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	06/26/2026

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interviews, and record reviews, theˆfacility failed toˆensure theˆtrash bins were properly covered and in sanitary receptacles in accordance with the facility's policy and procedure titled, Sanitation and Infection Control: Waste Control and Disposal. The facility failed to ensure: 1. There was no large puddle of green, foul-smelling water pooled underneath the dumpsters and in the dumpster area on 6/23/26. 2. One of two large dumpster bins was not overflowing with trash with the lid unable to close on 6/23/26. 3. The facility staff did not dispose of an empty box carton onto the large puddle of green, foul-smelling water on the ground of the dumpster area then walked away on 6/23/26. 4. A bag of trash was not left on the ground in the dumpster area on 6/26/26. These failures had the potential to attract pests (unwanted animal or insects that can contaminate food or create unsanitary conditions, such as rodents, flies, or cockroaches) and increased the risk of contamination that could negatively affect the health and safety of residents who rely on the facility for safe food handling and environmental sanitation. Findings: During an observation on 6/23/26 at 11:57 AM, the facility's dumpster area had a large puddle of green, foul-smelling water pooled underneath the dumpsters. One of two dumpster bin was observed overflowing with trash and the lid was unable to close. During another observation on 6/23/26 at 1:45 PM, the same dumpster area was observed. A kitchen staff member was observed throwing an empty box labeled Apple Juice Base onto the puddle of green, foul-smelling water in the dumpster area then walked away. During an interview with the Maintenance Supervisor (MS) on 6/23/26 at 12 PM, the MS stated that the dumpster area was supposed to remain clean and the lid of the dumpster should remain closed to prevent attracting pests to the facility. The MS also stated that the large puddle of green, foul-smelling water had been an ongoing issue for two months and, because the puddle obstructed the path from the kitchen to the dumpster area, the kitchen staff had to step on the water to throw trash from the kitchen into the dumpster. The MS stated the puddle of green, foul-smelling water was unsanitary and risked attracting insects like flies and mosquitoes to the dumpster area. During an interview with the Dietary Supervisor (DS) on 6/23/26 at 12:08 PM, the DS stated that it was not convenient or sanitary for the kitchen staff to step into the puddle of green, foul-smelling water every time they had to throw trash into the dumpsters. The DS stated that stepping in the green, foul-smelling water posed a sanitation issue and risked tracking disease into the kitchen. During another observation on 6/26/26 at 1:51 PM, the same dumpster area was observed with a large bag of trash on the ground next to the two dumpsters in the dumpster area. During a concurrent observation and interview with the Administrator (ADM) on 6/26/26 at 1:52 PM, the dumpster area was observed with a bag of trash on the ground. The ADM stated the trash should have been placed in the dumpster because it was unsanitary to leave trash on the ground. During a review of the facility's Policy and Procedure (P&P) titled, Pest control and dated 6/14/26, the P&P indicated to keep the facility grounds free of trash and brush and to keep the dumpster area clean and the lid closed. During a review of the facility's P&P, Sanitation and Infection Control: Waste Control and Disposal and dated 2023, the P&P indicated to keep lids of outside trash dumpsters closed.

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

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

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain essential mechanical equipment in safe operating condition in accordance with the facility's policy and procedures titled Fire System Maintenance and Sanitation and Infection Control: Dishwashing Procedures (Dish machine). 1. The facility's dishwashing machine's thermometer was not reading accurately for an unknown amount of time between 6/16/26 to 6/23/26. This deficient practice had the potential to expose residents to foodborne illnesses (any sickness caused by eating or drinking foods contaminated with harmful germs [like bacteria or viruses] or toxic chemicals) due to improperly sanitized dishware. 2. The facility's sprinkler system had a leak for weeks and was not repaired until 6/24/26. This deficient practice placed the sprinkler system at risk of malfunction and created the potential for compromised fire protection for residents, staff, and visitors. 1. During an interview with the Dietary Supervisor (DS) on 6/23/26 at 8:29 AM and concurrent observation of the facility's kitchen, the facility's dishwashing machine was observed. The DS stated the dishwashing machine was a low temperature dishwasher, and the staff were required to check and log two temperatures when the dishwasher ran: the Wash Temperatureˆandˆ RinseˆTemperature. The DSˆstatedˆthe wash temperature, and rinse temperatures should both beˆat a minimum ofˆ120 degrees Fahrenheit (F)ˆtoˆproperly cleanˆthe dishware.ˆThe dishwashingˆmachine was run three times and had the following temperatures:ˆ Run 1:ˆWashˆtempˆ110ˆ F, Rinseˆtempˆ110ˆ Fˆ Run 2: Washˆtempˆ110ˆ F, Rinseˆtempˆ110ˆ Fˆˆ Run 3: Washˆtempˆ110ˆ F, Rinseˆtempˆ112ˆ Fˆ The DSˆstatedˆthat the dishwashingˆmachine's waterˆtemperaturesˆhad not reached the goal temperature of at least 120ˆ Fˆafter running it three times.ˆThe DSˆstatedˆthat the staff had to use the facility's two-compartment dishwashing sinksˆto handwash the facility's dishes whileˆthe dishwashingˆmachine was out of order.ˆˆ During another interview with the DS on 6/23/26 at 8:29 AM, the DS stated it was important to make sure that the dishwashing machine's temperature goals were met to make sure that the dishware was clean. The DS further explained that if the dishes were dirty, it could contaminate clean food and residents could become sick from foodborne illnesses (also known as food poisoning caused by consuming contaminated food or water containing bacteria, toxins, or viruses leading to symptoms like nausea, vomiting, diarrhea and stomach cramps). During an interview with the Maintenance Supervisor (MS) on 6/23/26 at 9:45 AM and concurrent observation of the facility's low temperature dishwashing machine, the MS was observed manually checking the water temperature inside of the dishwashing machine. The MS's manual thermometer read 135.1 Fˆand the dishwashing machine's thermometer read 118 F. The MS stated that the dishwashing machine's thermometer was not reading accurately. During another interview with the DS on 6/23/26 at 10:05 AM, the DSˆstatedˆthat she did not know how long the dishwashing machine's thermometer was not reading accurately but the last time it was inspected by the dishwashing machine's company was on 6/16/26. During a review of the facility's Policy and Procedure (P&P) titled, Sanitation and Infection Control: Dishwashing Procedures (Dish machine) and dated 2023, the P&P indicated, Chemical