STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055293	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Anita Convalescent Hospital	5522 Gracewood Ave. Temple City, CA 91780

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 fully inform the resident/ resident's responsible party (RP) in advance, of the risks and benefits of proposed care for two of five sampled residents (Residents 218 and a) reviewed for unnecessary medications in accordance with the facility policy by failing to ensure: 1. An informed consent was obtained from Resident 1 /RP for the use of Valproic Acid (a prescribed anticonvulsant used as a psychotropic medication [a drug that changes brain function and results in alterations in perception, mood, consciousness or behavior]) to stabilize moods in bipolar disorder [a mental illness that causes unusual shifts in mood, energy, and concentration]).2. An informed consent was obtained from Resident 1, who was receiving Rexulti (antipsychotic medication for depression [mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities], schizophrenia [chronic brain disorder that impairs how an individual interprets reality], and dementia-related agitation) and Seroquel (antipsychotic that treats schizophrenia and bipolar disorder [mental health condition causes extreme mood swings that include emotional highs called mania, and lows, known as depression]). This deficient practice had the potential for Residents 1 and 218 not to be able to exercise their right to choose their treatment plan. Findings: 1. During a review of Resident 218's admission Record (AR), the AR indicated Resident 218 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included metabolic encephalopathy (a broad term for any brain disease that alters brain function or structure), dementia (the loss of cognitive functioning [thinking, remembering, and reasoning] to such an extent that it interferes with a person's daily life and activities), major depression disorder (mood disorder that causes a persistent feeling of sadness and loss of interest in life), unspecified psychosis (severe mental condition involving abnormal thinking, perceptions, and loss of contact with reality), anxiety disorder (a group of mental disorders characterized by significant feelings of fear that affect with daily activities), and bipolar disorder. The AR indicated Resident 218's responsible party (RP) is RP 1. During a review of Resident 218's Order Summary Report (OSR), the OSR indicated Resident 218 had a physician order on 2/14/2026 for Valproic Acid oral (by mouth) capsule 250 mg (milligram, unit of weight) to give 1 capsule by mouth two times a day for bipolar disorder manifested by verbal aggression. During a review of Resident 218's care plan related to the use of Valproic Acid, dated 2/15/2026, the care plan indicated the goal was for the resident to be free or remain free of drug related complications and the interventions included to educate the resident and the resident's family about risks, benefits and the side effects (an unintended, secondary response to a medication or medical treatment that occurs in addition to the primary, intended effect) and/or toxic symptoms of (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication. During a review of Resident 218's [NAME] Data Set (MDS, a resident assessment), dated 2/18/2026, the MDS indicated Resident 218's was severely impaired (difficulty with or unable to make decisions, learn, or remember things) with cognitive skills for daily decision making. During a concurrent interview and record review on 5/28/2026 at 10:30 AM with Assistant Director of Nursing (ADON), Resident 218's Electronic Health Record (a digital version of a patient's medical chart) and physical medical chart (the official, systematic documentation of a patient's medical history and clinical care) from 2/15/2026 to 5/28/2026 were reviewed. ADON stated that Resident 218 has been receiving Valproic Acid since 2/15/2026 but there was no consent on file for its use. During an interview on 5/28/2026 at 3:12 PM with RP 1, RP1 stated he was not aware that Resident 218 was receiving Valproic Acid for verbal aggression. RP 1 stated that the facility did not inform RP 1 about the use of Valproic Acid, did not explain the associated risks and benefits, and did not indicate whether any alternative interventions were attempted before initiating the medication on Resident 218. During an interview on 5/28/2026 at 5:07 PM with the Director of Nursing (DON), the DON stated that prior to initiating Valproic Acid, consent should have been obtained from RP1 to review the purpose of the medication, its potential side effects and reactions, and how the medication would help the resident's condition. During a review of the facility's policy and procedures (P&P) titled, Guidelines for Psychotherapeutic Medications, revised June 2017, the P&P indicated When anticonvulsants are utilized for treatment of behavior, monitoring of behaviors and side effects shall be completed. Informed consent shall be obtained and documented for each new order. 2. During a review of Resident 1's admission Record indicated a readmission to the facility on [DATE] with diagnoses that included vascular dementia (a decline in thinking and memory skills caused by restricted or blocked blood flow to the brain), schizophrenia (severe, chronic brain disorder that impairs a person's ability to interpret reality, causing symptoms like hallucinations, delusions, and disorganized thinking), unspecified mood (affective) disorder (mental disorders characterized by a disturbance in mood which is abnormally depressed or elated). During a review of Resident 1's History and Physical Assessment (H&P) dated 3/1/2026 indicated Resident 1 had good decision-making capacity. During a review of Resident 1's Order Summary Report indicated the following physician's orders: Seroquel Oral Tablet 25 milligram (mg, unit of measure) give 1 tablet via gastrostomy (g-tube, medical device inserted through the abdomen directly into the stomach) two times a day for schizophrenia manifested by yelling out without cause, ordered 4/21/2026 and discontinued on 5/11/2026. Rexulti Oral Tablet 1 mg (Brexpriprazole) give 1 tablet via g-tube one time a day for dementia manifested by yelling without cause, ordered 5/15/2026. During a review of Resident 1's Informed Consent for the use of Seroquel, dated 4/21/2026, the Informed Consent did not reflect a signature from Resident 1 or Resident 1's Representative to (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicate that an informed consent was obtained. During a review of Resident 1's Consents for the use of Rexulti dated 5/15/2026, the Informed Consent did not reflect a signature from Resident 1 or Resident 1's Representative to indicate that an informed consent was obtained. During an interview with the DON on 5/28/2026 at 4:47 PM, the DON stated Informed Consent is explained to resident/responsible party by the Physician. The resident or family will then agree or disagree with the treatment or medication. The DON stated the informed consent on the electronic medical record is printed out for the resident/responsible party and physician to sign. The DON stated the hard copy with the signature is left in the resident's physical medical chart. The DON stated if the signed consent is not found in the physical medical chart, it should be found on the electronic medical chart, uploaded in the documents section. The DON stated it was important for the informed consent to be completed and signed because it validates that the resident/family agreed to the treatment. A review of the facility's policy and procedure (P&P) titled Informed Consent, dated 4/1/2024 indicated the Informed consent must be signed by the resident or the resident's representative and the physician who provided the material information. The P&P indicated copies of the signed informed consent form shall be given to the resident or the resident's representative.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure call lights (communication system in care facilities that allowed residents to instantly alert nursing staff when help was needed) were within reach and readily accessible for four of 35 residents (Resident 38, 77, 301, and Resident 386) by failing to: Provide an adaptive call light (customized version of a call light that allowed resident's with limited strength, mobility, or dexterity to easily call for help) when the resident was observed not being able to use the call light provided.Place Resident 77's call light within reach and provide an adaptive call light when the resident was observed not being able to use the call light provided.Place Resident 301's call light within reach and provide an adaptive call light when the resident was observed not being able to use the call light provided.Place Resident 386's call light within reach. These deficient practices placed Resident 38, 77, 301, and Resident 386 at risk for delayed staff response, unmet needs, and potential negative outcomes related to resident safety and well-being.Findings: 1. During a review of Resident 38's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included adult failure to thrive (a decline caused by chronic disease and functional impairments which could cause weight loss, decreased appetite, poor nutrition, and inactivity), lack of coordination, and muscle weakness. During a review of Resident 38's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 4/11/2026, the MDS indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember, used judgement, and make decisions). The MDS indicated the resident was dependent (helper did all of the effort and the resident did none of the effort to complete the activity) on facility staff in all functional abilities. During a review of Resident 38's Occupational Therapy (OT) Evaluation & Plan of Treatment dated 3/23/2026 to 4/19/2026, the Evaluation indicated the resident's medical factors included bilateral upper extremity (BUE) joint contractures (a stiffening/shortening at any joint, that reduced the joint's range of motion) and Resident 38 was dependent of all Activities of Daily Living (ADLs, routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves). The Evaluation indicated during Resident 38's Musculoskeletal System Assessment, the resident's upper extremity range of motion (ROM) and strength were impaired. The Evaluation indicated the reason for Resident 38's skilled services included the resident presenting with impairments in fine motor coordination (the ability to use small muscles, mostly in your hands and fingers to make precise, controlled movements), mobility, and strength. During an observation in Resident 38's room on 5/26/2026 at 3:54 PM, the resident was observed with the call light in the resident's right hand and Resident 38 was asking for milk. Resident 38 was asked to pull the call light to request facility staff for assistance but was unable to physically pull the call light. During a concurrent observation and interview in Resident 38's room on 5/26/2026 at 4:34 PM, Licensed Vocational Nurse (LVN) 16 stated the resident was unable to use the call light because Resident 38's right hand doesn't really work well. LVN 16 stated Resident 38 should have been able to use the call light to call for help when the resident needed assistance otherwise the facility would not know and if there was an emergency the resident would not be able to call the facility staff. 2. During a review of Resident 77's AR, the AR indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included hemiplegia (partial weakness) and hemiparesis (total or near-total paralysis) affecting left non-dominant side, left hand contracture, and muscle wasting and atrophy (muscles shrink, lose tissue mass, and become weak). During a review of Resident 77's MDS dated [DATE], the MDS indicated the resident had severe cognitive impairment. The MDS indicated the resident needed substantial/maximal assistance (helper did more than half the effort) from facility staff for transfers, upper/lower body dressing, and oral/toileting hygiene. During a review of Resident 77's OT Evaluation & Plan of Treatment dated 5/15/2026 to 6/25/2026, the (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Evaluation indicated Resident 77 was dependent on all ADLs. The Evaluation indicated Resident 77 required total assistance from basic ADLs due to limited strength which significantly impacted the resident's ability to perform functional tasks independently. During an observation in Resident 77's room on 5/26/2026 at 10:43 AM, Resident 77's call light was observed behind the resident's right shoulder and when the resident was asked to call the facility staff for assistance, the resident was unable to reach or physically pull the call light. During a concurrent observation and interview in Resident 77's room on 5/26/2026 at 10:54 AM, Certified Nursing Assistant (CNA) 4 stated the call light was used for residents to call the facility staff for anything the resident needed. CNA 4 stated Resident 77 did not have the call light within reach and was unable to pull the call light. CNA 4 stated if the call light was not within reach and the resident was unable to use the call light; Resident 77 could fall or get hurt and break a bone. During a concurrent observation and interview in Resident 77's room on 5/26/2026 at 11:15 AM, LVN 17 stated the call light was used to call facility staff for care or if the resident have questions and should have always been within the resident's reach otherwise the facility staff would not be notified if the resident needed something or something happened to the resident. LVN 17 stated Resident 77 was not able to physically pull the call light but should have been able to if the resident was provided with the adaptive call light which is appropriate for the resident's need. LVN 17 stated if the resident was unable to pull or use the call light, Resident 77 would not be able to get the help the resident needed. 3. During a review of Resident 301's AR, the AR indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included mild neurocognitive disorder (any condition that caused a decline in brain function, affecting memory, thinking, or reasoning), cerebral ischemia (blood flow to the brain was blocked or reduced), and dementia (a progressive state of decline in mental abilities). During a review of Resident 301's History & Physical (H&P) dated 7/9/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 301's MDS dated [DATE], the MDS indicated the resident had severe cognitive impairment. The MDS indicated the resident required substantial/maximal assistance and/or was dependent on facility staff in all functional abilities. During a review of Resident 301's OT Evaluation & Plan of Treatment dated 10/2/2025 to 10/8/2025, the Evaluation indicated Resident 301 was dependent on all ADLs and the resident's Mobility Function Score was zero (ranged from zero to 12, 12 being the highest). The Evaluation indicated the resident's right and left upper ROM was impaired. The Evaluation indicated the reason for Resident 301's skilled services included impairments in gross motor coordination and mobility resulting in limitations and/or participation restrictions in the areas of self-care. During an observation in Resident 301's room on 5/26/2026 at 10:47 AM, Resident 301's call light was observed clipped to the top right-hand side of the bed and when the resident was asked to call the facility staff for assistance, the resident was unable to reach or physically pull the call light. During a concurrent observation and interview in Resident 301's room on 5/26/2026 at 10:59 AM, CNA 4 stated Resident 301 did not have the call light within the resident's reach and the resident was unable to use the call light. CNA 4 stated the call light should have been within Resident 301's reach and the resident should have been able to use the call light otherwise Resident 301 could fall or get hurt and break the resident's arm. During a concurrent observation and interview in Resident 301's room on 5/26/2026 at 11:23 AM, LVN 17 stated the resident was not able to pull the call light to call for facility staff assistance. LVN 17 stated if the resident was unable to call for facility staff due to the call light is not appropriate for the resident, Resident 301 would not get the help the resident needed. 