important to provide time orientation. During a concurrent observation and interview on 6/4/2025 at 10:15 AM, Resident 42 ' s was in her room, staring at the clock. Resident 42 stated, she had been asking for a wall clock for a while, and it made her frustrated because she had to ask for the time from the staff every day. Resident 42 stated, she was thankful with the surveyor on pointing it out to the facility staff and she stated it made her more comfortable being able to tell time. During an interview on 6/4/2025 at 11:09 AM with the DON (Director of Nurses), DON stated, having a wall clock that reads the accurate time of the day is important to have in every resident ' s room, it provides orientation, a comfortable and homelike environment. DON stated, not having it in the room had the potential to cause disorientation and/or even frustration to the residents. A review of the facility ' s policy and procedure (P&P) titled, Quality of Life - Homelike Environment, dated 10/2017 indicated: a) Residents are provided with a safe, clean , comfortable and homelike environment, b) staff shall provide person-centered care that emphasizes the residents comfort , independence and personal needs and preferences and c) the facility staff and management shall maximize to the extent possible, the characteristics of the facility that reflects a personalized, homelike setting.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a baseline care plan within 48 hours of resident ' s admission to address the resident ' s medical and physical needs for one of one sampled resident (Resident 241) who was admitted on [DATE] with diagnoses that included chronic congested hear failure (CHF) (heart doesn't pump enough blood for your body's needs), history of pneumonia (an infection of the lungs) and history of acute respiratory failure with hypoxia (lungs cannot release enough oxygen into your blood, which prevents your organs from properly functioning). Resident 241 had a physician order for oxygen inhalation at two liters per minute (a unit that expresses flow rate) via nasal cannula (lightweight tube with two prongs that go gently inside your nostrils) as needed for shortness of breath (SOB) and albuterol (medication used to treat breathing difficulties) as needed for SOB. This deficient practice had the potential for delayed care and services that could negatively affect Resident 241's quality of life. Findings: A review of Resident 241's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses that included chronic congested heart failure, history of pneumonia and history of acute respiratory failure with hypoxia. A review of Resident 241's History and Physical (H & P) dated 5/30/2025, the H & P indicated Resident 241 did not have the capacity to understand and make decisions. A review of Minimum Data Set (MDS - federally mandated resident assessment tool), dated 6/2/2025, indicated Resident 241 required partial/moderate assistance (helper does less than half the effort) with eating and personal hygiene, and required substantial/maximal assistance (helper does more than half the effort) with toileting, bathing and dressing. A review of Resident 241's Physician Order Report (POR) dated 5/29/2025 to 6/30/2025 indicated: a) provide oxygen inhalation at two liters per minute via nasal cannula as needed for shortness of breath, b) administer solution for nebulization (turns liquid medicine into a mist that can be easily inhaled) 2.5 mg (a unit of measurement of mass) every four hours as need for SOB. During a concurrent interview and record review of care plans, on 6/5/2025, at 8:38 AM, with RN (Registered Nurse)1, Resident 241's Electronic Health Record (EHR) (A collection of medical information about a person that is stored on a computer) dated 5/29/2025 (admission date) up to 6/5/2025 were reviewed. The EHR did not include a baseline care plan for Resident 241that indicated the management of CHF, pneumonia, and acute respiratory failure with hypoxia as well as the interventions for SOB (such as oxygen and Albuterol therapy). RN 1 stated, Resident 241 did not have a care plan and interventions for her respiratory diagnoses. RN 1 stated, having the baseline care plan was important to ensure proper care will be provided to Resident 241, not having a care plan had the potential for delayed of care and treatment. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 6/5/2025, at 9:04 AM, with the DON (Director of Nurses), Resident 241's EHR dated 5/29/2025 (admission date) up to 6/5/2025 care plans was reviewed. DON stated, Resident 241 should have a baseline care plan for her respiratory diagnoses within 48 hours upon admission per facility policy to ensure proper guidance and communication between nursing staff with interventions, goals and to promote safety. DON stated, not having a baseline care plan for Resident 241's respiratory diagnoses had the potential to delay the care and services necessary for her quality of life. A review of the facility's policy and procedure (P&P) titled, Base Line Care Plan, (undated), indicated; a) a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission, b) assure that the resident's immediate care needs are met and maintained, and c) the interdisciplinary team (a group of professionals from different fields who work together collaboratively to achieve a common goal) will review healthcare practitioner ' s orders and implement a bassline care plan to meet the residents needs includes initial goals based on the admission records.