low temperature dish machines must maintain a water temperature of 120F - 140F. 2. During an interview with the MS on 6/23/26 at 11:57 AM and concurrent observation of the facility's dumpster area, water was observed leaking from the roof and dripping into a large puddle of green, foul-smelling water that pooled underneath the dumpsters. The MS stated the water leaking from the roof came from the facility's air-conditioning (AC) system and had been an issue for two to three weeks and needed to be repaired. During another interview with MS on 6/24/26 at 2:20 PM, the MS stated that he initially thought the roof leak came from the AC system but, after investigating further on 6/23/26, it was discovered that the leak came from the sprinkler system. The MS further explained that the release valve for the facility's sprinkler system was damaged which caused the leak from the roof to the dumpster area. The MS stated that the leaking from the sprinklers started two to three weeks ago and required repairs from the sprinkler (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	system's company to fix it. The MS stated that it was important to make sure the sprinkler system was working so it did not leak and, in the event of a fire emergency, the system would work to stop the fire. During a review of the facility's P&P titled, Fire System Maintenance and dated 2/20/26, the P&P indicated . Sprinkler systems. are inspected and maintained periodically in accordance with applicable regulations. The P&P also indicated that a staff member verified the inspection of the sprinkler system and reported any sprinkler problems to the maintenance advisor.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a sanitary environment for 86 of 86 residents, the facility's staff, and the public when water from the facility's roof leaked into a large puddle of green, foul-smelling water in the dumpster area on 6/23/26. This failure created unsanitary conditions and increased the risk of pests, odors, and potential health hazards in an area accessible to staff and visitors. Findings: During an interview and concurrent observation with the Maintenance Supervisor (MS) on 6/23/26 at 11:57 AM, the facility's dumpster area was observed with water leaking from the roof and dripping into a large puddle of green, foul-smelling water that pooled underneath the dumpsters. The MS stated that the large puddle of green, foul-smelling water had been an ongoing issue for two to three weeks and, because the puddle obstructed the path from the kitchen to the dumpster area, the kitchen staff had to step on the water to throw trash from the kitchen into the dumpster. The MS further stated that his assistant usually washed the puddle away every day with a hose, but his assistant was out sick that day. The MS stated the puddle of green, foul-smelling water was not sanitary and risked attracting insects like flies and mosquitoes to the dumpster area. During an interview with the Dietary Supervisor (DS) on 6/23/26 at 12:08 PM, the DS stated that it was not convenient or sanitary for the kitchen staff to step into the puddle of green, foul-smelling water every time they had to throw trash into the dumpsters. The DS stated that stepping in the green, foul-smelling water posed a sanitation issue and risked tracking disease into the kitchen. During another interview with MS on 6/24/26 at 2:20 PM, the MS stated that he initially thought the roof leak came from the AC system but, after investigating further on 6/23/26, discovered that the leak came from the sprinkler system. The MS further explained that the release valve for the facility's sprinkler system was damaged which caused the leak from the roof to the dumpster area. The MS stated that the leaking from the sprinklers started two to three weeks ago and required repairs from the sprinkler system's company to fix it. During a review of the facility's Policy and Procedure (P&P) titled, Pest control and dated 6/14/26, the P&P indicated to keep the facility grounds free of trash and brush and to keep the dumpster area clean and the lid closed. During a review of the facility's P&P titled Sanitation and Infection Control: Waste Control and Disposal dated 6/14/26, the P&P indicated, Facility will dispose of waste that will create the minimum amount of inconvenience, be in concert with all Federal, State, and City regulations . During a review of the facility's P&P titled Infection Control Program and dated 5/12/26, the P&P indicated that important facets of infection prevention included: Identifying possible infections or potential complications of existing infections Instituting measures to avoid complications or dissemination

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide privacy and maintain dignity during the provision of personal hygiene and dressing for four of eight sampled residents (Resident 66 , 16, 10 and 77) in accordance with the facility's policy and procedure titled Resident Dignity & Personal Privacy. This deficient practice had compromise residents' privacy and dignity that could result in embarrassment, emotional distress and a loss of personal respect. Findings: 1.During a review of Resident 66's face sheet (summary of resident's medical record) indicated the resident was admitted on [DATE] with a diagnosis that included fracture of the right femur (broken thigh bone), anemia (blood has too little healthy red blood cells to carry enough oxygen) and muscle wasting and atrophy (a loss of muscle mass and strength). During a review of Resident 66's Minimum Data Set (MDS-a resident assessment tool) dated 5/24/2026, indicated the resident had severely impaired cognition (with significant memory impairment, reduced ability to make decisions and solve problems). 2. During a review of Resident 16's Face sheet (summary of resident' s medical record) indicated the resident was admitted to facility on 9/24/2023, with a diagnosis that included heart disease (general term for conditions affecting the heart), dementia (a progressive condition that causes a decline in memory, thinking and reasoning), anxiety (excessive worry, fear, or nervousness). During a review of Resident 16's History and physical (H&P) dated 11/30/2025, indicated resident 16 lacks capacity to make health care decisions. During a review of Resident 16's Minimum Data Set (MDS-a federally mandated resident assessment tool dated 5/12/2026, indicated Resident 16 is severely cognitively impaired (memory impairment, confusion and disorientation, and limited ability to communicate needs effectively) and dependent on staff for all activities of daily living (ADL's). During an observation on 6/23/2026 at 10:08AM in Resident 66's room with opened privacy curtain while Certified Nursing Assistant (CNA) 1 assisted Resident 66 with dressing after a shower and putting on an incontinent brief, exposing residents' private area. The privacy curtain was open to the hallway and between resident care areas, sliding glass door to the patio remained uncovered. During a concurrent observation and interview on 6/23/2026 at 10:11AM, with CNA 1, CNA1 stated Resident 66 should be provided privacy during personal care and draw the privacy curtains to prevent resident from exposure while dressing. The CNA 1 stated she was focused on the resident from risk of falling and failed to maintain the resident's privacy while assisting the resident with dressing after shower. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 6/23/2026 at 10:16 AM with Registered Nurse (RN) 4, stated Resident 66's privacy and dignity should have been maintained during dressing after shower. RN 4 stated the privacy curtains should have been drawn while providing care to shield the resident from view. During an interview on 6/25/2026 at 2:08 PM with Director of Nursing (DON) stated, CNA1 should have kept Resident 66 covered for privacy while dressing the resident after the shower to maintain the resident's dignity. The DON stated the resident's exposure to the hallway and patio could have embarrassed the resident and made him feel bad. DON stated if he was exposed to the hallway and the patio, it will probably be embarrassing. During an observation on 6/23/2026 at 11: 15 AM in Resident 16's room with the privacy curtain not drawn closed while CNA 2 provided personal hygiene care to Resident 16 who was lying in bed, with the incontinent brief removed, exposing the resident while personal hygiene care was being provided. Resident 16 was nonverbal (unable to talk) with contractures of the upper and lower extremities. During a concurrent observation and interview on 6/23/2026 AT 11:17 AM with CNA 2 in Resident 16's room, CNA 2 she was expected to draw the privacy curtains closed while providing personal care to the residents. CNA 2 stated she knows to have the curtains drawn closed. CNA 2 further stated I should have drawn the curtain closed to provide privacy, respect and dignity to the resident. CNA 2 stated, if someone walks into the room, the resident is exposed. During an interview on 6/25/2026 at 2:08 PM with the DON, the DON stated when providing personal hygiene, the privacy curtain should be drawn to prevent resident exposure. The DON further stated the curtain should have been closed to maintain the residents' privacy and dignity. During a concurrent observation and interview on 6/23/2026 at 11:19 with Licensed Vocational Nurse (LVN 2) in Residents 16 room, LVN 2 acknowledged staff are expected to maintain resident' s privacy and dignity during personal care. LVN 2 further stated yes, we are to have the privacy curtains drawn even if the door is closed and further stated this is necessary to maintain the resident' s dignity, privacy and respect. 3.During a review of Resident 10's, admission Record (AR), (undated), indicated Resident 10 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease (COPD) (progressive lung disease that makes it hard to breathe), diabetes mellitus (blood sugar is too high), and heart failure (heart isn't pumping blood effectively enough to meet your body's needs). A review of Resident 10's Minimum Data Set (MDS-a resident assessment tool) dated 5/14/2026, the MDS indicated Resident 10's cognitive status (the mental process of thinking and understanding) was severely impaired. MDS indicated Resident 10 required partial/moderate assistance (helper does less than half the effort) with eating and personal hygiene. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a review of Resident 77's AR, (undated), indicated Resident 77 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses dementia (umbrella term for a loss of memory, language, and thinking abilities), atrial fibrillation (irregular heartbeat), and COPD. A review of Resident 77's Minimum Data Set, dated [DATE], the MDS indicated Resident 77's cognitive status was severely impaired. MDS indicated Resident 77 required supervision or touching assistance (Helper provides verbal cues and or touching steadying) with eating and personal hygiene. During a concurrent observation and interview on 6/24/2024 at 7:55 AM in Residents 10's and 77's room (roommate's). CNA 5 was observed standing next to Resident 10, who was in bed sitting upright in bed with head of bed elevated, while feeding resident for breakfast. When interviewed, CNA 5 stated, she forgot to sit on a chair to be at the eye level of Resident 10 while feeding, it was dignity issue. During another concurrent observation and interview on 6/24/2024 at 7:55 AM, CNA 6 was also observed standing next to Resident 77, who was in bed sitting upright in bed with head of bed elevated, while feeding resident for breakfast. When interviewed, CNA 6 stated, she should have sat on a chair to be at the eye level of Resident 77 and not stand next to the resident as it violates the resident's rights, and the resident was not treated with dignity. During an interview on 6/24/2026 at 8:30 AM with Licensed Vocational Nurse (LVN) 4, LVN 4 stated, CNAs should be sitting down on a chair to be at the eye level of the resident when assisting with feeding and not stand next to the residents as it violates the resident rights and the resident was not treated with dignity. During an interview on 6/24/2026 at 9 AM with the Director of Nurses (DON), DON stated, she expected the CNAs sitting next to the resident to see eye level while feeding the resident, it was more dignified than standing next to the resident during the process, which violates resident rights and dignity. A review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 5/7/2026, indicated the company protects and promotes the rights of each resident, the right for dignified existence. A review of the facility's policy and procedure (P&P) titled, Assisting the Resident to Eat, dated 6/17/2026, indicated, if the resident needs to be fed, sit at eye level in front of the resident. During a review of the facility's policy titled Resident Dignity & Personal Privacy dated 5/7/2026, indicated Dignity means, when interacting with residents, staff carries out activities that assist the resident in maintaining and enhancing his or her self-esteem and self-worth. The policy indicated the facility will provide care in a manner that respects each resident's dignity, individuality, and right to (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	personal privacy. The policy further requires staff to use a closed door, a drawn curtain, or both to shield residents during personal care and treatment procedures: drape and dress residents appropriately at all times to avoid exposure and embarrassment by maintaining residents' privacy during toileting, bathing, and other personal hygiene activities and cover residents during transfers to the shower or toilet.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 for three (3) of 18 sampled residents (Resident 46, Resident 93, and Resident 6) by failing to: 1. Ensure a bed pad alarm (a weight sensitive mat placed under a resident that alerts staff when they are attempting to get out of bed without supervision or assistance) was connected and functioning for Resident 46. 2. Identify and address potential risks of accident for Resident 93, who was diagnosed with dementia (a severe decline in memory, thinking, and reasoning skills that interferes with a person's ability to perform everyday tasks) and had a pattern of grabbing and pulling on objects including his gastrostomy tube (GT-the tube inserted into the abdomen used to deliver liquid food and medications). 