4. During a review of Resident 386's AR, the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included muscle weakness, hemiplegia and hemiparesis affecting the right dominant side, and heart failure (condition that developed when the heart did not pump enough blood for the body's needs). During a review of Resident 386's H&P dated 5/14/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 386's MDS dated [DATE], the MDS indicated the resident had severe cognitive impairment. The MDS indicated the resident (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	required substantial/maximal assistance from facility staff for transfers and was dependent on facility staff for lower body dressing, toileting hygiene, and walking 10 feet. During a review of Resident 386's OT Evaluation & Plan of Treatment dated 5/14/2026 to 6/10/2026, the Evaluation indicated the resident was referred to OT due to a decline in ability to perform functional activities without physical assistance, ADL participation, functional mobility/capacity, and strength. The Evaluation indicated the resident required partial/moderate assistance, substantial/maximal assistance, and was dependent on facility staff for all ADLs. The Evaluation indicated the resident's right and left upper extremity strength was impaired. The Evaluation indicated the reason for Resident 386's skilled services was due to impairments in fine motor coordination, mobility and strength resulting in limitations and/or participation restrictions in areas of mobility and self-care. During an observation in Resident 386's room on 5/26/2026 at 11:07 AM, the resident's call light was observed hanging from the wall and the clip attached to the call light was broken and unable to be secured. Resident 386 could not reach the call light while in bed. During a concurrent observation and interview in Resident 386's room on 5/26/2026 at 10:40 AM, LVN 17 stated the resident's call light clip was broken and did not clip on the bed. LVN 17 stated this must have been missed during the morning rounds, but the call light should have been placed within Resident 386's reach so the resident could get help when needed. During an interview on 5/28/2026 at 4:30 PM, the Director of Nursing (DON) stated call lights should have been within the residents' reach and was used to let the facility staff know when the resident needed help. The DON stated if the call light was not within the resident's reach the facility staff would not know when the residents need help or assistance. The DON stated if a resident was unable to physically use the call light, the rehabilitation department (medical unit dedicated to helping people recover or improve skills needed for daily life) would have to evaluate and screen for a more appropriate device such as an adaptive call light to meet the resident's needs. During a concurrent interview and record review on 5/28/2026 at 4:33 PM with the DON, the facility's policy and procedure (P&P) titled Communication - Call System dated 10/24/2022 as reviewed. The P&P indicated the purpose of the P&P was to provide a mechanism for residents to promptly communicate with nursing staff. The P&P also indicated the facility would provide a call system (call light) to enable residents to alert the nursing staff from their beds and would be placed within the resident's reach in the resident's room. The P&P indicated an adaptive call bell or call light (e.g. flat pad call cord, hand bell, etc.) would be provided to a resident per the resident's needs. The DON stated the facility staff were not following the policy but should have been to ensure the resident's needs were being met. The DON stated if the facility was not following the policy there could be extended waiting times for the resident's needs to be met.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the Minimum Data Set (MDS, a federal mandated resident assessment tool) was accurate for six of seven sampled residents (Residents 55,126, 134, 233, 263 and 346) in accordance with the facility's policy and procedure. This failure had the potential for Residents 55,126, 134, 233, 263 and 346 resulted in inaccurate documentation in the resident's medical record which could impact continuity of care, facility reporting accuracy, and regulatory compliance.Findings: 1. During a review of Resident 55's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (when problems with your metabolism cause brain dysfunction), and chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs).During a review of Resident 55's MDS, dated [DATE], the MDS for Section A indicated an incorrect Resident 55's first and last name.During a review of Resident 55's MDS dated [DATE], the MDS for Section A indicated an incorrect Resident 55's first and last name. 2. During a review of Resident 126's admission Record (AR), the AR indicated the resident was originally admitted to the facility on [DATE] and then readmitted on [DATE] with diagnoses including osteoarthritis of the hip (wear-and-tear condition where the protective cartilage covering the ends of the thigh bone (femur) and hip socket gradually wears away), chronic kidney disease (when the kidneys are damaged for more than a few months). During a review of Resident 126's MDS dated [DATE], the MDS for Section A indicated an incorrect Resident 126's first and last name. During a review of Resident 126's MDS dated [DATE], the MDS for Section A indicated an incorrect Resident 126's first and last name. 3. During a review of Resident 134's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] with diagnoses including cerebral ischemia (a condition that occurs when there isn't enough blood flow to the brain), end stage renal disease (when the kidneys no longer work well enough to meet the body's needs).During a review of Resident 134's MDS dated [DATE], the MDS for Section A indicated an incorrect Resident 134's first and last name. During a review of Resident 134's MDS dated [DATE], the MDS for Section A indicated an incorrect Resident 134's first and last name. 4. During a review of Resident 233's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] with diagnoses including kidney failure (when your kidneys lose the ability to filter waste products from your blood effectively), type 2 diabetes mellitus (your body does not use insulin properly)During a review of Resident 233's MDS dated [DATE], the MDS for Section A indicated an incorrect Resident 233's first and last name. During a review of Resident 233's MDS dated [DATE], the MDS for Section A indicated an incorrect Resident 233's first and last name. 5. During a review of Resident 263's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] with diagnoses including hypertension (high blood pressure), angina pectoris (chest pain or discomfort that occurs when a part of your heart doesn't get enough blood and oxygen)During a review of Resident 263's MDS dated [DATE], the MDS for Section A indicated an incorrect Resident 263's first and last name.During a review of Resident 263's MDS dated [DATE], the MDS for Section A indicated an incorrect Resident 263's first and last name. 6. During a review of Resident 346's admission Record (AR), the AR indicated the resident was originally admitted to the facility on [DATE] with diagnoses including anemia (the body does not have enough healthy red blood cells to carry oxygen to the body's tissues), cardiomyopathy (a disease of the heart muscle).During a review of Resident 233's MDS dated [DATE], the MDS for Section A indicated an incorrect Resident 233's first and last name.During a review of Resident 233's MDS dated [DATE], the MDS for Section A indicated an incorrect Resident 233's first and last name. During an interview and concurrent record review of Resident's 55,126, 134, 233, 263, and 346's MDS on 5/28/2026 at 12:55 PM with the MDS Nurse (MDSN), the MDSN stated she was responsible in making sure all the resident MDS assessments were completed and transmitted to the Centers for Medicare and Medicaid (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Services (CMS) system timely and accurately. MDSN stated the facilities MDS system auto populates the residents name from their electronic health care record. MDSN stated sometimes when residents are admitted , the admitting nurse will input names incorrectly and when business office corrects the names in the system, they should let her know so she can complete modification MDS and submit to CMS. MDSN stated this will notify the CMS on the change in the residents' name and the correct residents' information are being transmitted. MDSN stated she was unaware of the name changes that had been made to Resident's 55,126, 134, 233, 263 and 346 names and that is why she did not submit a modification MDS. During an interview on 5/28/2026 at 4:33 AM with the Director of Nursing (DON), the DON stated if there are any changes in a resident's status, names or if the MDS was not documented accurately, it could affect the continuation of care for the residents negatively and result in the incorrect tracking for the resident's outcome. DON stated all MDS should be documented correctly with correct patient's names to ensure the facility is assessing the residents accurately and transmitting the correct patient's information to CMS. During a review of the facility's Policy and Procedure (P&P), titled RAI Process, with a revision date of 10/01/2019, the P&P indicated, The facility will utilize the Resident Assessment Instrument (RAI) process as the basis for the accurate assessment of each resident's functional capacity and health status, as outlines in the CMS RAI manual.

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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 maintain a safe environment for four of five residents (Residents 187, 228, 275, and 338) in the accidents care area when:1. The facility did not ensure both of Resident 187's siderails were (a bar attached to the bed that is used to prevent patients from accidentally rolling off or falling) padded for seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) precautions as indicated in the facility's policy and procedure (P&P) titled, Seizure Precautions.2. The facility did not post an Oxygen in Use sign on the door frame of Resident 228's room, who was actively using an oxygen machine, as indicated in the facility's P&P titled, Oxygen Administration.3. The facility failed to ensure Certified Nurse Assistant (CNA) 1 verify the resident's need for substantial or maximal assistance (helper does more than half the effort. Helper lifts, or holds trunk or limbs and provides more than half the effort) to request help before attempting to transfer Resident 275 from the toilet seat to the resident's wheelchair and ensure LVN 1 revise the resident's plan of care specific to the resident's physical assistance needs with interventions that included the level of assistance to address the resident's left below knee amputation (LBKA, surgery to remove the lower part of the left leg) to reduce the risk of falls. 4. The facility failed to ensure bed brakes were locked for Resident 338 in accordance with the facility's policy and procedure (P&P) titled Fall Management Program These deficient practices placed Resident 187 at risk of injury in the event of a seizure and placed Resident 228 at risk of injuries from fire hazards and improper handling of oxygen equipment. In addition, it had the potential to create unintended bed movement resulting in potential injury to Resident 338 and resulted in Resident 275's slid down and his LBKA stump (the remaining part of an amputated arm or leg) hit the floor. Findings: 1. During a review of Resident 187's admission Record, the record indicated Resident 187 was admitted to the facility on [DATE] with diagnoses including epilepsy (a long-term brain disorder caused by sudden bursts of electrical activity in the brain that lead to repeated seizures, which can include uncontrollable shaking, staring spells, or brief loss of consciousness) and other disorders of the brain. During a review of Resident 187's Minimum Data Set (MDS- a resident assessment tool) dated 5/6/2026, the MDS indicated Resident 187 had severe cognitive impairment (a profound decline in mental functioning—affecting memory, language, reasoning, and understanding—that significantly impairs daily life and typically necessitates substantial supervision) and was dependent (helper does all the effort) for all cares including turning in bed. During an observation on 5/26/2026 at 10:19 AM, Resident 187 was observed in her bed. Resident 187's left siderail was padded but the right siderail was not. A siderail pad was observed under 187's bed. During a concurrent observation and interview with Licensed Vocational Nurse (LVN) 19 on 10/26/2026 at 10:26 AM, Resident 187's unpadded right siderail was observed. LVN 1 stated both of Resident 187's siderails should have been padded for seizure precautions. LVN 19 stated the pad should not have been left under Resident 187's bed and should have been placed back on the siderail after staff provided care. LVN 19 further stated all staff were responsible for ensuring the pads on the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	side rails were placed for residents with seizure precautions to ensure the residents did not suffer an injury in the event of a seizure. During an interview with the Director of Nursing (DON) on 5/28/2026 at 9:57 AM, the DON stated Resident 187 could have sustained injuries if the resident had a seizure and the pads were not on Resident 187's siderails. The DON further stated that staff should have ensured proper placement of the siderail pads every time they performed cares for residents on seizure precautions. During a review of the facility's Policy and Procedure (P&P) titled, Seizure Precautions and revised on 6/1/2017, the P&P indicated, The facility will provide preventative measures prior to and during seizure activity to prevent resident injury to the extent possible. The P&P further indicated that residents considered at high risk for seizure activity had seizure precautions initiated including seizure pads placed on the resident's side rails. 