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 2. During a review of Resident 9's Face Sheet (admission record), the Face Sheet indicated the facility initially admitted the resident on 10/16/2020 , and readmitted on [DATE] with diagnoses including epilepsy (is a neurological disorder characterized by recurrent seizures(uncontrolled movement of body), hypertension(high blood pressure), and pneumonia (infection in the lungs). During a review of Resident 9's History and Physical (H&P) dated 5/10/2025, the H&P indicated Resident 9 did not have the capacity to understand and make decisions. During a review of Resident 9's MDS, dated [DATE], indicated the resident's cognition was severely impaired (a condition that significantly limits the individual's physical or mental abilities, so that he or she is unable to perform basic work activities). During a review of Resident 9's Care Plan with the start date 1/19/2022 indicated the resident was at risk of experiencing seizure and sustaining injury during seizure. The goal with target date 8/31/2025 indicated the resident will have decreased risk of sustaining injury during seizure. The interventions included to apply sheep skin on both siderails to prevent injury at the time of seizure activity and to monitor placement every shift. During an observation on 6/4/2025 at 8:37 AM, in Resident 9 room, the resident was lying in bed with no sheep skin or padded siderails. During an observation and interview on 6/04/2025 at 8:39 AM, in Resident 9 room, with LVN 4 stated she was assigned to Resident 9 with diagnosis of seizure and currently on seizure medication and precaution. LVN 4 stated Resident 9 side rails were not padded. During an interview and record review of Resident 9's active care plan approach start date 6/4/2025, on 6/4/2025 at 8:39 AM, LVN 4 stated the care plan indicated to place sheep skin on both siderails on the side rails and to confirm placement every shift which was not followed. LVN 4 stated the care plan was not followed which could potentially result in injury if Resident 1 has a seizure. During an interview and record review of Resident 9's active care plan approach start date 6/4/2025, on 6/5/2025 at 12:10 PM with DON, the DON stated Resident 9 has a diagnosis of seizure and there was a care plan to place a pad on the siderails and to confirm placement every shift to prevent injury during seizure. The DON stated care plan was not followed and placement was not confirmed every shift which could potentially result in injury to head if Resident 9 has a seizure. 3. During a review of Resident 64' s admission Record (AR), the AR indicated that Resident 64 was originally admitted to the facility on [DATE] with diagnoses including left side maxillary fracture (a break in the upper jaw bone), dementia, and concussion (a mild traumatic brain injury that affects brain function) with loss of consciousness (wakefulness, awareness, or alertness). During a review of Resident 64's Physician Orders dated 4/17/2025, the orders indicated the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Donepezil tablet 10 mg one tablet, oral at bedtime 9 PM. Special Instructions: Give one tablet PO at bedtime for Dementia. b. Memantine tablet 10 mg one tablet, oral twice a day at 9 AM, 5PM. Special Instructions: Give one tablet PO BID (bis in die- twice a day) for Dementia. During a review of Resident 64's History and Physical (H&P) dated 4/21/2025, the H&P indicated that Resident 64 had diagnoses that included dementia. During a review of Resident 64's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 4/21/2025, the MDS indicated that Resident 64 was moderately cognitively impaired (difficulty in memory, language, judgment, and problem-solving). The MDS also indicated that Resident 64 was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity; or the assistance of 2 or more helpers is required for the resident to complete the activity) on rolling left and right, sitting to lying, lying to sitting on side of bed, and sitting to standing. During a review of Resident 64's Care Plans dated from 4/17/2025 to 6/3/2025, there was no documented evidence indicating care plan developed for cognitive impairment / dementia. During a review of Resident 64's Progress Notes dated from 4/17/2025 to 6/3/2025, there was no documented evidence identifying Resident 64's behavior related to cognitive impairment and care interventions addressing care for residents with dementia. During a review of Resident 64's Baseline Care Plan (BCP) dated 4/18/2025, the BCP indicated that Resident 64 was admitted on [DATE] for skilled rehabilitation. The BCP also indicated that the Interdisciplinary Team (IDT) identified behavior concerns related to Resident 64 ' s dementia. There ' s no documented evidence in relation to goals or interventions for dementia care. During an observation on 6/3/2025 and 6/4/2025 in Resident 64's room, observed Resident 64 with disoriented speech such as pointing to the water cup on his bedside table and stated, Is this my