3. Implement intervention consistent with resident needs and care plan in accordance with the facility's policy and procedure titled Fall Management to minimize complications from falling for Resident 6, who had history of an actual fall, a high risk for fall, and was observed in bed without a floor mattress as per physicians order. These deficient practices had the potential to result in a major injury from a fall for Resident 6 and Resident 46, and a potential to result in serious harm or injury to Resident 93 when the resident pulled his feeding tube (a flexible straw-like device that delivers food from a liquid food bag directly into the stomach), which caused his GT pole (a tall stand used to hang a bag of liquid food) fell on him on 6/23/26. 1. During a review of Resident 46's admission Record (AR),ˆthe AR indicated Resident 46 was admitted to the facility on [DATE] with the following diagnoses but not limited to; malignant neoplasm of bladder (uncontrolled growth of cells in the urinary bladder), pulmonary embolism (an obstruction that restricts blood flow to the lungs putting strain on the heart), and history of falling. During a review of Resident 46's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 4/28/2026, the MDS indicated Resident 46 has severe problems with thinking and memory and requires supervision or touching assistance for functions of daily living. During a review of Resident 46's care plan (CP) titled Actual Fall, dated 5/20/2026, the CP indicated that Resident 46 will be included in the Falling Star Program. During an observation on 6/23/2026 at 10:07AM, in Resident 46's room, Resident 46's bed pad alarm was disconnected, and no alarm was heard when he was getting out of bed by himself. During an interview on 6/23/2026 at 10:08AM with Licensed Vocational Nurse (LVN) 1, LVN1 stated that Resident 46 should have an alarm, but he always disconnected it. During an observation on 06/24/2026 at 8:28AM, in Resident 46's room, Resident 46's pad alarm was disconnected while he was sitting in bed. During an interview on 6/24/2026 at 8:33AM, with the Director of Nursing (DON), the DON stated that Resident 46 disconnects his pad alarm all the time. The DON stated that none of Resident 46's CPs indicate interventions with his bed alarm when he unplugs it. The DON stated that this is a concern because there is no documentation about communication with staff about Resident 46's pad alarm issue. During a review of the facility's policy and procedure (P&P) titled, Safety Supervision of Residents, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 9/12/2025, the P&P indicated that there will be an individualized, resident-centered approach to safety by communicating specific interventions, assigning responsibility for carrying out interventions, and ensuring that interventions are implemented. During a review of the facility's P&P titled Falling Star Program, dated 3/24/2026, the P&P indicated that bed pad alarms are to be used for residents in this program. 2. During a review of Resident 93's AR,ˆthe AR indicated that Resident 93 was admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing), intracerebral hemorrhage (stroke), and dementia. During a review of Resident 93's Physician Order Report (POR), the POR indicated on 6/19/26, the physician ordered staff to observe and maintain safety precautions for Resident 93. During a review of Resident 93's SBARˆ(situation, background, assessment, and recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents),ˆdatedˆ6/21/26, the SBAR indicated that the resident had dislodged his GT. During a review of Resident 93's SBAR dated 6/22/26, the SBAR indicated that the resident had dislodged (removed forcefully) his GT for a second time. During a review of Resident 93's MDS, dated [DATE], the MDS indicated that Resident 93 has severe problems with thinking and memory, is dependent (helper does all of the effort) on or needs maximal assistance (helper does more than half the effort) from another person for functions of daily living, and maintains nutritional status (the state of a person's physical health as it relates to how their body takes in, absorbs, and uses nutrients) through the resident's GT. During a review of Resident 93's SBAR, dated 6/23/26, the SBAR indicated Resident 93 had an incident of GT pole fell on resident's abdomen on 6/23/26 at 10 AM. The SBAR indicated Resident 93 was assessed with no pain and no injury, Resident 93's physician was notified and Resident 93's family member was made aware of the accident. The SBAR indicated with an add-on note documented on 6/24/26 at 3:55 PM that Resident 93's family member complained that Resident 93 had pain and discomfort on the left lateral rib cage (the curved, bony structure located on the outer left side of the chest) with the level of 3/10 and Tylenol (medication for pain) was administered as ordered to relieve the resident's pain. During a review of Resident 93'sˆCP, dated from 6/19/2026 to 6/22/2023, there was no documented evidence that a CP was developed and implemented to address the resident's tendency to grab and pull at objects. During an observation onˆ6/23/26ˆat 9:40 AM, in Resident 93's room, Resident 93 was lying on his back in bed with a feeding tube pole on top of his abdomen. Resident 93 was wearing a medical hand mitten (soft, padded covers worn over resident's hands to stop them from pulling at important medical tubes), and the GT extension tubing was entangled around the resident's left wrist. Registered Nurse (RN) 1 was called into Resident 93's room who immediately lifted the pole off Resident 93's abdomen, left the room and stated, does not know the resident well. During a concurrent observation and interview on 6/23/2026 at 9:50 AM with LVNˆ1 in Resident 93 's room, LVN1 assessed Resident 93's abdomen, head, and back for injuries related to the GT falling on (continued on next page)

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	055288	A. Building B. Wing	06/26/2026