2. During a review of Resident 228's admission Record, the record indicated Resident 228 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing) and muscle weakness. During a review of Resident 228's MDS dated [DATE], the MDS indicated Resident 228 was cognitively intact and only required setup or clean-up assistance with most cares such as eating and personal hygiene. During a review of Resident 228's physician orders report dated 5/28/2026, the report indicated the following order, OXYGEN at two (2) liters per minute [lpm- a measure of oxygen flow] via nasal cannula [a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen] as needed for prevention of oxygen saturation [O2 sat- a measurement of how much oxygen the blood is carrying as a percentage] below 92%. During an observation on 5/26/2026 at 9:35 AM, Resident 228 was observed with a nasal cannula on and oxygen machine at the resident's bedside. There was no Oxygen in Use sign posted on the door frame of Resident 228's room. During an interview with LVN 19 on 5/26/26 at 9:40 AM, LVN 19 stated the staff forgot to put an Oxygen in Use sign on the door frame of Resident 228's room. LVN 19 further explained that the oxygen sign was a warning for anyone who entered Resident 228's room not to have an open flame near his oxygen machine in order to prevent a fire or explosion. During an interview with the DON on 5/28/2026 at 4:57 PM, the DON stated oxygen usage signs were supposed to be posted outside the resident's room to notify staff and visitors that oxygen was being used in the room. The DON stated if the sign was not posted, flammables could be brought close to the oxygen which could cause combustion. The DON further explained that not posting the Oxygen in Use sign was a safety issue. During a review of the facility's P&P titled, Oxygen Administration and revised 6/1/2017, the P&P indicated, residents using oxygen will have an 'Oxygen in Use' sign placed on the door frame of their room. 3. During a review of Resident 275's admission Record (AR), the AR indicated Resident 275 was admitted on [DATE] and readmitted on [DATE] with diagnosis that included diabetes mellitus (a (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	group of diseases that result in too much sugar in the blood), left eye blindness (the complete or nearly complete loss of sight), and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). The AR indicated on 4/15/2026, Resident 275 had a new diagnosis of acquired absence of LBKA. During a review of Resident 275's care plan (CP) for the resident's risk for falls and/or injuries related to unsteady gait related to DM with foot ulcer (an open sore or wound on the foot that fails to heal properly), revised on 3/28/2026 the CP indicated the resident will reduce risk of falls and/or injury with added new interventions on 4/24/2026 that included to provide assistance with transferring and locomotion (the act or power of moving from one place to another) as needed. During a review of Resident 275's admission summary, dated [DATE], the summary indicated Resident 275 was readmitted to the facility with LBKA. During a review of Resident 275's Fall Risk Assessment, dated 4/15/2026, the assessment indicated Resident 275 was at a moderate risk for falling with weak gait. During a review of Resident 275's Physical Therapy Discharge Summary (PTDS) for the period of 4/16/2026 to 5/8/2026, the PTDS indicated on 4/16/2026, Resident 275 was dependent on chair-to-chair transfer and needed substantial/maximal assistance in sit to stand. During a review of Resident 275's Physician Progress Note (PPN), dated 4/17/2026, the PPN indicated Resident 275 was readmitted to the facility and on therapy services for decline in ADLs (Activities of Daily Living, daily self-care activities), function, mobility after hospitalization with a LBKA procedure on 4/9/2026. During a review of Resident 275's [NAME] Data Set (MDS, a resident assessment tool), dated 4/19/2026, the MDS indicated Resident 275's cognition (the ability to think, remember, and reason) is intact, Resident 275 utilized wheelchair as mobility device. During a review of Resident 275's Change in Condition Evaluation (CIC), dated 4/21/2026, indicated on 4/21/2026, in the afternoon time (not specify when), Resident 275 had an accidental slight impact to LBKA during patient care. The CIC indicated Resident 275 reported to LVN 1 that the resident's LBKA stump accidentally made contact with the floor, upon transfer by the CNA from the toilet back to his chair. During a review of Resident 275's Nurses Progress Notes (NPN) documented by LVN 1 on 4/21/2026, the NPN indicated on 4/21/2026 at around 6:50 PM, Resident 275 reported to LVN 1 that the resident's LBKA stump accidentally made contact with the floor, upon patient transfer by the CNA 1 from the toilet back to the resident's chair due to the CNA trying to put him (Resident 275) back onto the chair by herself. During a concurrent observation and interview on 5/26/2026 at 3:35 PM with Resident 275 at the facility's activity area, Resident 275 was sitting on his wheelchair with the LBKA stump covered with wound dressing. Resident 275 stated on 4/21/2026, CNA 1 attempted to transfer him alone by herself even though he normally required two staff members to assist him. Resident 275 stated, when transferring him from the toilet seat to his wheelchair, CNA 1 was unable to hold him up, causing him to slide down and his left stump hit the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/29/2026 at 11:40 AM with LVN 1, LVN 1 stated on 4/21/26, CNA 1 asked for her assistance, and when she entered the room, Resident 275 was not on the floor, but the resident's left stump was touching the floor. LVN 1 stated, Resident 275 reported that CNA 1 was helping Resident 275 transfer from his toilet seat to his wheelchair when the resident slid down because CNA 1 could not hold him up. LVN 1 stated, CNA 1 had attempted to help Resident 275 by herself, but the resident was too heavy for CNA 1 to handle. During an interview on 5/29/2026 at 12:40 PM with CNA 1, CNA 1 stated on 4/21/2026 in the afternoon time (CNA 1 could not remember the exact time), she was helping to transfer Resident 275 from the toilet seat to the resident's wheelchair. CNA 1 stated, the wheelchair handles were facing away from Resident 275, he could not use them to stand up so CNA 1 tried lifting the resident up by holding under the resident armpits. CNA 1 stated Resident 275 was too heavy for her to lift, so he slid down and his left stump landed on the floor. CNA 1 stated Resident 275 was still on the edge of the toilet seat with his left stump on the floor when CNA 1 came out to call for help from LVN 1. CNA 1 stated she had never cared for Resident 275 before, had not received any change of shift report regarding the level of assistance that Resident 275 required, and therefore attempted to transfer the resident alone. During a concurrent interview and record review on 5/29/2026 at 1:43 PMˆwith Rehabilitation Program Manager (RPM), Resident 275's PTDS dated 4/16/2026 and weight summary dated 4/21/2026, were reviewed. RPM stated, the record indicated Resident 275 was dependent on transferring from chair to chair including transferring from his wheelchair to the toilet seat. RPM added that due to Resident 275's new readmission diagnosis of LBKA and recorded weight of 212 pounds (unit of weight) on 4/21/2026, the resident required two-person physical assistance from the nursing staff and this information was communicated verbally to the nursing staff during daily huddle (to gather closely together in a small group) on 4/21/2026. During a concurrent interview and record review on 5/29/2026 at 2:41 PMˆwith the MDS Nurse (MDSN), Resident 275's care plans for the resident's risk for falls were reviewed. MDSN stated when Resident 275 was readmitted on [DATE] after LBKA surgery, the fall risk care plan should be revised to reflect the resident' most current condition of LBKA. MDSN stated the added intervention of provide assistance with transferring on 4/24/2026 was too general and it should be specific on how much assistance and how many person physical assistance that Resident 275 required for transferring. During a concurrent interview and record review on 5/29/2026 at 2:50 PMˆwith the MDS Nurse (MDSN), Resident 275's MDS dated [DATE] and care plan that address the resident's risk for falls and/or injuries related to unsteady gait with added new intervention on 4/24/2026 were reviewed. MDSN stated that the MDS indicated Resident 275 required maximal assistance for toilet hygiene and transfers. MDSN stated based on the resident's condition of 200pound in weight, and new LBKA, the resident required two-person physical assistance, which should have been clearly specified in the care plan for safety. The MDSN added that without adequate and proper assistance, the residents could fall. During an interview on 5/29/2026 at 3:40 PM with the Director of Nursing (DON), the DON stated the resident's care plan should be specific to the resident with the level of assistance needed for the resident to prevent fall.ˆ During a review of the facility's policy and procedures (P&P) titled Fall Risk Assessment, revised (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	June, 2017, the P&P indicated: A)The Facility will ensure that the resident's environment remains as free of accident hazards as it possible, and that each resident receives adequate supervision and assistance to prevent accidents. B) An episode where a resident lost his/her balance and would have fallen, if not for staff intervention or if the resident caught themselves, is considered a fall. C)Facility Staff, with the support of the Attending Physician, will evaluate any post admission changes in a residents' functional and psychological status (a person's current mental [how a person thinks] and emotional [how a person feels] condition) that may increase fall risk, such as: changes in ambulatory ability, and balance. During a review of the facility's P&P titled, Fall Management Program, revised May 2026, the P&P indicated the program is to prevent resident falls and minimize complications associated with falls. The P&P indicated the facility will provide the highest quality care in the safest environment for the residents residing in the facility and the Fall Management Program is designed to prevent residents falls through meaningful assessments, interventions, education, and re-evaluation. The P&P also indicated the Nursing Staff will develop a plan of care specific to the resident's needs with interventions to reduce the risk of falls and interventions will be implemented or changed based on the resident's condition and response. 4. During a review of Resident 338's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included parkinsonism (a group of brain conditions that caused slowed movements, stiff muscles, tremors, and balance issues), osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D), and adult failure to thrive (a decline caused by chronic disease and functional impairments which could cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 338's Fall Risk (Morse) Assessment (a quick checklist used by healthcare providers to predict how likely a resident was to fall) dated 4/19/2025 at 12:04 PM, the Assessment indicated the resident was high risk for fall. During a review of Resident 338's History and Physical (H&P) dated 12/16/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 338's Physical Therapy Progress Report dated 5/1/2026 to 5/7/2026, the Progress Report indicated the resident was on precautions for falls and the resident's Functional Skills Assessment (evaluated how well a person could perform everyday tasks needed for independent living or work) indicated the resident was dependent (needing someone else for support, help, or survival). The Progress Report indicated the resident's Mobility Function Score was zero (ranged from zero to 12, 12 being the highest function). During a review of Resident 338's Minimum Data Set (MDS, resident assessment tool) dated 5/8/2026, the MDS indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). During a review of Resident 338's History of Risk for Fall Care Plan dated 5/14/2026, the Care Plan indicated a goal for the resident to reduce the risk of falls or injury through appropriate interventions daily. The Care Plan indicated interventions to include a low bed, wheels locked, and call light within reach. During an observation in Resident 338's room on 5/26/2026 at 2:44 PM, the resident was observed in (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bed and the bed brake indicator was in the horizontal position with the left side of the indicator being green and the right side of the indicator being red. The indicator was not positioned toward the red marking that indicated the brakes were engaged or locked. During a concurrent observation in Resident 338's room and interview in Resident 338's room on 5/26/2026 at 3:02 PM, Certified Nursing Assistant (CNA) 5 stated the resident's bed was not locked and it should have been locked otherwise the bed could have moved and the resident could have fallen. During an interview on 5/26/2026 at 3:16 PM, Licensed Vocational Nurse (LVN) 18 stated Resident 338's bed was not locked because the bed brake indicator was in a horizontal position. LVN 18 stated the resident's brakes should have always been locked otherwise the resident could have fallen and have an injury or worse. During an interview on 5/28/2026 at 4:35 PM, the Director of Nursing (DON) stated bed safety features included for the bed to be lowered to the ground, and ensuring the beds were locked. The DON stated Resident 338's bed did not seem to be locked but should have been to prevent staff and resident injury. The DON stated if the bed was not locked, Resident 338 could have had a fall or fracture (break in the bone) and the resident could have been scared. During a concurrent interview and record review on 5/28/2026 at 4:49 PM with the DON, the facility's policy and procedure (P&P) titled Fall Management Program dated 6/1/2017 was reviewed. The P&P indicated the purpose of the P&P was to prevent resident falls and minimize complications associated with falls through the development of a Fall Management Program. The P&P also indicated the policy of the facility was to provide the highest quality of care in the safest environment for the residents residing in the facility. The P&P indicated universal fall prevention measured for all residents included placing the residents bed in the lowest position with the brakes locked. The DON stated the facility staff were not following the policy but should have been to prevent fall and injury like a fracture.