water? Resident 64 was also observed pointing to his roommate's area and stated, I think my bed is over there but it ' s fine I ' ll stay here. Resident 64 was also observed making inappropriate comment about surveyor during interview and observation. During a record review and concurrent interview on 6/4/2025 at 3:20 PM with the registered nurse (RN) 1, the RN 1 stated she could not find comprehensive care plan for dementia care in Resident 64 ' s record. RN 1 stated direct care nursing staffs including certified nurse assistants (CNAs) and licensed vocational nurses (LVNs) should follow a comprehensive care plan, which RN 1 stated should have but was never developed since admission, with its focused and person-centered intervention when providing care to Resident 64. The RN 1 also stated that with no care plan developed, Resident 64 ' s dementia care could be compromised when staff had no proper understanding of the goals or clear objectives for Resident 64 about how he should be cared during his stay. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/5/2025 at 3:50 PM with the Director of Nursing (DON), the DON stated a comprehensive care plan for dementia is a guidance for nursing staff who take care of those residents day in day out. DON stated the goal to develop a care plan for residents with impaired cognition generally is to help residents maintain their best function and quality of life. It's the IDT's responsibility to identify and develop a care plan based on the resident ' s condition and level of support needed. During a review of the facility's Policy and Procedure (P&P) titled, Dementia Care Protocol undated. This P&P indicated the following: a. The physician will help identify individuals who have been diagnosed as having dementia and those with otherwise impaired cognition. b. For the individuals with confirmed dementia, the IDT will identify a resident-centered care plan to maximize remaining function and quality of life. c. The IDT will identify and document the resident ' s condition and level of support needed during care planning and review changing needs as they arise. d. The IDT will adjust interventions and the overall plan depending on the individual ' s responses to those interventions and relevant factors. During a review of the facility ' s Policy and Procedure (P&P) titled, Comprehensive Plan of Care undated. This P&P indicated that each resident would have a comprehensive care plan developed that include goals, measurable objectives, and timetables to meet their medical, nursing, mental, and psychosocial needs identified during the comprehensive assessment. The P&P indicated that comprehensive care plan is completed within seven (7) days after completion of the comprehensive assessment (MDS). The P&P also indicated to ensure to maintain the comprehensive care plan in the resident ' s current electronic medical record. Based on observation, interview, and record review, the facility failed to ensure that a comprehensive care plan was completed for three out of three sampled residents (Resident 37, 9, and 64) in accordance to the facility's policy and procedure (P&P) for Comprehensive Plan of Care by failing to: 1. Ensure a care plan for the use of side rails was developed for Resident 37. 2. Ensure a care plan was implemented to apply side rails pads for Resident 9 who has diagnosis of seizure (an abnormal electrical activity in the brain that cause uncotrolled jerking movements, loss of consciousness). 3. Ensure a care plan was developed for Resident 64 who was admitted with diagnosis of dementia (a progressive state of decline in mental abilities). This deficient practice had the potential for residents to sustian injuries and not receive care and services specific to their needs. Findings: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During a review of Resident 37's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), difficulty walking, and muscle wasting. During a review of Resident 37's History and Physical (H&P), dated 12/26/2024, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 37's Minimum Data Set (MDS- a resident assessment tool), dated 3/28/2025, the MDS indicated the resident has severely impaired cognition (the ability to process thoughts). The MDS indicated the resident requires supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) on activities such as rolling left and right while in bed, sitting to lying, sitting to standing, and transferring from chair/bed-to -chair. During a review of Resident 37's Facility Verification of Informed Consent, dated 12/24/2024, the Consent indicated the resident may use bilateral half side rails. During a review of Resident 37's active care plans, the care plans did not indicate a care plan initiated for the use of bilateral half side rails. documented evidence of a care plan to address the resident ' s use of bilateral half side rails. During a concurrent interview and record review on 6/4/2025 at 2:23 PM with Registered Nurse (RN) 2, Resident 37's active care plans were reviewed. RN 2 indicated there was no care plan initiated for Resident 37's use of the bilateral side rails. During an interview on 6/4/2025 at 2:38 PM with Director of Nursing (DON), DON stated there should be a care plan for Resident 