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 - Some	top of Resident 93's abdomen. LVN1 stated that she came in and assessed the resident's skin as soon as she heard about the accident. During a concurrent observation and interview on 6/23/2026 at 9:55 AM with the DON in Resident 93's room, the DON moved the feeding tube pole further away from resident's bed. The DON stated that based on Resident 93's condition, it was kind of expected that he would pull the pole on top of himself. During an interview on 6/26/26 at 10:20 AM, the DON stated that the facility failed to address Resident 93's behavior of grabbing and pulling objects to prevent the incident of GT pole falling on the resident on 6/23/26, which increases the potential risk of serious harm or injury. During a review of the facility's Policy and Procedure (P&P) titled, Safety Supervision of Residents, dated 9/12/2025, the P&P indicated: -The facility-oriented approach to safety addresses risks for groups of residents. -Individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents -The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. During a review of the facility's P&P titled, Comprehensive Plan of Care dated 2/9/2026, the P&P indicated that staff must develop a comprehensive care plan for each resident that addresses their individual needs. 3. During a review of Resident 6'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 dementia (decline in brain function that is severe enough to interfere with daily life), heart failure (heart isn't pumping blood effectively enough to meet your body's needs), blindness on left eye, difficulty walking, and muscle wasting and atrophy (weakening, shrinking, and loss of muscle). During a review of Minimum Data Set (MDS, a resident assessment tool), dated 4/13/2026, the MDS indicated Resident 6's cognitive skills (ability to make daily decisions) was severely impaired. The MDS indicated Resident 6's required substantial/maximal assistance (helper does more than half the effort) with toileting and dressing, and partial/moderate assistance (helper does less than half the effort) to roll left and right (the ability to roll from lying on back to left and right side and return to lying on back on the bed). During a review of Resident 6's care plan (CP) dated 1/14/2026, the CP indicated Resident 6 had an actual fall due to a slide from low bed, with the goal that Resident 6 will not have a major injury from possible repeat fall, and the interventions that included the use of low bed with floor mattress. During a review of Resident 6's Physician Order Report (POR), the POR indicated Resident 6 had a physician order on 4/3/2026 to use a low bed with a floor mattress. During a review of Resident 6's Fall Risk Data Collection (FRDC), dated 4/3/2026, it was noted that the resident had poor cognitive skills, had experienced one to two falls in the past three months, was (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	regularly incontinent with assistance, had gait and balance issues, and was considered at high risk for falls. During a review of Resident 6's FRDC, dated 4/22/2026, the FRDC indicated Resident 6 was high risk for falls. During an observation on 6/24/2026 at 8 AM in Resident 6's room, Resident 6's was in bed without a floor mattress. During a concurrent observation and interview on 6/24/2026 at 10 AM with Licensed Vocational Nurse (LVN) 4, in Resident 6's room. Resident 6 was lying in bed without a floor mattress, and LVN 4 checked Resident 6's room but was unable to locate a floor mattress. LVN 4 stated, she does not know where Resident 6's floor mattress is. LVN 4 stated, Resident 6 should always have her floor mattress available to prevent potential major injury from a fall. During an interview on 6/24/2026 at 11 AM with the Director of Nurses (DON), DON stated, Resident 6 should always have a floor mattress when in bed due to her history of fall and being a high-risk for fall. The DON stated the floor mattress was an intervention to minimize complication from a fall. The DON stated, not having a floor mattress had the potential to result in a major injury from a fall which could affect Resident 6's quality of life. During a review of the facility's policy and procedure (P&P) titled, Fall Management, dated 3/24/2026, the P&P indicated: a) staff will identify interventions to the residents' specific risks and try to reduce the risk of the resident falling and to try to minimize complications from falling, and b) fall risk factors include cognitive impairment, lower extremity weakness and visual deficits. During a review of the facility's P&P titled, Comprehensive Plan of Care, dated 2/9/2026, the P&P indicated: a) must address the residents individual needs, include treatment goals and include interventions to attempt to manage risk factors.

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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 proper food safety and sanitation to prevent foodborne illness (also known as food poisoning caused by consuming contaminated food or water containing bacteria, toxins, or viruses leading to symptoms like nausea, vomiting, diarrhea and stomach cramps) for 84 of 86 residents in accordance with the facility's policy and procedure (P&P) titled Sanitation and Infection Control: Personal Hygiene and Sanitation and Infection Control: Handwashing when: 1. [NAME] 1 did not wash his hands upon entering the kitchen and handled food during meal preparation service 2. Dietary Aid (DA) 1 did not wash his hands upon entering and starting work in the kitchen 3. DA 1 did not put on a hair net upon entering the kitchen and during meal prep service. This deficient practice had the potential to result in contamination (transfer of harmful, or dangerous substances [such as chemicals, toxins, or pathogens] into a material, environment, or product) of food and food contact surfaces, increasing the risk of foodborne illness to residents. Findings: During an observation on 6/24/26 at 11:53 AM, tray line (the assembly line used in food-service operations to prepare and portion resident meal trays), [NAME] 1 was observed leaving the kitchen and discarding chicken grease into a grease barrel located outdoors. [NAME] 1 then returned into the kitchen without washing his hands and removed a tray of chicken from the oven and placed the tray of chicken into the food warmers. During the same tray line observation on 6/24/26 at 12:04 PM, DA 1 was observed entering the kitchen with a dolly (a small, wheeled platform used to move heavy items more easily) of boxes. Upon entering the kitchen, DA 1 removed a hair net from the dispenser by the door then put it into the back pocket of his pants. DA 1 then walked to the back of the kitchen into the storage room without a hair net and without washing his hands. During an interview with DA 1 on 6/24/26 at 12:06 PM, DA 1 stated he forgot to put the hair net on when he entered the kitchen. DA 1 further stated he did not wash his hands because the boxes containing food were considered contaminated from the outside. During an interview with the Dietary Supervisor (DS) on 6/24/26 at 12:09 PM, the DS stated that the protocol upon entering the kitchen was for staff to put on a hair net and immediately wash their hands even if they were going to the storage room. The DS further explained that DA 1 and [NAME] 1 needed to wash their hands prior to touching anything in the kitchen. During a review of the facility's Policy and Procedure (P&P) titled, Sanitation and Infection Control: Handwashing and dated 2023, the P&P indicated, Hands must be properly and frequently washed to prevent cross contamination of food supplies or equipment. The P&P also indicated that staff were to wash hands: Before starting work in the kitchen After handling carts, soiled dishes, and utensils Before and after doing cleaning procedures Before and after handling foods After using the toilet, sneezing, using a handkerchief or tissue After touching the face or hair During a review of the facility's P&P titled, Sanitation and Infection Control: Personal hygiene and dated 2023, the P&P indicated, A hair net and/or head covering that covers all hair should be worn during meal preparation and service.