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures to ensure the accurate acquiring, administering of drugs and biologicals to meet the needs for two (2) of three (3) sampled residents (Residents 2 and 202) observed for medication administration by failing to:Administer Resident 2's Lactulose oral solution (a medication used to treat chronic constipation)Administer Resident's 202's Rivaroxaban (to help prevent strokes or serious blood clots) oral tablet 20 milligrams (mg, units of measurement) and Venlafaxine Hydrochloride (a medication used to treat depression (a mood disorder characterized by persistent feelings of sadness, hopelessness, and a loss of interest in activities)) oral tablet 75 mg with foodThis deficient practice had resulted in Resident 2 and Resident 202 not receiving their medications as physician's order, which could negatively affect the residents' overall wellbeing.3. An accurate Controlled Drug (a drug or chemical whose manufacture, possession, and use are strictly regulated by the government because of its potential for abuse, misuse, or dependence) Record (CDR)s for Resident 2's use of hydrocodone-acetaminophen (a controlled drug to manage moderate to serve pain).This deficient practice had potential to lead to controlled drug abuse and diversion (when a medication is taken for use by someone other than whom it is prescribed or for an indication other than what is prescribed). Findings: 1. During a review of Resident 2's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems) and atrial fibrillation (an irregular and often very rapid heart rhythm). During a review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care planning screening tool), dated 4/11/2026, indicated Resident 2 had intact cognitive (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 2 was independent with eating. The MDS indicated Resident 2 required partial/moderate assistance (helper does less than half) with toileting hygiene, shower/bathe self and chair/bed-to-chair transfer. During a review of Resident 2's Order Summary Report dated 5/28/2026, the Order Summary Report indicated a physician's order for Lactulose oral solution 20 grams (g-a unit of measurement) per 30 milliliters (ml-a unit of measurement) give 30 ml by mouth two times a day for bowel management, hold for loose stools. During a review of Resident 2's Medication Administration Record (MAR), dated May 2026, the MAR indicated Resident 2 to receive Lactulose oral solution 20 grams give 30 ml at 9 AM and 6 PM. During a concurrent medication pass observation and interview on 5/27/2026 at 9:19 AM with Licensed Vocational Nurse 12 (LVN 12), LVN 12 was observed preparing eight medications as listed below: 1.Cranberry (dietary supplement) 450 mg tablet (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.Depakote 125 (medication used to treat bipolar disorder (mental health condition causes extreme mood swings) mg tablet 3.Calcium Supplement (dietary supplement) 600 mg tablet 4.Stool Softener Docusate Sodium (medication for constipation)100 mg tablet 5.Cymbalta (medication used to treat depression) 60 mg cap tablet 6.Eliquis (anticoagulant medication) 2.5 mg tablet 7. Fish oil (dietary supplement)-1,000 mg tablet 8.Mutil Vitamin with minerals tablet During an observation on 5/27/2026 at 9:32 AM, LVN 12 brought the eight medications into Resident 2's room and started administering the medications. Resident 2 stated he did not see her Lactulose among the eight medications and asked LVN 1 where her Lactulose was. LVN 12 stated she forgot and returned to the medication cart to get Resident 2's Lactulose. LVN 12 stated the medication cart had an empty bottle of Lactulose and proceeded to ask LVN19 for Lactulose from the facilities medication storage room. During a follow up interview and observation on 5/27/2026 at 9:45 AM, LVN 19 was observed informing LVN 12 that the facility had run out of Lactulose, and she would be calling the pharmacy to ask them to deliver the medication as soon as possible. During an interview and record review on 5/28/2026 at 4:25 PM with the Director of Nursing (DON), the DON stated the licensed nurses should administer medications as scheduled to avoid medication error and prevent potential adverse effects from the underdosing and overdosing the residents. The DON 1 stated nurses should reorder medication before it runs out to prevent Residents from missing scheduled medications. 2.During a review of Resident 202's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] with diagnoses including paraplegia complete (total loss of function, including the ability to feel sensation and move) and hypotension (low blood pressure). During a review of Resident 202's MDS, dated [DATE], indicated Resident 202's had intact cognitive skills for daily decision making. The MDS indicated Resident 202 requires supervision (helper provides verbal cues) with eating. The MDS indicated Resident 202 required partial/moderate assistance with oral hygiene, upper body dressing and personal hygiene. The MDS further indicated Resident 202 was dependent (helper does all of the effort) toileting hygiene, showers and lower body dressing. During a review of Resident 202's Order Summary Report dated 5/12/2026, the Order Summary Report indicated a physician's order for: Rivaroxaban oral tablet 20 mg give 20 mg by mouth one time a day for DVT (a blood clot that forms within the deep veins). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Venlafaxine Hydrochloride (HCL) oral tablet 75 mg, given by mouth one time a day for depression manifested by verbalization of sadness. During a review of Resident 202's Medication bubble pack for Rivaroxaban oral tablet 20 mg, the medication bubble pack indicated take medication with food. During a review of Resident 202's Medication bubble pack for Venlafaxine HCL oral tablet 75 mg, the medication bubble pack indicated take medication with food. During a medicationˆpass observation on 5/27/2026 at 9:04 AM with LVN 12, LVN 12 was observed administering Rivaroxaban oral tablet and Venlafaxine HCL oral tablet to Resident 202 with water and without food. After administering the medications, LVN 12 walked back to her medication cart to document Resident 202's medication administration record. During a concurrent interview and record review with LVN 12 on 5/27/2026 at 9:40 AM, LVN 12 stated she was aware that Resident 202's Rivaroxaban oral tablet and Venlafaxine HCL oral tablet required administration with food, but she assumed it was acceptable to administer them without food because Resident 202 had eaten breakfast around 7AM. During an interview and record review on 5/28/2026 at 4:20 PM with the Director of Nursing (DON), the DON stated Resident 202's medication bubbleˆpack label indicated to administer Rivaroxaban oral tablet and Venlafaxine HCL oral tablet medications with food. The DON stated LVN 12 should have provided Resident 202 with a cracker or cookie if it was not mealtime and should not have administered the medications without food. The DON stated all licensed nurses administering medications should follow the medication orders to prevent potential undesired side effects. During a review of the facility's Policy and Procedure (P&P) titled, Medication Administration, revised 6/1/2017, the P&P indicated, Medications will be administered by a licensed nurse per the order of an attending physician or licensed independent practitioner. 3. During a review of Resident 2's admission Record (AR), the AR indicated the facility originally admitted Resident 2 on 10/21/2023 and readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (a progressive, incurable lung disease that blocks airflow and makes it hard to breathe) and arthritis (a disease that causes damage in your joints). During a review of Resident 2's Minimum Data Set (MDS, an assessment and care planning tool), dated 4/11/2026, indicated Resident 2 had intact cognitive (ability to think and reason) skills for daily decision making. During a review of Resident 2's Order Summary Report, dated 5/29/2026, the report indicated the physician ordered to administer: 1. hydrocodone-acetaminophen oral tablet 5-325 milligram (MG, a measurement unit) one tablet by mouth every four hours as needed for moderate pain, starting on 4/15/2026. 2. administer hydrocodone-acetaminophen oral tablet 5-325 MG two tablets by mouth every four hours as needed for severe pain, starting on 5/27/2026. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2's Controlled Drug Record (CDR) of hydrocodone-acetaminophen 5-325 MG 5-325 MG one-tablet and observation of the bubble pack, it showed the following: The CDR indicated a licensed nurse signature (not identified) on 5/27/26 at 1:40 AM on the line indicating 30 units/tablets (leaving 29 units/tablets) LVN 13's signature on 5/28/2026 at 12 AM on the line indicating 29 units/tablets (leaving 28 units/tablets). The bubble pack showed 28 tablets. The CDR did not reflect the medication administered on 5/27/2026 at 9:39 AM, which should leave the bubble pack with 27 tablets. During a review of Resident 2's CDR of hydrocodone-acetaminophen 5-325 MG 5-325 MG two-tablets and observation of the bubble pack, it showed the following: A licensed nurse signature (not identified) on 4/22/2026 at 6:55 PM on the line indicating 30 units/doses (leaving 29 units/doses = 58 tablets) LVN 12's signature on 5/27/2026 at 9:37 AM on the line indicating 29 units/doses (leaving 28 units/doses = 56 tablets) The bubble pack showed 29 units/doses = 58 tablets The bubble pack should have been left with 28 units/doses = 56 tablets. During a review of Resident 2's Medication Administration Record a(MAR), dated 5/1/2026 to 5/31/2026, the MAR indicated Resident 2 received hydrocodone-acetaminophen 5-325 MG one-tablet on 5/27/2026, timed at 9:39 AM. The MAR did not reflect that Resident 2 received hydrocodone-acetaminophen 5-325 MG one-tablet on 5/28/2026 at 12 AM. During a concurrent observation, interview, and CDR review on 5/28/2026 at 2:08 PM with LVN 12, LVN 12 stated she administered hydrocodone-acetaminophen 5-325 MG one tablet to Resident 2 on 5/27/2026 at 9:39 AM. LVN 12 stated she signed the CDR form indicating two tablets instead of the CDR indicating one tablet of hydrocodone-acetaminophen 5-325 MG. During an interview with LVN 13 on 5/29/2026 at 9:53 AM, LVN 13 stated Resident 2 complained of pain and had requested hydrocodone-acetaminophen 5-325 MG one tablet on 5/27/2026 at around 11:30 PM. LVN 13 stated she signed the CDR hydrocodone-acetaminophen 5-325 MG 5-325 MG one-tablet on 5/28/2026 at 12 AM. LVN 13 stated she did not end up administering the medication because Resident 2 refused. LVN 13 stated she should not have signed the CDR form prior to (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration and since she did not administer it at all, she should have put a strike through on her signature and indicate error. LVN 13 stated it was important to have an accurate documentation to ensure necessary resident care was provided. During an interview with LVN 13 on 5/29/2026 at 9:57 AM, LVN 13 stated she conducted the narcotic count, including Resident 2's CDR, with LVN 14 on 5/27/2026 at 11 PM and with LVN 12 on 5/28/2026 at 7AM. During an interview with LVN 14 on 5/29/2026 at 11:07 AM, LVN 14 stated she conducted the narcotic count, including Resident 2's CDR, with LVN 12 on 5/27/2026 at 3PM and with LVN 13 on 5/27/2026 at 11PM. LVN 14 stated there were no discrepancies on Resident 2's CDR as compared to the bubble pack for both hydrocodone-acetaminophen 5-325 MG 5-325 MG and two tablets. During a concurrent review of Resident 2's CDR of hydrocodone-acetaminophen 5-325 MG 5-325 MG one and two tablets and observation of the bubble packs and interview with the Director of Nursing (DON) on 5/29/2026 at 2:40 PM, the DON stated the nurses should verify the discrepancies on the CDR and bubble pack. The DON stated the nurses should document correctly on the CDRs to ensure correct counts for the controlled medications. The DON stated the nurses should verify the physical doses of the controlled medication counts against the CDRs during their shift change controlled drug reconciliation. The DON further stated this will ensure all controlled medications were accounted for and are reported immediately if there are any discrepancies. The DON stated correct documentation and thorough controlled drug count could prevent abuse, diversion and ensure necessary care is provided to the residents. During a review of the facility's Policy and Procedure (P&P) titled, Medication Storage in the Facility-ID2: Controlled Substance Storage, dated 1/2022, the P&P indicated At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items is conducted by two licensed nurses and is documented. During a review of the facility's P&P titled, Medication Administration, dated 6/1/2017, indicated licensed nurse will chart the drug, time administered, and initial his or her name with each medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to:1. Discard an expired Bottle and Dressing Pack (a sterile, single-use kit used to safely drain fluid buildup from the chest or stomach) and eight (8) boxes of expired Arginaid Oral Powder (an oral supplement to support nutritional needs of wound patients) in Unit 900's Medication Storage Room.2. Store Resident 147's lorazepam (a scheduled IV controlled medication [a drug regulated by the government because it carries a risk of misuse, abuse, or physical and psychological dependence] that can create mental and physical addiction or dependency and used to treat anxiety [fear of the unknown]) in a locked container separate from the other non-scheduled medications (drugs that not regulated under federal schedules and they have a low potential for abuse or dependence). inside the medication refrigerator in the Unit 900's Medication Storage Room. 3. Ensure medications were properly stored and secured for one of 15 Medication Carts when 10 loose medications were observed in two separate areas of Medication Cart Number One in Station Two.4. Store Resident 27's unopened Latanoprost (a prescription eye drop used to lower pressure inside the eye) in the refrigerator as instructed by pharmacy.5. Maintain a first aid kit in Unit 400's medication room when it the kit was found to be expired. These deficient practices had the potential to cause infection and malfunction of drainage system for the residents who required drainage care and had the potential to result in accidental consumptions and result in adverse reactions (undesired effects) from the supplements and harms for the residents. In addition, these deficient practices had the potential for medication theft or diversion (when a medication is taken for use by someone other than whom it is prescribed or for an indication other than what is prescribed) and had the potential to affect residents receiving medications from the medication cart through medication error (any preventable event that may cause or lead to inappropriate medication use or patient harm) and/ or contamination. 1. During a concurrent observation in Unit 900's Medication Storage Room and interview on 5/28/2026 at 11:40 AM with Licensed Vocational Nurse (LVN) 11, observed a sealed Bottle and Dressing Pack with the expiration date of 8/14/2025 on the shelf in the Medication Storage Room. LVN 11 stated the Bottle and Dressing Pack was used for drain fluid from a resident, but this pack was expired. LVN 11 stated the nurse should remove the expired Bottle and Dressing pack from the Medication Storage Room and discard it to avoid accidental usage on a resident to prevent infection and malfunction. During a concurrent observation in Unit 900 Medication Storage Room and interview on 5/28/2026 at 11:45 AM with LVN 11, observed four (4) boxes of Arginaid Oral Powder packets with the expiration date of 11/26/2025 and 4 boxes of Arginaid Oral Powder packets with the expiration date of 1/29/2026 stored in the shelf LVN 11 stated the 8 boxes of Arginaid Oral Powder packets were expired, should not be stored in the Medication Storage Room and it should have been discarded to avoid accidental consumption and cause adverse effects. 2. During a review of Resident 147's admission Record (AR), the AR indicated the facility originally admitted Resident 147 on 8/16/2021 and readmitted her on 4/3/2026 with diagnoses that included type II diabetes mellitus (a condition that happens when your blood sugar is too high) and chronic kidney disease (a disease that kidneys [an organ that filter waster from the blood] were damaged). During a review of Resident 147's Minimum Data Set (MDS, a resident assessment tool), dated 2/28/2026, indicated Resident 147 had moderately impaired memory and cognition (ability to think and reason). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 147's Order Summary Report, dated 5/29/2026, the report indicated the physician ordered to administer Lorazepam oral concentrate two milligram (MG, a measurement unit)/ milliliter (ML, a measurement unit) 0.5 ML every two hours as needed for anxiety, starting on 5/28/2026. During a concurrent observation in the Unit 900 Medication Storage Room and interview on 5/28/2026 at 12:06 PM with LVN 11, one bottle of Resident 147's Lorazepam oral concentrate was stored with other medications inside the medication refrigerator. LVN 11 stated Lorazepam was a controlled medication, and it was stored inside the locked refrigerator together with all other medications inside the refrigerator. During an interview on 5/29/2026 at 2:38 PM with the Director of Nursing (DON), the DON stated the nurses should check the medications and supplies in the medication storage rooms to ensure the medications, supplements and supplies were not expired to prevent accidental consumption and use that could cause undesired adverse effects to the residents. The DON stated according to the facility's policy, Lorazepam should be stored in a permanently affixed locked box within the refrigerator, separating from all other medications to prevent abuse or diversion. During a review of the facility's Policy and Procedure (P&P) titled, Disposal of Medications and Medication-Related Supplies-IE5: Medication Destruction for Non-Controlled Medications, dated 1/2022, the P&P indicated Unused, unwanted and non-returnable medications should be removed from their storage area and secured until destroyed. During a review of the facility's P&P titled, Medication Storage in the Facility-ID2: Controlled Substance Storage, dated 1/2022, the P&P indicated Schedule [II-V] medications and other medications subject to abuse or diversion are stored in a permanently affixed, double locked compartment separate from all other medications or per state regulation and Controlled-substances that require refrigeration are stored within a locked box within the refrigerator. This Box must be attached to the inside of the refrigerator. 3. During an observation of medication cart number one in Station Two, on 5/28/2026 at 1:22 PM, six loose medication pills were found in the second right hand drawer – four small round white colored pills, one larger round white colored pill, and one oval sized beige colored pill underneath the resident's medication blister packs (a safe, easy-to-use packaging method where the pharmacist organized your pills into clear plastic bubbles). During an observation of medication cart number one in Station Two, on 5/28/2026 at 1:35 PM, four loose medication pills were found in the third right hand drawer – two small round white colored pills, one slightly larger white colored pill, and one small round peach colored pill underneath the resident's medication blister packs. During an interview on 5/28/2026 at 1:25 PM, Licensed Vocational Nurse (LVN) 17 stated she did not know the type of medications that were found and did not know which resident's the medications belonged to. LVN 17 stated there should not have been any loose medications in the medication cart for residents' and staff's safety. LVN 17 stated having loose medications in the medication cart was a hygiene and safety issue and someone could take them. LVN 17 stated there were different types of medications within this section of the medication cart including blood pressure medications and if someone were to take them, that persons blood pressure could elevate or drop, especially if that person were not taking those types of medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/28/2026 at 4:38 PM, the Director of Nursing (DON) stated all medications should have been in a labeled container to know what medications were being administered to the residents. The DON stated that when there were medications not in labeled containers, the medications could be dropped on the floor, other resident's could have picked them up, and those resident's could have had an allergic reaction or adverse reaction (an unexpected, unwanted, or harmful physical response to a medication or treatment) to the medications. During a concurrent interview and record review on 5/28/2026 at 4:52 PM with the DON, the facility's policy and procedure (P&P) titled Medication Storage in the Facility dated January 2022 was reviewed. The P&P indicated medications and biologicals (advanced medicines made from living cells rather than artificial chemicals) were stored safely, securely, and properly, following manufacturer's recommendations. The P&P also indicated the provider pharmacy dispenses medications in containers that meet regulatory requirements, medications were to be kept in theses containers, and all medications dispensed by the pharmacy were to be stored in the container with the pharmacy label. The DON stated the facility staff were not following the policy but should have been to prevent medication and administration errors. The DON stated if the facility was not following the policy those loose medications could have been administered to residents and the residents could have had an adverse reaction or a side effect to the medication. 4. During a review of Resident 27's admission Record (AR), the AR indicated the facility admitted Resident 27 on 7/22/2025 with diagnoses that include diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension (high blood pressure). During a review of Resident 27's Physician's Order, dated 11/1/2025, the order indicated 1 drop of Latanoprost eye drop to be administered in each eye at bedtime every day. During a review of Resident 27's Minimum Data Set (MDS – resident assessment tool), dated 4/29/2026, the MDS indicated Resident 27 had moderate impairment in cognition (ability to understand and make decisions) and memory. During a concurrent observation and interview on 5/29/2026 at 10:34 AM with Licensed Vocational Nurse (LVN) 9 in Unit 300 hallway, an unopened Latanoprost was observed in medication cart 1. LVN 9 stated the unopened Latanoprost should be kept in the refrigerator. LVN 9 stated, the medication would not be effective since it was not kept in the fridge. During an interview on 5/29/2026 at 11:09 AM with Assistant Director of Nursing (ADON) ADON stated the directions from pharmacy for Latanoprost is to refrigerate the medication prior to opening it. ADON also stated that the Latanoprost that was stored in the medication cart needs to be disposed of because it is no longer effective for use. During a review of the United States Food and Drug Administration (FDA) label titled, Xalatan (Latanoprost), dated August 2011, the FDA indicated store unopened bottle(s) under refrigeration .once a bottle is opened for use, it may be stored at room temperature for six weeks. During a review of the facility's P&P titled, Medication Ordering and Receiving from Pharmacy, dated 1/2022, the P&P states medications are provided in packaging to facilitate accurate administration and accountability of the medication. The P&P also indicated medications that are not stored in the medication cart may have different regulations such as medications requiring refrigeration. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During a concurrent observation in Unit 400's medication storage room and interview on 5/27/2026 at 11:58 AM with Unit Manager Licensed Vocational Nurse (LVN) 10, an expired first aid kit was observed with the emergency supplies. LVN 10 stated, the first aid kit expired last 4/30/2019. During an interview on 5/29/2026 at 11:09 AM with ADON, ADON stated first aid kits are to be maintained with the emergency supplies. ADON also stated it is the responsibility of the nursing staff to check expiration dates prior to using materials for residents and maintenance is responsible for ensuring emergency supplies are available. ADON stated, using expired materials may lead to infection. During a review of the facility's P&P titled, Emergency Equipment and Systems, dated 4/1/2024, the P&P indicated the facility will maintain emergency equipment and the Director of Maintenance is responsible for documenting that the facility has the necessary emergency equipment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure standard infection prevention control practices (a set of practices that prevent or stop the spread of infections and or diseases in the healthcare setting) were followed for two of seven sampled residents (Residents 380 and 2) in accordance with the facility's policy and procedure when:1. Resident 380's Peripheral Inserted Central Catheter (PICC, a long, thin, flexible tube inserted through a vein in the upper arm and guided into a large vein near the heart) line dressing was not changed every seven (7) days) in accordance with the physician's order.2. Licensed Vocational Nurse 12 (LVN 12) did not wear gloves during an intramuscular (IM) injection medication administration of Resident 2's Ceftriaxone (medication used to treat bacterial infections) on 5/27/2026.These deficient practices have the potential to cause infection to Resident 2 and to Resident 380's PICC line site, which could result in other complications. 3. The lids of 7 of 20 disinfectant wipe containers were not closed.This failure had the potential to allow the disinfectant wipes to dry out and become exposed to environmental contaminants, decreasing their effectiveness in killing viruses and bacteria, which could increase the risk of infections in residents. 1. During a review of Resident 380's admission Record (AR), the AR indicated the Resident 380 was admitted on [DATE] and readmitted on [DATE] with diagnoses that include Extended-Spectrum beta-lactamase (ESBL, bacteria resistant to many common antibiotics, making infection harder to treat) resistance and presence of right artificial knee joint (right knee replacement). During a review of Resident 380's Minimum Data Set (MDS, an assessment and screening tool), dated 4/5/2026, the MDS indicated Resident 380 had intact cognitive (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 380 required setup or clean-up assistance with eating, partial/moderate assistance (helper does less than half the effort) with oral hygiene and personal hygiene, and was dependent (helper does all of the effort) with toileting hygiene, shower/bathe self, and chair/bed-to-chair transfer. During a review of Resident 380's Order Summary Report, dated 5/27/2026, the report indicated the physician ordered to change transparent dressing and injection cap and extension for PICC line every day every 7 days and as needed if integrity is compromised, starting on 5/24/2026. During a concurrent observation and interview on 5/26/2026 at 10:54 AM with Licensed Vocational Nurse 7 (LVN 7), Resident 380 observed with a PICC line with a dressing covered at her right upper arm. T without a date and initial. LVN 7 stated there was no date and initial on Resident 380's PICC line dressing. During a concurrent observation and interview on 5/26/2026 at 10:56 AM with Registered Nurse (RN) 3, RN 3 stated Resident 380 has a PICC line for intravenous (IV, a medical technique used to deliver fluids, medications, or nutrients directly into a person's bloodstream through a vein) antibiotic (medications that treat bacterial infections) administration. RN 3 stated she does not know whether Resident 380's PICC line was changed or when it was changed because there was no date and initial on the resident's PICC line dressing. RN 3 stated Resident 380's PICC line dressing should be changed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	every 7 days per the facility's policy. RN 3 stated the nurse should date and initial on the PICC line dressing so other nurses would know when it was changed and when to change it again to prevent infection at the PICC line site. During an interview on 5/29/2026 at 2:33 PM with the Director of Nursing (DON), the DON stated the nurse should date and initial the PICC line dressing to ensure the dressing would be changed every 7 days to prevent infection at the PICC line site and prevent potential complications to the residents. During a review of the facility's policy and procedure (P&P) titled, PICC Line Dressing Change Protocol, dated 7/26/2010, the P&P indicated to Date and initial dressing. The P&P also indicated to change PICC line dressing every week. Findings: 2. During a review of Resident 2's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), and atrial fibrillation (an irregular and often very rapid heart rhythm). During a review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care planning screening tool), dated 4/11/2026, indicated Resident 2's had intact cognitive (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 2 was independent with eating. The MDS indicated Resident 2 required partial/moderate assistance toileting hygiene, shower/bathe self and chair/bed-to-chair transfer. During a review of Resident 2's Order Summary Report dated 5/28/2026, the Order Summary Report indicated a physician order for: 1.Ceftriaxone sodium injection 1 gram (GM-a unit of measurement), inject 1 GM intramuscularly one time a day for urinary tract infection (UTI) for 10 days with 1.2 milliliters (ML-a unit of measurement) lidocaine (sterile solution) During a medication pass observation on 5/27/2026 at 9:35 AM with Licensed Vocational Nurse 12 (LVN 12), LVN 12 was observed injecting Resident 2 in the right upper arm without wearing gloves. During an interview on 5/27/2026 at 9:39 AM with LVN 12, LVN 12 stated she should always wear gloves when administering injection medications to any residents. LVN 12 stated she got distracted while talking to Resident 2 and forgot to put on gloves before administering Resident 2's Ceftriaxone IM medication. During an interview on 5/28/2026 at 4:26 PM with Director of Nursing (DON), the DON stated licensed nurses should always wear new clean gloves before giving any injection medications to any residents. The DON stated this is part of the facility's infection control practices to prevent any contamination to the residents. During a review of the facility's policy and procedure (P&P) titled, Medication Administration, revised (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/01/2017, the P&P indicated, Gloves will be worn to administer medications when contact with blood or potentially infectious body fluid is anticipated. 