37's use of the bilateral side rails. DON stated care plans were required to assist facility staff in addressing the residents' specific needs and to track interventions to monitor if they are effective of not. having a care plan helps in meeting the resident ' s needs. DON added having the care plan helps the facility staff track if interventions are working or need revisions. During a review of the facility's P&P titled, Comprehensive Plan of Care, undated, indicated the each resident will have a comprehensive care plan developed that includes goals, measurable objectives, and timetables to meet their medical, nursing, mental, and psychosocial needs identified during the comprehensive assessment. The P&P also indicated the care plan must describe services that are provided to the resident to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being. The P&P also indicated the care plan must reflect interventions to meet both short and long term resident goals.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide safe and hazard free environment to two of 3 sampled residents (Resident 12 and 9) by failing to: 1. Ensure to place a bed pad alarm (a weight sensor pad used to alert staff when resident gets out of bed which is the most effective tools for reducing falls within the elderly population) Resident 12 who was at high risk for fall as indicated on physician order and comprehensive care plan. 2. Ensure to place a sheep skin on the side rails and confirm placement every shift as indicated in the care plan and physician's order for Resident 9 who has a diagnose of epilepsy (a neurological disorder characterized by recurrent seizures (eratic electrical activity in the brain that causes uncontrolled movement of body). This deficient practice had the potential for the resident to sustain severe injuries and result a decline the residents well being during a fall or seizure. Findings: 1. During a review of Resident 12's Face Sheet (admission record), the Face Sheet indicated the facility initially admitted the resident on 7/3/2024, and readmitted on [DATE] with diagnoses including respiratory failure (a condition where the lungs cannot adequately exchange oxygen and carbon dioxide, leading to low blood oxygen levels or high carbon dioxide levels), chronic kidney disease (a progressive and irreversible condition where the kidneys become damaged over time, affecting their ability to filter waste and fluid from the blood) and unspecified dementia (a progressive state of decline in mental abilities). During a review of Resident 12's History and Physical (H&P - a formal assessment of a patient and their medical condition performed by a healthcare provider, usually during an initial visit) dated 11/21/2024, the H&P indicated Resident 12 did not have the capacity to understand and make decisions. During a review of Resident 12's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 4/3/2025, the MDS indicated the resident ' s cognition (thought process) was severely impaired (a condition that significantly limits the individual's physical or mental abilities, so that he or she is unable to perform basic work activities). During a review of Resident 12's Fall Risk Data Collection dated 5/29/2025 and timed 12:25 PM, indicated the resident was at high risk for fall with the score 16. During a review of Resident 12's Physician order dated 6/1/2025 to 6/30/2025, the physician order start date 3/26/2025 indicated to apply pad alarm in bed and wheelchair to remind Resident not to get up unassisted and monitor placement and function every shift. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Hills Health Care Center	430 N.Glendale Ave Glendale, CA 91206

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 12's Care Plan with start date 7/4/2024 indicated Resident 12 was at high risk for fall that may result to physical harm due to history of fall, balance problem, and muscle weakness. The goal was to decrease Resident's risk for fall and injury with intervention. The interventions included to apply pad alarm in bed and wheelchair to remind resident not to get up unassisted, monitor placement and function every shift. During an observation on 6/5/2025 at 11:26 AM, in Resident 12 room, Resident 12 was lying in bed without a pad alarm in bed and the resident was trying to get out of bed. During an observation and interview on 6/5/2025 at 11:28 AM, in Resident 12 room, with LVN (Licensed Vocational Nurse) 1, LVN 1 stated she was assigned to Resident 12 who had a tendency to get out of the bed unassisted. LVN 1 stated Resident 12 does not have a bed alarm at this time. During an interview and record review of Resident 12's physician order dated 3/26/2025 with LVN 1 on 6/5/2025 at 11:28 AM, LVN1 stated Resident 12 had a physician order to apply pad alarm in bed and wheelchair to remind the resident not to get up unassisted, and to monitor placement and function every shift. LVN 1 stated the physician order was not followed and there was a potential risk for the resident to fall since she was at high fall risk. During another observation and interview on 6/5/2025 at 11:36 AM, in Resident 12 room, LVN 2 stated Resident 12 has a tendency to get out of the bed unassisted and the resident does not have a bed alarm at this time. During an interview and record review of Resident 12's care plan dated 7/4/2024 with LVN 2 on 6/5/2025 at 11:40 AM, the LVN 2 stated there is a care plan to apply pad alarm in bed to remind Resident 12 to not get up unassisted and to alert the staffs if the resident gets up go to the restroom and to assist the resident to prevent potential fall and injury. During an interview on 6/5/2025 at 12:30 PM with DON, the DON stated Resident 12 was at high risk for fall and there was active care plan and physician order to place pad alarm in bed to prevent fall. DON stated care plan and physician order was not followed and there was a potential for the resident to fall and sustain injury. 