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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 observation interview and record review, the facility failed to ensure the facility obtained a signed informed consent (written document that demonstrates the resident or the resident's legally authorized representative about the resident's provision of care) prior to using bolster (a long, firm cylindrical or wedge-shaped cushion device secured to the bed frame with straps that restricted the resident to freely move in bed) for one of two sampled residents (Residents 67) as indicated in the facility Policy and Procedure (P&P) titled Informed Consent dated 11/3/2025 and Physical Restraints Management. This deficient practice resulted in the resident receiving treatment or interventions without informed consent, compromising the resident's right to make informed healthcare decisions, autonomy, dignity, and self - determination. Findings: During a review of Resident 67's Face Sheet (admission Record) indicated the resident was originally admitted to the facility on [DATE], with a diagnosis that included dementia (a progressive disorder affecting memory, thinking, reasoning, communication, and the ability to perform daily activities), fracture (broken bone) of left humerus (upper arm), and muscle wasting (the loss or shrinking of muscle tissue). During a review of Resident 67's History and Physical (H&P) dated 9/25/2025, indicated Resident 67 does not have the capacity to understand and make decisions. During a review of Resident 67's [NAME] Data Set (MDS - Care-screening tool), dated 3/27/2026 indicated Resident 67's cognitive (thought process) skills mental action or process of acquiring knowledge and understanding for daily decision - making) are severely impaired. The MDS indicated Resident 1 requires moderate assistance (helper does less than half the effort with most tasks of activities of daily living (ADL). During an observation on 6/23/8:54 AM in Resident 67's room, Resident 67 was observed lying in bed in a low position. The Bolster was positioned along the resident's left side and secured to the bed frame with a black strap. The bolster extended from approximately the resident's shoulder to the lower extremities, creating a padded barrier along the left side of the bed. Bilateral half side rails were raised up, and a floor mat was observed on the floor adjacent to the left side of the bed. During a concurrent interview and record review on 6/23/2026 at 9:10AM with RN 2, Resident 67's electronic medical record (PCC) and hard copy chart were reviewed. RN 2 stated there was no documented evidence a consent for use of bolster was obtained from the resident's RP which the resident currently uses. RN 2 further stated the bolster was used to keep the resident from rolling over and getting out of bed. During a concurrent observation and interview on 6/23/2026 at 9:17 AM with Regional Director of Clinical Operations (RDCO) in Resident 67's room, Resident 67 was observed with a bolster secured to the left side of bed, creating a barrier. The RDCO stated, if the bolster inhibits the resident's ability to get out of bed, then the bolster is considered a restraint. The RDCO further stated the bolster was used for resident's safety, so she does not get out bed. RDCO further stated that informed consent should have been obtained because a bolster may be used as a restraint and the resident or the resident's responsible party should have been informed of the risks and benefits prior to its use. During a Concurrent interview and record review on 6/25/2026 at 8:44 AM with Director of Nursing (DON) , Resident 67's medical records were reviewed. The record review revealed no informed consent had been obtained. During an interview with on 6/25/2026 at 2:08 PM with Director of Nursing, DON stated a resident or RP should have been notified, and consent should have been obtained prior to placing any kind of restraint. DON further stated by placing the bolster without consent and by not notifying the residents representatives we are not providing a choice and could be considered being against their free will. During a review of the facility's Policy and Procedures (P&P) dated 11/3/2025, indicated the policy is to ensure that all residents and / or their legally authorized representatives are fully informed and provide voluntary, written informed consent prior to the initiation of any use of physical / chemical restraints. P&P further indicated the main purpose of this Policy is to safeguard resident' s right to autonomy and informed decision - making. During a review of the facility's policy and procedure (P&P) (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled, Physical Restraints Management dated 9/12/2025 indicated: Any mechanical device attached to or adjacent to a resident's body that restricts the resident's freedom of movement or access to one's body is considered a physical restraint. The policy further indicated that physical restraints require a physician's order, informed consent obtained by the physician from the resident or resident representative, documentation in the medical record, care planning, ongoing monitoring, and periodic reevaluation.

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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 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 ensure that the advance directive (a legal document that outlines your preferences for medical care) documentation was readily retrievable by any facility staff for one of 18 sampled residents (Resident^7). This deficient practice had the potential to result in the resident receiving treatment or interventions without informed consent, compromising the resident's right to make informed healthcare decisions, autonomy, dignity, and self - determination having the potential for services not to be provided during medical emergencies according to the residents' wishes. Findings: During a review of Resident^7's admission Record,^the admission Record indicated that Resident^7^was admitted to the facility on [DATE] with diagnoses including^but not limited to; type two diabetes (where the body either cannot make process sugars in the blood properly), chronic kidney disease (kidneys are slowly damaged over time and lose their ability to filter waste and extra fluid from the body), and malignant neoplasm of colon (uncontrolled growth of cells in the large intestine). During a review of Resident^7's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 5/31/2026,^the MDS indicated that Resident^7^was^cognitively impaired, confused, disoriented (lacking mental action or process of acquiring knowledge and understanding) and dependent or needed maximal assistance from another person for functions of daily living. During a review of Resident 7's^Electronic Medical Record (EMR) on 6/24/2026 at 9:45AM, the advance directive documentation could not be located. During a review of Resident 7's physical medical record on^6/24/2026 at 9:55AM, the advance directive documentation could not be located. During an interview on 6/24/2026 at 9:57AM, with Registered Nurse (RN) 3, RN3 stated that she could not locate Resident 7's advance directive documentation in the EMR or physical medical record. During an interview on^6/24/2026 at 10:01AM with the Social Service Director (SSD), the SSD stated that she could not locate Resident 7's advance directive documentation in the EMR or physical medical record. The SSD stated that she provided education to Resident 7 and their family on admission to the facility, but they refused to have an advance directive on file. The SSD stated that it is not the policy to have the advance directive documentation in the resident's EMR or physical medical record. During an interview on 6/24/2026 at 10:10AM, the SSD stated that she found Resident 7's advanced (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	directive documentation in document titled, Social Services Assessment, dated 5/31/2026. During a concurrent interview and record review on 6/25/2026 at 10:10AM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Advance Directives, dated 4/25/2026, indicated that the facility must document in a prominent part of the resident's medical record whether the resident has issued an advance directive. The DON stated that by not filing Resident 7's advance directive documentation in his medical record, staff is not following the P&P correctly and there is potential for services to not be performed during medical emergencies according to the residents' wishes.