3. During an observation on 5/29/2026 at the hallway of Nursing Unit 2, the lids of 3 disinfectant wipe containers were open, with the cloth hanging out of the top of the containers mounted in front of Resident Rooms 201, 214 and 226. During an observation on 5/29/2026 at 11:10AM in the hallway of Nursing Unit 8, the lids of 2 disinfectant wipe containers were open, with the cloths hanging out of the top of the container mounted in front of Resident rooms [ROOM NUMBERS]. During an observation on 5/29/2026 at 11:20AM in the hallway of Nursing Unit 9, the lids of 2 disinfectant wipe containers were open, with the cloths hanging out of the top of the container mounted in front of Resident rooms [ROOM NUMBERS]. During an interview on 5/29/2026 at 11:25AM with the Charge Nurse (CN), CN stated that the disinfectant wipes were to be used to clean side rails, bedside tables, and equipment. CN also stated that staff were taught to close disinfectant container lids after each use. During an interview on 5/29/2026 at 11:30AM with Infection Preventionist Nurse (IPN), IPN stated that the disinfectant wipe container lids must be closed to prevent the wipes from drying out, thus not providing the proper disinfecting qualities. IPN also stated that when the disinfectant wipe container lids are left open, it could cause an increased risk of infection in residents. During a review of the facility's disinfectant wipes manufacturer's instructions (undated), the instructions indicated closing the lid after each use to retain moisture. During a review of the facility's policy and procedure titled (P&P), Cleaning & Disinfection of Environmental Surfaces, dated January 2026, the P&P indicated that all disinfectants must be used per the manufacturer's instructions.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 did not provide privacy for one of one sampled resident (Resident 217) reviewed for dignity when Resident 217 was exposed from the waist down during activities of daily living on 5/27/2026.The deficient practice had the potential to result in Resident 217 not being able to enhance the resident's sense of well-being and feeling of self-worth and self-esteem.Findings: During a review of Resident 217's admission Record (AR), the AR indicated Resident 217 was admitted on [DATE] with diagnosis that included Parkinson's disease (progressive neurological disease characterized by a fixed inexpressive face, tremor at rest, slowing of voluntary movements), type 2 Diabetes Mellitus (DM 2, a condition that results in too much sugar circulating in the blood), anxiety disorder (a group of mental disorders characterized by significant feelings of fear that affect with daily activities), and bipolar disorder (a mental illness that causes unusual shifts in mood, energy, and concentration). During a review of Resident 217's [NAME] Data Set (MDS, a resident assessment), dated 5/13/2026, the MDS indicated Resident 217 had an intact cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 217 needed substantial/maximal assistance in toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement).During an observation on 5/27/2026 at 12:50 PM in Resident 217's room, Resident 217 was naked from the waist down while no curtain was drawn.During an interview on 5/27/2026 at 12:52 PM with CNA 2, CNA 2 stated she was in Resident 217's room and was about to help her change but CNA 2 needed to attend to another resident in the next room, so CNA 2 left the room without closing the curtain. CNA 2 stated she should have closed the curtain before she left Resident 217's room. During an interview on 5/27/2026 at 1 PM, LVN 2 stated CNA 2 should have drawn the curtain to provide privacy for Resident 217 before CNA 2 left the resident's room. During an interview on 5/27/2026 at 2 PM with Resident 217, Resident 217 stated she was very angry because of being seen by strangers when she was naked from the waist down. Resident 217 stated, CNA 2 told her that she would come back and did not close the curtain when she left the room. During an interview on 5/28/2026 at 5:17 PM with the Director of Nursing (DON), the DON stated Resident 217 should have privacy at all time and CNA 2 should have closed the curtain before leaving the room to protect Resident 217's privacy. During a review of the facility's policy and procedures (P&P) titled, Privacy and Dignity, revised June 2017, the P&P indicated the facility promotes resident care in a manner and an environment that maintains or enhances dignity and respect, in full recognition of each resident's individuality. During a review of the facility's P&P titled, Resident Rights, revised June 2017, the P&P indicated that the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment, that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality; and that employees are to treat all residents with kindness, respect, and dignity.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete the Minimum Data Set (MDS, a standardized assessment and care screening tool) within 14 calendar days of admission for one of seven sampled residents (Resident 336) reviewed for Resident Assessment.This failure had the potential to delay the development of a resident centered care plan which may result in Resident 336 not receiving timely care and services needed for overall wellbeing.Findings:During a review of Resident 336's admission Record, the admission Record indicated Resident 336 was admitted on [DATE], with the following diagnoses but not limited to; malnutrition (imbalance between the nutrients the body needs to function and the nutrients it gets), type two diabetes (where the body either cannot make process sugars in the blood properly), and dementia (a decline in mental abilities severe enough to interfere with daily life).During a review of Resident 336's MDS, dated [DATE], the MDS did not indicate it was completed within 14 days of Resident 336's admission [DATE]). The MDS sections for Mood, Behavior, and Participation in Assessment and Goal Settings were not completed.During a concurrent interview and record review on 5/29/2026 at 11:25 AM with the MDS Nurse (MDSN), Resident 336 MDS was reviewed. The MDS indicated sections for Mood, Behavior, and Participation in Assessment and Goal Settings were completed on 5/28/2026 at 1:04 PM (23 days after admission). MDSN stated this assessment was not completed on time which could affect how Resident 336 is cared for and when the care begins.During a review of the facility's Policy and Procedure (P&P) titled, Resident Assessment Instrument Process, reviewed 6/2017, the P&P indicated that MDS Completion Date for admission is to be on the 14th calendar day of the resident's admission.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a Minimum Data Set (MDS-a resident assessment and care-screening tool) discharge tracking assessment (a type of assessment conducted when a resident leaves a nursing home, which includes clinical items for quality monitoring as well as discharge tracking and is transmitted to the Centers for Medicare and Medicaid Services [CMS, a United States government agency that administers healthcare programs]) for one (1) of seven (7) sampled residents (Resident 319) reviewed for Resident Assessment. This deficient practice had the potential to result in the facility's inaccurate quality monitoring data at transition points, such as when residents enter or leave the facility.Findings: During a review of Resident 319's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] with diagnoses including osteoarthritis of the knee (wear-and-tear joint disease) and hypertension (blood pressure that is higher than normal). During a review of Resident 319's medical records, the Medical Records indicated Resident 319 was discharged to home on 1/30/2026.During a review of resident 319's MDS summary, the MDS Summary indicated a Discharge-return not anticipated MDS, dated [DATE], but was completed on 2/15/2026 (2 days after discharge). During an interview and concurrent record review of Resident 319's Discharge MDS on 5/28/2026 at 12:46 PM with the MDS Nurse (MDSN), the MDSN stated she was responsible to make sure all the residents' MDS assessments were completed and transmitted to CMS system timely. The MDSN stated the facility has 14 days to complete a Discharge MDS from Resident 309's discharge date and another 14 days after completion to transmit to CMS. The MDSN stated Resident 319's discharge MDS was completed late, which was past the 14-day after the resident was discharged from the facility. During a review of the facility's Policy and Procedure (P&P), titled Resident Assessment Instrument (RAI) Process, revised 10/01/2019, the P&P indicated, The facility will transmit MDS assessments in accordance with the transmission dates outlined in the RAI Omnibus Budget Reconciliation Act (OBRA, comprehensive federal law that applies to all nursing homes receiving Medicare and/or Medicaid funding, establishing enforceable standards for resident care and facility operations) required assessment summary and Medicare assessment reporting schedule. During a review of the CMS Long-Term Care Facility MDS 3.0 RAI User's Manual, updated 10/2025, indicated the discharge MDS must be completed within 14 calendar days after the resident's discharge date (i.e., discharge date + 14 days) and once completed, the assessment must then be submitted within 14 calendar days of completion

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to create a measurable activities care plan for one of 35 sampled residents (Resident 336).This failure has the potential for Resident 336's activity needs not to be met which could result in negatively affecting the resident's psychosocial wellbeing.Findings:During a review of Resident 336's admission Record, the admission Record indicated Resident 336 was admitted on [DATE], with the following diagnoses but not limited to; malnutrition (imbalance between the nutrients the body needs to function and the nutrients it gets), type two diabetes (where the body either cannot make or process sugars in the blood properly), and dementia (a decline in mental abilities severe enough to interfere with daily life).During a review of Resident 336's Minimum Data Set (MDS) dated [DATE], the MDS indicated Resident 336 was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated that Resident 336 needed some help (partial assistance from another person to complete activities) with activities of daily living such as bathing, dressing, using the toilet, or eating.During a concurrent interview and record review on 5/29/2026 at 12:02 PM with the Activities Director (AD), Resident 336's Activity Care Plan, dated 5/5/2026 was reviewed. The Activity Care Plan indicated Resident 336 was dependent on staff for activities, cognitive stimulation, and social interaction due to cognitive deficits, immobility, and physical limitations. The goal for Resident 336 was to remain involved in cognitive stimulation and social activities as desired, but no measurable objectives (defined quantity or duration) were included. The AD stated that Resident 336's Activities Care Plan did not include measurable objectives for the goal.During an interview on 5/29/2026 at 2:30 PM with the Activities Care Consultant (ACC), the ACC stated that she has noticed the facility's activity care plans' goal are not measurable or quantifiable. The ACC further stated that care plans must be measurable because, if a resident has cognitive impairment, they could experience further decline and be at risk for isolation.During a review of the facility's Policy and Procedure (P&P) titled, Care Planning, revised 10/24/2022, the P&P indicated that the care plan will include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to review and revise all care plans by the target date for one of one sampled resident (Resident 336) reviewed for care planning.This failure had the potential to negatively impact the timeliness and appropriateness of Resident 336's interventions and care needs.Findings:During a review of Resident 336's admission Record, the admission Record indicated Resident 336 was admitted on [DATE], with the following diagnoses but not limited to; malnutrition (imbalance between the nutrients the body needs to function and the nutrients it gets), type two diabetes (where the body either cannot make or process sugars in the blood properly), and dementia (a decline in mental abilities severe enough to interfere with daily life).During a review of Resident 336's Minimum Data Set (MDS) dated [DATE], the MDS indicated Resident 336 was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated that Resident 336 needed some help (partial assistance from another person) with activities of daily living such as bathing, dressing, using the toilet, or eating.During a concurrent interview and record review on 5/29/2026 at 12:44 PM with the MDS Nurse (MDSN), Resident 336's care plans on the facility's electronic medical records (EMR) system, the page titled, Care Plan Reviews, was reviewed. Resident 336's Dietary, Nursing, Social Services, and Therapy care plans did not indicate they were reviewed and completed by the target date of 5/25/2026. The MDSN stated that Resident 336's care plans were not reviewed and revised by the 5/25/2026 target date. The MDSN stated that when care plans are not reviewed and completed by the target completion date, there is a delay in the resident's care.During a review of the facility's Policy and Procedure (P&P) titled, Care Planning, dated 10/24/2022, the P&P indicated that the care plan must be periodically reviewed and revised by a team of qualified persons after each assessment.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper maintenance and position of an indwelling urinary catheter (Foley catheter [FC]- a hollow tube inserted into the bladder to drain or collect urine) for one of two sampled residents (Resident 330) reviewed for catheter care area when staff did not maintain the FC tubing free of dependent loops (a U^shaped sag in the drainage tubing that dips below the collection bag, allowing urine to pool and increasing the risk of infection). This deficient practice placed Resident 330 at risk for impaired urine drainage and increased the potential for urinary tract infection (UTI- an infection in the bladder/urinary tract).Findings:During a review of Resident 330's admission Record, the record indicated Resident 330 was admitted to the facility on [DATE] with diagnoses including quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), kidney failure, and urine retention (a condition where the bladder is unable to empty completely). During a review of Resident 330's Minimum Data Set (MDS- a resident assessment tool) dated 5/28/2026, the MDS indicated Resident 330 was cognitively intact (no issues with memory, attention, problem solving, judgement, and planning) and dependent on staff (helper does all of the effort) for all cares such as bathing and toileting. The MDS also indicated Resident 330 used a FC for urinating. During an observation on 5/26/2026 at 10:34 AM, Resident 330's FC was observed. The drainage catheter was observed hanging with a U-shaped sag that dipped below the collection bag with urine pooled in the drainage catheter. During another observation on 5/29/2026 at 11:50 AM, Resident 330's FC was observed with a dependent loop and urine pooled in the looped portion of the drainage catheter. During an interview with Licensed Vocational Nurse (LVN) 19 on 5/26/2026 at 11:02 AM and concurrent observation of Resident 330's FC, LVN 19 stated that FCs should drain continuously without dependent loops or kinks. LVN 19 stated dependent loops, like the one on Resident 330's FC tubing, could cause urine to flow back up into the resident and could cause discomfort, pain, and infection. During an interview with the Director of Nursing (DON) on 5/28/2026 at 4:57 PM, the DON stated foley catheters should not have a dependent loop and the staff was not following the facility's policy when there were dependent loops along Resident 330's FC. During a review of the facility's Policy and Procedure (P&P) titled, Catheter - Care of, revised 6/1/2017, the P&P indicated, An unobstructed flow of urine should be maintained. In order to achieve a free flow of urine. Catheter tubing should be secured to prevent dependent loops.