2. During a review of Resident 9's Face Sheet (admission record), the Face Sheet indicated the facility initially admitted the resident on 10/16/2020 , and readmitted on [DATE] with diagnoses including epilepsy (is a neurological disorder characterized by recurrent seizures(uncontrolled movement of body), hypertension(high blood pressure), and pneumonia (infection in the lungs). During a review of Resident 9's History and Physical (H&P - a formal assessment of a patient and their medical condition performed by a healthcare provider, usually during an initial visit) dated 5/10/2025, the H&P indicated Resident 9 did not have the capacity to understand and make decisions. During a review of Resident 9's MDS, dated [DATE], indicated the resident ' s cognition was severely impaired [a condition that significantly limits the individual's physical or mental abilities, so that he or she is unable to perform basic work activities]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 9 ' s Care Plan with the start date 1/19/2022 indicated the resident was at risk of experiencing seizure and sustaining injury during seizure. The goal with target date 8/31/2025 indicated the resident will have decreased risk of sustaining injury during seizure. The interventions included to apply sheep skin on both siderails to prevent injury at the time of seizure activity and to monitor placement every shift. During an observation on 6/4/2025 at 8:37 AM, in Resident 9 room, the resident was lying in bed with no padded siderails. During an observation and interview on 6/04/2025 at 8:39 AM, in Resident 9 room, with LVN 4 stated she was assigned to Resident 9 with diagnosis of seizure and currently on seizure medication and precaution. LVN 4 stated Resident 9 side rails were not padded. During an interview and record review of Resident 9's active care plan dated 1/19/2022, on 6/4/2025 at 8:39 AM with LVN 4, LVN 4 stated the care plan indicated to place sheep skin on both siderails on the side rails and to confirm placement every shift which was not followed. LVN 4 stated the care plan was not followed which could potentially result in injury if Resident 1 has a seizure. During an interview and record review of Resident 9's active care plan dated 1/19/2022, on 6/5/2025 at 12:10 PM with DON, the DON stated Resident 9 has a diagnosis of seizure and there was a care plan to place a sheep skin pad on the siderails and to confirm placement every shift to prevent injury during seizure. The DON stated care plan was not followed and placement was not confirmed every shift which could potentially result in injury to head if Resident 9 has a seizure. During a review of the facility's policy and procedure P&P titled Physician Orders, approved in August 2024, indicated Physician orders are obtained to provide a clear direction in the care of the resident. During a review of the facility's P&P titled Fall Management , approved on March 2025, indicated Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to reduce the risk of the resident falling and to try to minimize complications from falling . A fall prevention program will be developed for each resident that will provide staff with creative functional strategies to minimize the risk for falls and undue injuries from such incidents, while recognizing the residents' rights and their need to maintain their highest level of functioning. The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident centered falls prevention plan based on relevant assessment information. During a review of the facility ' s policy and procedure (P&P) titled Comprehensive Plan of care , approved on December 2024, indicated Each resident will have a comprehensive care plan developed that includes goals, measurable objectives, and timetables to meet their medical, nursing, mental, and psychosocial needs identified during the comprehensive assessment.