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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. Based on observations, interviews, and record reviews, the facility failed maintain a safe, clean and homelike environment for one of 6 sampled residents (Resident 29) with soiled privacy curtains in the resident's room. This deficient practice had the potential to expose residents to an unsanitary environment and does not promote a clean and homelike living environment. During a review of Resident 29's Face Sheet (summary document of clinical information) indicated Resident 29 was admitted to facility on 7/3/2022 with a diagnosis that includes dementia (a decline in memory, thinking, reasoning), heart failure (heart cannot pump enough blood to meet the body' s needs), and glaucoma (eye diseases that decreases vision due to increased pressure in the eye). During a review of Resident 29's Minimum Data Set (MDS - a standardized assessment and care screening too) dated 7/31/2022, indicated the resident had severe cognitive impairment (significant memory loss, and impaired decision making) and required maximum assistance for most activities of daily living (ADLs). During an observation on 6/23/2026 at 9:59 AM, Resident 29 was observed lying in bed touching and grasping with her hand the visibly soiled window curtains hanging alongside her bed adjacent to a sliding glass door. The window curtains were had dried food spots, stains. During a concurrent observation and interview on 6/23/2026 at 10AM with the Administrator (ADM) in Resident 29's room, Admin tated, Yes, the curtains are dirty. I believe the resident grabs them with her hands. The ADM further stated maintenance would be contacted to replace the curtains. The administrator stated the curtains should not be dirty, and acknowledged they could present an infection control concern, stating the condition was not consistent with a home- like environment. During a review of the facility' s policy and procedure titled Resident' s Home- Like Environment dated 1/22/2026, indicated residents must be provided with a home - like , resident - centered environment that promotes dignity, autonomy, comfort, and quality of life while maintaining health, safety, and infection prevention standards. Further indicating the facility environment and furnishings must be : clean, safe, and well - maintained.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility's failed to ensure one of 6 sampled residents (Resident 67) was free from physical restraints (any mechanical device or equipment that is attached to or adjacent to the resident's body, which restricts freedom of movement) in accordance with the facility ?s policy and procedure titled Physical Restraints Management. Resident 67 was observed with Roll Bolster (long, firm cylindrical or wedge-shaped cushion, secured to the bed frame with straps) placed on the left side of the bed which restricted Resident 67 from shoulder to feet, which restricted her ability to sit up, or stand, resulting in the resident unable to reposition independently. The facility failed to: 1. Provide alternative methods to prevent falls prior to the use of Roll Bolster. 2. Obtain a physician order for the use of Roll Bolster to ensure resident was evaluated for appropriate use and safety for use. 3. Informed consent (written document that demonstrates the resident or the resident's legally authorized representative was informed about and voluntarily agree to the use of restraint) obtained from responsible party prior to the use of Roll Bolster. 4. Develop a care plan for the ongoing monitoring, and periodic reevaluation. This deficient practice has the potential for Resident 67 to have increased risk for decreased range of motion, development of pressure ulcer (skin injury due to prolonged unrelieved pressure on the bony portion of the body) and loss of functional mobility to participate in the activities of daily living (ADL). Findings: During a review of Resident 67's Face Sheet (admission Record) indicated the resident was originally admitted to the facility on [DATE], with a diagnosis that included dementia (a progressive disorder affecting memory, thinking, reasoning, communication, and the ability to perform daily activities), fracture of left humerus (upper arm), and muscle wasting (the loss or shrinking of muscle tissue). During a review of Resident 67's History and physical (H&P) dated 9/25/2025, indicated Resident 67 does not have the capacity to understand and make decisions. During a review of Resident 67's [NAME] Data Set (MDS - Care-screening tool), dated 3/27/2026 indicated Resident 67's cognitive skills (mental action or process of acquiring knowledge and understanding for daily decision - making) was severely impaired. The MDS indicated Resident 1 Requires moderate assistance (meaning helper does less than half the effort with most tasks of activities of daily living (ADL's). During a review of Resident 67's active Order Summary Report for 6/2026 indicated no documented evidence the physician ordered Resident 67 to be placed on Roll Bolster. During a review of Resident 67's clinical records from 5/2026 to 6/2026 indicated no documented other alternative measured were used prior to the use of Roll Bolster. In addition, no consent was obtained from Resident 67's responsible party prior to the use of Roll Bolster. During a review of Resident 67's Fall Risk Data Collection dated 3/27/2026 indicated, Resident 67 was at high risk for falls. During an observation on 6/23/8:54 AM in Resident 67's room, Resident 67 was observed lying in bed in a low position. Roll Bolster was positioned along the resident's left side and secured to the bed frame with a black strap. The Roll bolster extended from approximately the resident's shoulder to the lower extremities, creating a padded barrier along the left side of the bed. Bilateral half side rails were in the raised position. A floor mat was observed on the floor adjacent to the left side of the bed. During a concurrent observation and interview on 6/23/2026 at 9AM with Certified Nursing Assistant (CNA) 3 in Resident 67 room, Resident 67 was observed with bolster secured to the left side of bed creating a barrier along the left side of the bed. CNA 3 stated, that is a bolster to prevent her from getting out of bed and further stated she always wants to get out of bed. CNA 3 stated she does not know how long the Roll Bolster has been in use for that remains in resident's bed at all times. During a concurrent interview and record review on 6/23/2026 at 9:10AM with RN 2, a review of Resident 67's electronic medical record (PCC) and hard copy chart were conducted. RN 2 stated there was no documented evidence an informed consent for use of Roll Bolster was obtained from the resident's responsible party. RN 2 further stated, the Roll Bolster was (continued on next page)

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	055288	A. Building B. Wing	06/26/2026

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