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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 respiratory care services for two (2) of five (5) sampled residents (Residents 16 and 57) reviewed for respiratory care by failing to: 1. Administer continuous oxygen at 2 liters per minute (L/min, Measurement units) to Resident 16 in accordance with the physician's order.This deficient practice had the potential for Resident 16 to experience respiratory distress. 2. Ensure Resident 57 received aerolized inhaled medications (breathing treatment) as indicated on the physician's order.This deficient practice resulted in Resident 57 not receiving breathing treatment as ordered, which increased the risk of shortness of breath, wheezing, and respiratory distress. 1. During a review of Resident 16's admission Record (AR), the AR indicated the facility originally admitted Resident 16 on 9/3/2025 and readmitted on [DATE] with diagnoses that include chronic obstructive pulmonary disease (a progressive, incurable lung disease that blocks airflow and makes it hard to breathe) and dementia (a term for a decline in mental ability severe enough to interfere with daily life). During a review of Resident 16's Minimum Data Set (MDS, an assessment and care planning screening tool), dated 5/6/2026, the MDS indicated Resident 16 had severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 16 required substantial/maximal assistance (helper does more than half the effort) with oral hygiene and personal hygiene, and was dependent (helper does all of the effort and resident does none of the effort to complete the activity) on toileting hygiene, shower/bathe self and chair/bed-to-chair transfer. The MDS indicated Resident 16 was on oxygen therapy. During a review Resident 16's Physician Summary Report, dated 527/2026, the report indicated the physician ordered to administer oxygen at 2 L/min via nasal cannula (NC, a flexible tube with two prongs used to deliver supplemental oxygen directly into the nostrils), with a start date of 5/11/2026. During a concurrent observation and interview on 5/26/2026 at 2:16 PM with Licensed Vocational Nurse 7 (LVN 7), Resident 16 was lying in bed with her oxygen NC was on the floor. LVN 7 stated Resident 16 should be receiving oxygen at 2 L/min continuously and the staff are expected to check on the resident to ensure she is receiving oxygen as ordered. During a concurrent observation and interview on 5/27/2026 at 9:50 AM with LVN 8, Resident 16 was lying in bed and was not receiving oxygen. Resident 16's oxygen concentrator (a medical device that filters ambient air to deliver 85-95% pure oxygen to individuals with respiratory conditions) was turned off, and both of the resident's oxygen tubing and concentrator were stored next to the bedside nightstand. LVN 8 stated she did not check Resident 16's physician orders and was not aware that the resident was supposed to receive oxygen continuously. LVN 8 stated when she started her shift at 7 AM, the resident was not on oxygen and her oxygen supplies were stored next to the nightstand, leading her to believe the resident was either no longer on oxygen or receiving it only as needed. LVN 8 further stated the previous shift nurse did not endorse that the resident was on continuous oxygen therapy. During a concurrent interview and record review on 5/28/2026 at 12:38 PM with the MDS Nurse (MDSN), Resident 16's Care Plan was reviewed. The MDSN stated the nurse did not develop a Care Plan to address the use of oxygen therapy for Resident 16. The MDSN stated the nurse should (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	develop the Care Plan for oxygen usage to ensure Resident 16's needs are met, maintain adequate oxygen, and prevent respiratory complications. During an interview on 5/29/2026 at 2:35 PM with the Director of Nursing (DON), the DON stated the nurse should check and follow the physician's order to ensure residents receive oxygen therapy. The DON stated the nurse should develop a Care Plan to address the oxygen usage to ensure residents receive adequate oxygen and prevent respiratory distress and complications. During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration, dated 6/1/2017, the P&P indicated for the staff to check the physician's order and turn on the oxygen at the prescribed rate to prevent or reverse hypoxemia (an abnormally low level of oxygen in the blood) and provide oxygen to the tissues. During a review of the facility's P&P titled, Care Planning, dated 10/24/2022, the P&P indicated To ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs. 2. During a review of Resident 57's admission Record, the admission Record indicated the resident was admitted on [DATE] with diagnoses that included aphasia (disorder that affects how you communicate) following cerebral infarction (ischemic stroke, occurs when a blood vessel in the brain is blocked or narrowed), acute and chronic respiratory failure with hypoxia (occurs when the lungs cannot adequately transfer oxygen into the blood stream), and chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty breathing) with acute exacerbation (a sudden, significant worsening of a chronic condition). During a review of Resident 57's History and Physical (H&P), dated 4/29/2026, indicated the resident had poor decision making capacity. During a review of Resident 57's Order Summary Report (OSR) dated 4/27/2026, the OSR indicated a physician order for Ipratropium-Albuterol Inhalation Solution (a combination bronchodilator [type of medication that makes breathing easier by relaxing the muscles in the lungs and widening the airways] used to prevent and treat airway narrowing [bronchospasm] in adults with COPD) 0.5-2.5 milligrams (mg, unit of measure) per three (3) milliliters (ml, unit of measure), 3 ml inhale orally every four (4) hours for shortness of breath (SOB)/wheezing. During a review of Resident 57's Care Plan titled The resident had COPD, dated 4/28/2026, the Care Plan indicated an intervention to give aerosol or bronchodilators (Ipratropium-Albuterol, Albuterol Sulfate) as ordered and to monitor/document any side effects and effectiveness. During an observation in Resident 57's room on 5/26/2026 at 9:50 AM, Resident 57 was observed sleeping and not wearing nebulizer mask (soft, face-covering device that connects to a nebulizer machine to deliver medication as a fine mist directly into the lungs) during breathing treatment. During a concurrent observation and interview in Resident 57's room with Assistant Director of Nursing (ADON) on 5/26/2026 at 10:17 AM, Resident 57 observed sleeping in the same position and (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not wearing nebulizer mask. ADON confirmed Resident 57's nebulizer mask was not on and stated the mask was used for his breathing treatment. ADON turned off Resident 57's nebulizer machine and stated the purpose of the breathing treatment was for shortness of breath and wheezing. ADON stated if Resident 57 does not receive the breathing treatment he could have shortness of breathing, wheezing, or require additional respiratory services. ADON stated the nebulizer mask should be in place during the duration of the treatment and the mask should be on the resident. During an interview with the Director of Nursing (DON) on 5/28/2026 at 4:45 PM, the DON stated the purpose of wearing the nebulizer mask during a breathing treatment was for better inhalation and delivery of medication. The DON stated if the mask was not worn, the resident did not receive the full dose of the medication and it could cause shortness of breath and respiratory distress. During a review of the facility's policy and procedure (P&P) titled, Aerosolized Medication Therapy-Small Volume Nebulizer, dated 5/1/2024, the P&P indicated the purpose was to deliver inhaled aerosolized medications to the lungs. The P&P indicated to ensure proper set-up and administration of aerosolized inhaled medications. The P&P indicated to administer medication as ordered and to document result of therapy including pre and post vital signs in the electronic health record.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) care in accordance with professional standards of practice (established guidelines and expectations that ensure a professional performs their duties safely, ethically, and competently) for one of one residents (Resident 21) reviewed for dialysis care area by failing to ensure Resident 21 who is on fluid restrictions and receiving dialysis was not left an pitcher of water at Resident 1's bedside in accordance with Resident 21's physician orders. This deficient practice placed Resident 21 at risk for exceeding daily fluid allowance and potentially causing fluid overload (excess body fluid resulting in swelling, weight gain, or respiratory compromise due to impaired fluid balance), thereby compromising the safety and effectiveness of dialysis treatment.Findings:During a review of Resident 21's admission Record, the record indicated Resident 21 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD- irreversible kidney failure) and dependence on renal dialysis. During a review of Resident 21's Minimum Data Set (MDS- a resident assessment tool) dated 4/22/2026, the MDS indicated Resident 21 had severe cognitive impairment (significant challenges with memory and awareness) and required partial assistance (helper does less than half the effort) with most cares such as dressing and personal hygiene. During a review of Resident 21's Order Summary Report (OSR) dated 4/19/2026, the OSR indicated the following order, Fluid Restriction: Limited to no water pitcher at bedside During an observation on 5/26/2026 at 9:16 AM, Resident 21 was observed eating breakfast in her room. A sign above Resident 21's bed indicated, No water pitcher at bedside. A pitcher of water was observed on Resident 21's table as she ate breakfast. During an interview with Licensed Vocational Nurse (LVN) 20 on 5/26/2026 at 9:21 AM, LVN 20 stated Resident 21 was on a fluid restriction due to being on dialysis and should not have had a water pitcher at the resident's bedside. LVN 20 further stated giving residents with fluid restrictions a water pitcher at bedside made it difficult for staff to monitor the residents' fluid intake and increased the chances of fluid overload. During an interview with the Director of Nursing (DON) on 5/28/2026 at 4:57 PM and concurrent record review, Resident 21's (OSR) dated 4/19/2026 was reviewed. The DON stated fluid restrictions for residents were implemented to prevent fluid overload. The DON stated there should not be a water pitcher at Resident 21's bedside because it put Resident 21 at risk of becoming hospitalized or requiring an extra dialysis treatment from fluid overload. The DON further stated if Resident 21 had fluid overload from excessive water at her bedside, she could have required extra medications to stabilize her condition. During a review of the facility's P&P titled Fluid Restrictions and revised 6/1/2017, the P&P indicated that residents on fluid restrictions would be monitored for intake and licensed nurses remove the water pitcher and notified care givers of the fluid restriction. During a review of the facility's Policy and Procedure (P&P) titled, Dialysis Care and revised 11/1/2017, the P&P indicated the following:Dialysis residents had fluid restrictions as ordered by the physicianThe Nursing and Dietary Staff carefully organized the division and distribution of fluidA water pitcher was to be provided at the bedside, unless contraindicated.

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed toˆprovide medically related social service (services that assist residents in attaining or maintaining their mental [how a person thinks, feels, and behaves] and psychosocial health (the interaction between a person's psychological state [thoughts, feelings, and mental health] and their social environment [relationships, community, and cultural background])ˆin accordance with the facility's policy and procedure titled,ˆ Social Services Programˆfor one of two sampled residents (Residentˆ361), who had loose upper teeth and had requestedˆnew denturesˆ(removable oral appliances that replace missing teeth). The facility failedˆto follow up with the dental clinic and update the resident's responsible party (RP) 1 with his request for new dentures from 3/2/2026 to 5/26/2026 (approximately 3 months). The deficient practice placed Resident 361 to experience fear of swallowing loose upper teeth if they dislodged and RP 1 feel disappointed due to receiving no information regarding the denture request. In addition, it had potential to increase the risk of the resident not being able to maintain his highest practical well-being.ˆ During a review of Resident 361's admission Record (AR), the AR indicated Resident 361 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that included metabolic encephalopathy (a broad term for any brain disease that alters brain function or structure), anxiety disorder (a group of mental disorders characterized by significant feelings of fear that affect with daily activities), dementia [the loss of cognitive functioning (thinking, remembering, and reasoning) to such an extent that it interferes with a person's daily life and activities], and adult failure to thrive (a state of decline and may be caused by chronic diseases and functional impairments; manifestations include weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 361's History and Physical (H&P), dated 5/11/2026, the H&P indicated Resident 361 does not have the capacity to understand and make decisions due to dementia and Responsible Party (RP) 1 is Resident 361's decision maker. During a review of Resident 361's Social Services Note (SSN), dated 3/2/2026, the SSN indicated Resident 361 was seen by the dentist on 2/23/2026 and SSW 1 will follow up in regard to family request for dentures. During a review of Resident 361's Social Services Note (SSN) dated from 3/2/2026 to 5/27/2026, there was no documented evidence that SSW 1 followed up with the dentist or informed RP 1 about the progress of the denture request. During a concurrent observation and interview on 5/26/2026 at 3:45 PM in Resident 361's room with Resident 361, Resident 361's upper teeth were loose. Resident 361's stated he wanted his upper teeth removed because he was worried that he might accidentally swallow them if they fell out without his awareness. During an interview on 5/26/2026 at 4 PM with LVN 3, LVN 3 stated she was aware that Resident 361's upper teeth have been loose for about two weeks. LVN 3 stated, Resident 361 was seen by the dentist a few months ago and has been waiting for the resident's denture appointment. During an interview on 5/28/2026 at 3:55 PM with RP 1 stated a few months ago, he spoke with facility staff and requested that Resident 361's teeth be fixed because the resident's upper teeth were loose and the resident was afraid of swallowing them. RP 1 added the facility did not provide him with any updates on the status of the denture request or when Resident 361 would receive the dental care for upper teeth removal. During a concurrent interview and record review on 5/28/2026 at 4:23 PM with Social Service Worker (SSW) 1, Resident 361's progress notes from 2/23/2026 to 5/26/2026 were reviewed. SSW 1 stated, she was made aware on 3/2/2026 by RP 1 that Resident 361's upper denture was loose and that Resident 361 needed new denture. SSW 1 stated, she did not follow up with the dental clinic regarding the family's request. During an interview on 5/28/2026 at 5 PM with the Director of Nursing (DON), the DON stated that SSW 1 should have follow up with the dentist, stay on top of the need of the resident and inform the resident's family what the plan is. During a review of the facility's policy and procedures (P&P) titled, Social Services Program, revised June 2021, the P&P indicated (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medically related social services are provided to residents in order to maintain and improve the resident's wellbeing. The P&P also indicated responsibilities of the Social Services Department may include but are not limited to: maintaining contact with the resident's family and involving them in the care planning; making appointments and arranging transportation to obtain needed services. During a review of the facility's policy and procedures (P&P) titled, Dental Services, revised November, 2017, the P&P indicated the facility is responsible to assist residents to obtain dental services as indicated for routine and emergency dental care including making appointments for the residents, if needed or requested and arranging transportation to and from the dentist's office.