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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 provide necessary respiratory care to one of four sampled residents (Resident 8) as indicated in the physician ' s order and consistent with professional standard of practice by failing to ensure: 1. Nursing staff properly assessed and documented Resident 8 ' s baseline SpO2 level (oxygen saturation level/O2 [oxygen] a measurement of how much oxygen the blood is carrying as a percentage). 2. Ensure the oxygen tubing was not compressed in the side rail to ensure oxygen flow to the resident. 3. Perform respiratory assessment, and document signs and symptoms (S/S) of respiratory distress or shortness of breath (SOB) when providing oxygen therapy to the resident. The deficient practice had the potential to cause over oxygenation (too much oxygen in the lungs) to Resident 8 who has a diagnosis of chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) that can lead to dangerous hypercapnia (too much carbon dioxide in the bloodstream). Findings: During a review of Resident 8 ' s admission Record (AR), the AR indicated that Resident 8 was originally admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including COPD, acute respiratory failure (ARF- a condition where there's not enough oxygen or too much carbon dioxide in the body), and congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 8 ' s Minimum Data Sheet (MDS- a resident assessment tool) dated 5/11/2025, the MDS indicated Resident 8 had severe cognitive (never/rarely made decisions) impairment. The MDS also indicated Resident 8 was diagnosed with heart failure, COPD, and ARF, and Resident 8 received intermittent oxygen therapy upon admission. During a review of Resident 8 ' s physician orders dated 5/7/2025, the order indicated to provide oxygen inhalation at two (2) LPM (liters per minute- a metric unit of capacity) via N/C (a small plastic tube, which fits into the person ' s nostrils for providing supplemental oxygen) PRN (as needed) for SOB. During a review of Resident 8 ' s physician orders dated 5/21/2025, the order indicated to monitor O2 (oxygen) Saturation level Q Shift (every shift), three times a day. During a review of Resident 8 ' s Progress Note (PN) dated from 5/7/2025 to 6/4/2025, there was no documented evidence that Resident 8 was monitored for any signs or symptoms of respiratory distress or SOB prior to providing Resident 8 with oxygen therapy. During a review of Resident 8 ' s Vitals Report dated from 5/7/2025 to 6/3/2025, the report indicated the following: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No documentation of Resident 8 ' s O2 Sat from 5/11/2025 after 5:45 AM to 5/21/2025 at 6:16 PM. When Resident 8 was provided with oxygen NC the liter flow was two (2) to three (3), and Resident 8 ' s O2 Sat was between 95~98%. There was no documented evidence that Resident 8 ' s O2 Sat was assessed for baseline oxygen level on room air prior to oxygen use to indicate the need for oxygen therapy and there was no documentation of oxygen saturation after oxygen N/C was removed. During a review of Resident 8 ' s Daily Medicare Notes (DMN) dated from 5/7/2025 to 6/3/2025, the DMN indicated the following information: DMN dated 5/17/2025 timed at 11:34 AM indicated Resident 8 ' s respiration rate was 18 (per minute) without SOB, lung sound was clear, oxygen saturation was 97 with oxygen given via NC PRN. No S/S of infection or aspiration. The notes indicated Resident 8 was alert, afebrile (no fever), skin warm to touch, resp (breathing) even, unlabored. DMN dated 5/18/2025 timed at 10:44 AM indicated Resident 8 ' s respiration rate was 18 (per minute) with no SOB, lung sound was clear, oxygen saturation was 97 on room air. O2 NC PRN was marked given. Pain level was 0. No S/S of infection or aspiration. And the Narrative Notes indicated Resident 8 was alert, afebrile, skin warm to touch, resp (breathing) even, unlabored. DMN dated 5/21/2025 timed at 3PM indicated Resident 8 ' s respiration rate was 18 (per minute) with no SOB, lung sound was clear, oxygen saturation was 97 with oxygen given via NC PRN. Pain level was 0. No S/S of infection or aspiration. And the Narrative Notes indicated Resident 8 was alert, afebrile, skin warm to touch, resp (breathing) even, unlabored. DMN dated 6/1/2025 timed at 8:39 AM indicated Resident 8 ' s respiration rate was 18 (per minute) with no SOB, lung sound was clear, oxygen saturation was 98 with oxygen given via NC PRN. Pain level was 0. No S/S of infection or aspiration. And the Narrative Notes indicated Resident 8 was alert, afebrile, skin warm to touch, resp (breathing) even, unlabored. DMN dated 6/3/2025 timed at 2:31 PM indicated Resident 8 ' s respiration rate was 18 (per minute) with no SOB, lung sound was clear, oxygen saturation was 97 with oxygen given via NC PRN. Pain level was 0. No S/S of infection or aspiration. And the Narrative Notes indicated Resident 8 was alert, afebrile, skin warm to touch, resp (breathing) even, unlabored. The DMN note documented respiratory assessment per day and not per shift as ordered by the physician. During a review of Resident 8 ' s Care Plan revised 6/5/2025, the care plan indicated to monitor Resident 8 ' s O2 Sat. The care plan also indicated to provide oxygen as prescribed. There was no documented evidence in Resident 8 ' s care plan specifying frequency of monitoring or safe range of O2 Sat or that it included clinical examination or assessment. During an observation and concurrent interview on 6/3/2025 at 10:40 AM with the Licensed Vocational Nurse (LVN 2), LVN 2 stated Resident 8 was receiving oxygen 2 LPM, the O2 tubing was compressed within the side rail and the N/C was not in Resident 8 ' s nose but on the resident ' s chin. LVN 2 stated the O2 tubing should be free from pulling and clear from obstruction. LVN 2 stated the N/C should be in the resident ' s nose to provide supplemental oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review and concurrent interview on 6/4/2025 at 3:30 PM with the registered nurse (RN 1), Resident 8 ' s Physician orders and Daily Medicare Notes (DMN) were reviewed. RN 1 stated Resident 8 ' s physician ordered to provide oxygen via N/C PRN for SOB so it ' s a PRN order. RN 1 stated LVN should document baseline assessment of O2 Sat, SOB present, or any respiratory S/S that made providing oxygen to Resident 8 necessary. RN 1 stated the licensed nurse should not keep Resident 8 on continuous O2 NC when the resident did not need oxygen, because too much oxygen can cause the body to decrease the drive to breathe and it can be toxic especially for residents with COPD. During an interview on 6/4/2025 at 3:50 PM with LVN 1, LVN 1 stated she was the day shift charge nurse for Resident 8 on 6/3/2025. LVN 1 stated she can ' t recall if she reviewed oxygen order when she started her shift that morning. LVN 1 stated she observed Resident 8 was breathing even and unlabored that morning around 9:00 AM, but LVN 1 did not check baseline O2 Sat, but instead Resident 8 continued using O2 NC at 2 LPM because she thought it was better for the resident to keep it on. LVN 1 stated CNAs should not overlook and leave Resident 8 ' s O2 tubing pressed and stuck by the side rail because it could cause limited movement, and the proper amount of O2 may not be delivered to the resident. During a record review and a concurrent interview on 6/6/2025 at 9:30 AM with RN 1, a nursing manual provided by the ADM was reviewed. ADM stated the manual is the standards of practice reference like policy that includes respiratory care for COPD or respiratory failure. RN 1 stated she was unaware of the policy as facility ' s standards of practice reference caring for COPD residents. During a record review and a concurrent interview on 6/6/2025 at 9:50 AM with the Director of Nursing (DON), the Nursing Manual provided by the ADM and DMN dated from 5/7/2025 to 6/3/2025 were reviewed. DON stated she could not find facility policy for COPD or respiratory failure care. DON stated she believed the licensed nurses were following the physician ' s orders and they provided oxygen to Resident 8 to maintain O2 Sat 95% or above. DON stated she could not validate the O2 Sat number she mentioned above as standards of practice because there was no policy to support it. DON also stated licensed nurses ' assessment and documentation should be thorough in regards to Resident 8 ' s oxygen PRN use, such as obtaining the baseline O2 Sat, S/S of respiratory distress, or COPD exacerbation (episodes of worsening of symptoms), and nurses also should have documented assessment again when taking off Resident 8 ' s O2 NC and leaving resident to room air. DON also stated direct care nursing staffs should be careful when they adjust the side rail and make sure O2 tubing not being pulled, pressed, or stuck with side rail. DON stated the nursing staff should also make sure when resident was on O2 NC, the O2 NC need to be in the resident ' s nose not on the chin. During a review of the facility ' s Policy and Procedure (P&P) titled Oxygen Administration undated, the P&P indicated the following: Assist in placing the oxygen delivery device on the resident and make sure it fits properly and is stable. Monitor the resident for signs of hypoxemia (low level of oxygen in the blood) as appropriate, such as: Level of consciousness Pulse oximetry (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Vital signs Skin and mucous membrane color Breathing patterns Dyspnea Cyanosis, cool, clammy skin In the vitals record, treatment Administration Record and/or Medication Administration Record, record: Date and time of oxygen administration, Type of delivery device Oxygen flow rate Resident ' s vital signs, skin color, respiratory effort, and lung sounds, and Resident ' s response before and after initiation of therapy. During a review of the Facility Assessment revised 5/14/2025, the Facility Assessment indicated that the residents of the facility have both chronic illnesses and post-acute conditions. Long-term residents have range of chronic diseases. COPD, the facility has a comprehensive process in place to assess residents needs and determine the care and services required.

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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 and interview and record review the facility failed to follow its policy and procedure and the professional standards of practice on food storage and safety by failing to label the date the bag was opened and when to use by date an open plastic bag with 6 hashbrowns. This deficient practice had the potential to result in food contamination, growth of microorganisms (disease causing organism) that could cause foodborne illness (food poisoning or food illness due to pathogens (harmful organism that cause illness such as bacteria, viruses, or parasites) and toxins that contaminate food and negatively affect the health of the residents who consumes it. Findings: During a concurrent initial kitchen tour observation and interview on 6/3/2025 at 8:05 AM with the Dietary Service Supervisor (DSS) the freezer had an open plastic bag with 6 hashbrowns without an opened date and when