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	used to keep the resident from rolling over and getting out of bed. During a concurrent observation and interview on 6/23/2026 at 9:17 AM with Regional Director of Clinical Operations (RDCO) in Resident 67's room, Resident 67 was observed with a Roll Bolster secured to the left side of bed, creating a barrier. The (RDCO) stated, if the bolster inhibits her ability to get out of bed, it is considered a restraint. The (RDCO) further stated we are using it for safety, so she does not get out bed and an informed consent should have been obtained from the resident's responsible party because a Roll Bolster may be used as a restraint and the resident or the resident's responsible party should have been informed of the risks and benefits prior to its use. During a concurrent interview and record review on 6/25/2026 at 8:44 AM with Director of Nursing (DON), Resident 67's medical records were reviewed. The DON stated there was no documented evidence that the physician ordered the use of Roll Bolster, no informed consent was obtained from the resident's responsible party, and no care plan developed for the use of Roll Bolster. DON stated Resident 67 had a tendency to get out of bed and the Roll Bolster prevents the resident from sitting up and exiting the bed independently. During an interview on 6/25/2026 at 2:08 PM with the DON, the DON stated that staff should have obtained a physician's order, consent, and notified the resident or responsible party before placing any restraint. The DON added that placing a Roll Bolster without these steps violates the resident's right to make informed decision and may be considered acting against their free will. During an interview on 6/26/2026 at 9:00AM with Resident 67, stated she could not get out of bed or sit up in bed because of the Roll Bolster that restricted her movement. During a concurrent observation and interview on 6/26/2026 at 9:05 AM CNA 4 stated Resident 67 was at risk for fall a fall and tries to get out of bed alone. CNA 4 stated We use the bolster to prevent her from trying to get out of bed. During a review of the facility's policy and procedure (P&P) titled, Physical Restraints Management dated 9/12/2025 indicated: Any mechanical device attached to or adjacent to a resident's body that restricts the resident's freedom of movement or access to one's body is considered a physical restraint. The policy further indicated that physical restraints require a physician's order, informed consent obtained by the physician from the resident or resident representative, documentation in the medical record, care planning, ongoing monitoring, and periodic reevaluation. The policy also stated that a device may only be considered an enabler if it provides greater function and the resident can independently remove it on command.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two sampled resident (Resident 63) who was a high risk for developing pressure ulcer (a skin injury due to prolonged unrelieved pressure or friction on the skin and body areas of the body) provided with bilateral (both sides) heel protector (a soft material designed to offload pressure from the heels, to prevent pressure ulcers) as ordered by the physicians order and in accordance with the facility's policy and procedures titled Pressure Ulcer/Injury Preventive Measures. This deficient practice had the potential to result in development of pressure ulcer and/or skin breakdown, which could negatively affect Resident 's quality of life.During a review of Residents 63's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included dementia (decline in mental abilities severe enough to interfere with daily life), muscle weakness, and muscle wasting and atrophy shrinking, and loss of muscle). During a review of Resident 63's Minimum Data Set (MDS, a resident assessment tool), dated 5/25/2026, indicated Resident 63's cognitive skills (ability to make daily decisions) was severely impaired. The MDS indicated Resident 63 required substantial/maximal assistance (helper does more than half the effort) with personal hygiene and dressing, roll left and right on the bed and was dependent (helper does all the effort) with eating, toileting and bathing. During a review of Resident 63's Physician Order Report (POR) (Physician Orders) dated 5/21/2026 indicated to always apply bilateral heel protectors when the resident was in bed. During a review of Resident 63's care plan (CP) dated 5/22/2026, indicated, Resident 63 was at risk for pressure ulcer risk related to needing assistance for bed mobility, intervention includes pressure relieving/reducing device in bed. During a review of Resident 63's Braden Scale (early identification of patients at risk for forming pressure sores) for Predicting Pressure Sore (ulcer) Risk dated 5/21/2026 indicated Resident 63 had very limited mobility and high risk for pressure ulcer. During a review of Resident 63's Braden Scale for Predicting Pressure Sore (ulcer) Risk dated 6/3/2026 indicated Resident 63 had very limited mobility and high risk for developing pressure ulcer. During a concurrent observation and interview on 6/23/2026 at 11:35 AM with Licensed Vocational Nurse (LVN) 4 in Resident 63's room, Resident 63 was lying in bed and had limited mobility on both extremities and did not have on his bilateral (both sides) heel protectors. LVN 4 checked Resident 63's room and closet and could not locate the bilateral heel protectors. LVN 4 stated, Resident 63 needs his bilateral heel protector as per physician's order because Resident 63's had limited mobility. LVN 4 stated, not having the bilateral heel protector on both heels had the potential for the resident to develop pressure ulcer and/or skin breakdown. During an interview on 6/24/2026 at 9 AM with Director of Nurses (DON), DON stated, Resident 63 needs to always have his bilateral heel protector on when in bed due to the resident's limited mobility and high risk for pressure ulcer. DON stated, not having the bilateral heel protector on had the potential to result in developing pressure ulcer and/or skin breakdown that could affect Resident 63's quality of life. A review of the facility's policy and procedure (P&P) titled, Pressure Ulcer/Injury Preventive Measures, (undated), indicated a) resident at risk for the development of pressure ulcers/injuries receive interventions to reduce the risk of pressure ulcers/injuries, b) select appropriate support surfaces based on resident's risk factors and c) select medical devices with consideration to the ability to minimize tissue damage and ability to secure the device.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on interview and record review, the facility failed to post in the nursing stations an accurate nurse staffing information of actual hours worked by Registered Nurses (RN), License Vocational Nurse (LVN) and Certified Nurse Aides (CNA) per shift on 6/17/2026 up to 6/24/2026 in accordance with the facility's policy and procedure titled Posting Direct Care Daily Staffing Numbers. This deficient practice of posting inaccurate nurse staffing information misinforms the residents and responsible parties about sufficient staffing ratio per residents to meet their needs which affects their quality of care.Findings: During a review of the facility documents titled Nursing Staffing Daily Posting, (posting of staffing information) dated 6/17/2026 up to 6/24/2026, the document did not indicate, the number of actual time worked per shift for each category (licensed or non-licensed) and type of nursing staff (RN, LVN and CNA), instead it had a combined total number of all nursing staff per shift. During a concurrent interview and record review of the document Nursing Staffing Daily Posting, on 6/24/2026, at 8:55 AM, with the Director of Nurses (DON), the DON stated the document indicated on 6/17/2026 up to 6/24/2026 the posting reflected the combined total nursing staff per shift and not by category or type of nursing staff. DON stated that the nurse posting was inaccurate, it should indicate the actual hours worked per shift, what type and what category of nursing, because the nursing type and category determine what kind of nursing care are provided to the residents. During a concurrent interview on 6/24/2026, at 9 AM, the DON stated, the daily nursing postings are intended to inform the residents, resident's responsible parties and the visitors about the type, category, and hours of nursing care provided in the facility per shift. DON stated these nursing posting must be accurate to prevent misinformation and confusion. A review of the facility's policy and procedure (P&P) titled, Posting Direct Care Daily Staffing Number (undated, indicated, a) shift staff information shall be recorded on the Nursing Staff Directly Responsible for Resident Care form for each shift, b) the information recorded on the form shall include, type (RN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift, and c) the actual time worked during that shift for each category and type of nursing staff.