to be used by date. The DSS stated, foods in the kitchen should be labeled with an opened date and with a used by date as per facility policy. If the bag was opened, it shortens the shelf life of the food. DSS stated, not having a label on an open bag of hashbrowns, had the potential for contamination and served old that can negatively affect residents ' health when consumed. During an interview on 6/4/2025 at 11:09 AM with Director of Nurses (DON), DON stated, food in the kitchen should be labeled with an opened date and with a used by date as per facility policy. DON stated, having the label was important so the kitchen staff would know when to get rid of the food and not to be serve to the residents. DON stated, it was important to follow these practices because, it potentially could cause food contamination, food borne illnesses that can negatively affect residents ' health. A review of the facility ' s policy and procedure (P&P) titled, Food Receiving and Storage of Cold Foods, (undated) indicated; a) all the perishable food items purchased by the department of food and dinning services will be stored properly, all open food items will have an open date and used by date per manufactures guidelines. A review of the Food Code 2022, indicated 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. Indicated READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5ºC (Celsius) (41ºF) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 3 did not document on the Medication Administration Record (MAR) and the Controlled Drug Record prior to the administration of the medication hydrocodone-acetaminophen (medication to control pain) for one of three sampled residents (Resident 314). This deficient practice had the potential for inaccuracies or discrepancies when administering medications. Findings: During a review of Resident 341 ' s admission Record (AR), the AR indicated the resident was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included rheumatoid arthritis (chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), artificial hip joint, and history of falling. During a review of Resident 341 ' s History and Physical (H&P), dated 5/7/2025, the H&P did not indicate if the resident has the capacity to understand and make decisions. The H&P indicated the resident had pain at the time of assessment. During a review of Resident 341 ' s Minimum Data Set (MDS, a resident assessment tool), dated 5/6/2025, the MDS indicated the resident has intact cognition (the ability to process thoughts). The MDS also indicated the resident receives medication for pain. During a review of Resident 341 ' s Physician Order Report for 6/1/2025 to 6/30/2025, the Report indicated an order for hydrocodone-acetaminophen (medication to control pain), 325 milligrams (mg, a unit of measuring weight) give 1 tablet (by mouth) every six (6) hours, as needed for moderate to severe pain. During a review of Resident 341's Controlled Drug Record for hydrocodone-acetaminophen, the Record indicated one dose of the medication was administered on 6/3/2025 at 9:05 AM. The Record indicated a note to Chart each dose administered. During a review of Resident 341's Medication Administration Record (MAR) for 6/1/20205 to 6/5/2025, the MAR indicated the resident received hydrocodone-acetaminophen at 9:05 AM. During a review of Resident 341's care plan for pain, initiated on 5/2/2025, indicated interventions to administer hydrocodone-acetaminophen. During an observation on 6/3/2025 at 9:05 AM inside Resident 341 ' s room, LVN 3 was observed preparing Resident 341 ' s hydrocodone-acetaminophen inside of a medication cup. After preparing the medication, LVN 3 signed the MAR and Controlled Drug Record. During an observation on 6/3/2025 at 9:08 AM inside Resident 341 ' s room, LVN 3 walked toward Resident 341 and administered the medication hydrocodone-acetaminophen. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/3/2025 at 9:10 AM with LVN 3, LVN 3 stated she signed the Controlled Drug Record and MAR prior to administering the hydrocodone-acetaminophen to Resident 341. LVN 3 stated it was her practice to sign the records prior to administering hydrocodone-acetaminophen since the Controlled Drug Record and MAR must indicate the same time. During a concurrent interview and record review on 6/5/2025 at 9:05 AM with the Director of Nursing (DON), the facility ' s policies and procedures (P&P) titled, Medication Administration, dated 2007, was reviewed. The DON stated when licensed nurses (LN) administer medications, the MAR must be signed after the medication was administered. The DON stated LN must not document on the MAR, prior to the administration of the medication since the resident may still refuse the medication. The DON stated the P&P must be followed by documenting only after a medication was administered. During a review of the facility ' s P&P titled, Medication Administration, dated 2007, the P&P indicated the individual who administers the medication dose, records the administration on the resident ' s MAR immediately following the medication being given. The P&P also indicated when PRN (as needed) medications are administered, the following documentation is provided: a. Date and time of administration, dose, route of administration