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure its medication error rate was less than five (5) percent (%). Two (2) medication errors (the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order/ manufacturer's specifications / accepted professional standards and principles) out of 25 opportunities (observed administered medications) for error, to yield an overall medication error rate of 8 % for one (1) of three (3) sampled residents (Resident 202) observed during medication administration (med pass). This deficient practice had the potential to result in adverse reactions (undesired effect of a drug or other type of treatment), ineffective treatment, worsening of Resident 202's condition, or potentially serious harm or injury.Findings:During a review of Resident 202's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] with diagnoses including paraplegia complete (total loss of function, including the ability to feel sensation and move) and hypotension (low blood pressure). During a review of Resident 202's Minimum Data Set (MDS, a standardized assessment and care planning screening tool), dated 3/15/2026, indicated Resident 202's had intact cognitive (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 202 requires supervision (helper provides verbal cues) with eating. The MDS indicated Resident 202 required partial/moderate assistance (helper does less than half) with oral hygiene, upper body dressing and personal hygiene. The MDS further indicated Resident 202 was dependent (helper does all of the effort) toileting hygiene, showers and lower body dressing. During a review of Resident 202's Order Summary Report dated 5/12/2026, the Order Summary Report indicated a physician's order for:Rivaroxaban oral tablet 20 mg give 20 mg by mouth one time a day for DVT (a blood clot that forms within the deep veins).Venlafaxine Hydrochloride (HCL) oral tablet 75 mg, given by mouth one time a day for depression manifested by verbalization of sadness. During a review of Resident 202's Medication bubble pack for Rivaroxaban oral tablet 20 mg, the medication bubble pack indicated take medication with food. During a review of Resident 202's Medication bubble pack for Venlafaxine HCL oral tablet 75 mg, the medication bubble pack indicated take medication with food. During a medicationˆpass observation on 5/27/2026 at 9:04 AM with LVN 12, LVN 12 was observed administering Rivaroxaban oral tablet and Venlafaxine HCL oral tablet to Resident 202 with water and without food. After administering the medications, LVN 12 walked back to her medication cart to document Resident 202's medication administration record.During a concurrent interview and record review with LVN 12 on 5/27/2026 at 9:40 AM, LVN 12 stated she was aware that Resident 202's Rivaroxaban oral tablet and Venlafaxine HCL oral tablet required administration with food, but she assumed it was acceptable to administer them without food because Resident 202 had eaten breakfast around 7AM. During an interview and record review on 5/28/2026 at 4:20 PM with the Director of Nursing (DON), the DON stated Resident 202's medication bubbleˆpack label indicated to administer Rivaroxaban oral tablet and Venlafaxine HCL oral tablet medications with food. The DON stated LVN 12 should have provided Resident 202 with a cracker or cookie if it was not mealtime and should not have administered the medications without food. The DON stated all licensed nurses administering medications should follow the medication orders to prevent potential undesired side effects. During a review of the facility's Policy and Procedure (P&P) titled, Medication Administration, revised 6/1/2017, the P&P indicated, Medications will be administered by a licensed nurse per the order of an attending physician or licensed independent practitioner.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to serve lunch meal at the facility's scheduled delivery time in accordance with the facility's policy and procedure tilted, Meal Service Time, for one of 35 sampled resident (Resident 217). The deficient practice resulted in Resident 217 not receiving her lunch tray at regularly scheduled time, in which the resident verbalized dissatisfaction with late lunch and food did not taste good anymore. In addition, it placed the resident to be hungry and feel angry.During a review of Resident 217's admission Record (AR), the AR indicated Resident 217 was admitted on [DATE] with diagnosis that included Parkinson's disease (progressive neurological disease characterized by a fixed inexpressive face, tremor at rest, slowing of voluntary movements), type 2 diabetes mellitus (DM 2, a condition that results in too much sugar circulating in the blood), anxiety disorder (a group of mental disorders characterized by significant feelings of fear that affect with daily activities), and bipolar disorder (a mental illness that causes unusual shifts in mood, energy, and concentration). During a review of Resident 217's History and Physical (H&P), dated 8/10/2025, the H&P indicated Resident 217 had a capacity to make medical decisions. During a review of Resident 217's [NAME] Data Set (MDS, a resident assessment), dated 5/13/2026, the MDS indicated Resident 217's cognition (ability to think, remember, and reason) was intact, and needed set up or clean-up assistance (helper sets up or cleans up, resident completes activity) in eating. During a concurrent observation and interview on 5/26/2026 at 2:10 PM with Resident 217 in Resident 217's room, the resident's lunch tray was at the bedside. Resident 217 stated, she just finished her lunch. During an interview on 5/26/2026 at 3:02 PM with Resident 217, Resident 217 stated, her lunch has been late in the past few months. Resident 217 stated, her lunch used to be delivered as late as 12:30PM and lately it has been around 1:30 PM in the last few months. Resident 217 stated because her lunch was delivered late, the food did not taste good anymore. During a concurrent observation and interview on 5/27/2026 1:25 PM with Resident 217 in Resident 217's room, Certified Nursing Assistant (CNA) 2 brought Resident 217's lunch tray into the resident's room and left the tray on the bedside table. Resident 217 stated, her lunch kept getting delivered around 1:30 PM every day. During an interview on 5/28/2026 at 5:19 PM with the Director of Nursing (DON), the resident's meal tray should not be one hour later than the scheduled meal delivery time. The DON stated, when the meal trays were delivered late, the residents would be hungry and can feel angry. During a concurrent interview and record review on 5/28/2026 at 5:30 PM with Kitchen Supervisor (KS), the facility's Meal Delivery Time (MDT), undated, as reviewed. The MDT indicated lunch is scheduled to be delivered to Resident 217's room at 12:40 PM. KS stated, if the tray is scheduled at 12:40 PM, she expects the resident to receive their meal tray around 12:40 PM. The KS stated it should not take one hour for the tray to get to the residents because the residents could be hungry waiting for their food and not want to eat any more. During a review of the facility's policy and procedures (P&P) titled Meal Service Times, revised June 2017 indicated meals are served at regularly scheduled hours and the Dietary Manager is responsible for monitoring meal service time daily to ensure the facility meets posted mealtimes. The P&P also indicated mealtimes are typically at 7 AM, 12 PM, and 5 PM for all the resident receiving food from the kitchen.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure food brought to residents by family/visitors was not shared for one of 35 sampled residents (Resident 149) in accordance with the facility's policy. This failure had the potential to result in inadvertently causing Resident 149 severe allergic reaction, diet conflict, infection, and or aspiration (unintentional entry of substance such as food, into the airway or lungs instead of the esophagus [flexible, muscular tube that moves swallowed food and drink to the stomach]).Findings: During a review of Resident 149's AR, the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included endocarditis (a serious and uncommon heart infection), peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs), and hypertension (HTN, high blood pressure). During a review of Resident 149's H&P dated 10/25/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 149's MDS dated [DATE], the MDS indicated the resident had severely impaired cognitive skills (problems with a person's ability to think, learn, remember, use judgement, and make decisions) for daily decision making. The MDS indicated Resident 149 required setup or clean-up assistance from facility staff for eating and partial/moderate assistance (helper did less than half the effort) from facility staff for transfers and oral/toileting hygiene. The MDS indicated that the resident was not on a mechanically altered (a diet that altered the texture of food to make it easier to chew and swallow) or therapeutic diet (a meal plan that was prescribed by a doctor and designed by a dietician to treat a medical condition). During a telephone interview on 5/27/2026 at 2:06 PM, Resident 234's Family Member (FM) 2 stated she brought in Twinkie's (small, oval-shaped sponge cake that was golden-yellow on the outside with a sweet, white, vanilla-flavored cream filling on the inside) for Resident 234 and for the staff. FM 2 stated they were mostly for the staff because she was unaware of other resident's diet to be able to share with them. During an observation in Station Two on 5/26/2026 at 2:44 PM, Certified Nursing Assistant (CNA) 5 was observed entering Resident 234's room picking up a Twinkie, walking over to Resident 149's room and handed the Twinkie to Licensed Vocational Nurse (LVN) 18. LVN 18 was wearing gloves when receiving the Twinkie and proceeded to open the wrapper for Resident 149 to consume. During an interview on 5/26/2026 at 3:05 PM, CNA 5 stated facility staff should not have taken personal food items from one resident's room to another resident's room because there could be bacteria on the item. CNA 5 stated there was a risk for cross contamination (accidental transfer of harmful bacteria, viruses [a tiny, non-living germ that invaded your cells to make copies of itself], allergens [harmless everyday substances that your immune system mistakenly treated as a threat], or toxins [any poisonous substance produced by a living organism] from one surface, person, or food to another) and concerns for infection control. During an interview on 5/26/2026 at 3:18 PM, LVN 18 stated facility staff should not have taken personal food items from one resident's room to another resident's room because facility staff must take proper precautions for infection control. LVN 18 stated there was a risk for cross contamination and concerns for infection control because bacteria were everywhere and could lead to infection especially if the resident had a wound (any damage or break to your skin or body tissue) or a cut. During an interview on 5/28/2026 at 12:39 PM, the Infection Prevention Nurse (IPN) stated facility staff should not have taken personal food items from one resident's room to another resident's room because there was a chance for cross contamination. The IPN stated resident were not supposed to share items between residents because there were many high-risk residents that were immunosuppressed (the process of slowing or reducing the activity of the body's immune system, making the body's natural defense against germs, infections, and diseases less active than normal) and could get an infection. During an interview on 5/28/2026 at 4:27 PM, the Director of Nursing (DON) stated there could have been a risk for cross contamination and concerns for infection control if the residents who were sharing items had an (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infection. During a concurrent interview and record review on 5/28/2026 at 5 PM with the DON, the facility's policy and procedure (P&P) titled Infection Prevention and Control Program dated 12/1/2021 was reviewed. The P&P indicated duties and responsibilities of facility staff included reviewing food handling practices and infection control policies and procedures applied equally to all facility staff. The DON stated the facility staff were not and should have followed the policy to prevent cross contamination. During a review of the facility's P&P titled, Food Brought in by Visitors dated 5/1/2023, the P&P indicated food may be brought to a resident by the family member, responsible party, or friends if the food was compatible with the Attending Physician's diet order. The P&P indicated food from outside sources should be stored in a sealable container with the resident's name and date the food item was brought to the facility.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain the complete and accurate medical records in accordance with the facility's policy and procedure (P&P) titled, Documentation-Nursing, for 2 of 35 sampled residents (Resident 380 and 273) as evidenced by:The nurse did not document in Resident 380's IV (intravenous, referring to delivering medicines or fluids through a needle or tube inserted into a vein) Administration Record after administering the residents meropenem (a medicine used to treat infections) IV which was scheduled at 10 PM on 5/24/2026.The nurse did not document in Resident 273's Controlled Drug (medications whose manufacture, possession, and distribution are strictly regulated by government authorities) Record after administering Endocet (a prescription medication used to relieve moderate to severe pain) on 5/27/2026 at 1:11 AM. These deficient practices had the potential to result in medication errors for Residents 380 and 273 and negatively impact on the delivery of services for the residents. 1. During a review of Resident 380's admission Record (AR), the AR indicated the facility admitted Resident 380 on 4/2/2026 and readmitted her on 5/22/2026 with diagnoses that include Extended-Spectrum beta-lactamase (ESBL, bacteria resistant to many common antibiotics, making infection harder to treat) resistance and presence of right artificial knee joint (right knee replacement). During a review of Resident 380's Minimum Data Set (MDS, an assessment and screening tool), dated 4/5/2026, the MDS indicated Resident 380 had intact cognition (ability to understand and make decisions) and memory. During a review of Resident 380's Order Summary Report, dated 5/27/2026, the report indicated the physician ordered to administer meropenem IV solution one gram (GM, a measurement unit) every eight hours, starting on 5/23/2026. During a concurrent interview and record review on 5/28/2026 at 3:40 PM with Registered Nurse (RN) 2, Resident 380's IV Administration Record, dated 5/2026, was reviewed. RN 2 stated according to Resident's 380's IV Administration Record, the resident did not receive her scheduled meropenem on 5/24/2026 at 10 PM. RN 2 stated she administered the medication on 5/24/2026 at 10 PM. RN 2 stated she did not verify that her documentation was complete for Resident 380. RN 2 stated accurate and complete documentation is important to ensure residents receive the required care. During an interview on 5/29/2026 at 2:30 PM with the Director of Nursing (DON), the DON stated the nurse should document the medication as given after administering the medication to a resident in the IV Administration Record to ensure accurate and complete documentation and prevent medication error. During a review of the facility's P&P titled, Documentation-Nursing, dated 6/1/2017, the P&P indicated the nursing staff to provide documentation of resident status and care given. The P&P indicated nursing documentation will be concise, clear, pertinent, and accurate. During a review of the facility's P&P titled, Medication-Administration, dated 6/1/2017, the P&P indicated The time and dose of the drug or treatment administered to the resident will be recorded in the resident's individual medication record by the person who administers the drug or treatment and Recording will include the date, the time and the dosage of the medication or type of the treatment. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 273's AR, the AR indicated the facility admitted Resident 273 on 1/30/2024 and readmitted on [DATE] with diagnoses that include peripheral vascular disease (PVD – a slow, progressive circulation disorder characterized by narrowing, blockage, or spasms in blood vessels commonly affecting the legs and feet), bilateral above knee amputations, and anxiety disorder (a group of mental health conditions defined by intense, excessive, and persistent fear or worry about everyday situations). During a review of Resident 273's MDS dated [DATE], the MDS indicated Resident 273 had intact cognition and memory. During a concurrent interview and record review on 5/27/2026 at 12:26 PM with Licensed Vocational Nurse (LVN) 6, Resident 273's Medication Administration Record (MAR), dated 5/2026 was reviewed. LVN 6 stated Endocet was last given on 5/27/2026 at 1:11 AM. During a concurrent interview and record review on 5/27/2026 at 12:26 PM with LVN 6, Resident 273's Controlled Drug Record, dated 4/18/2026 to 5/27/2026, was reviewed. LVN 6 stated according to Resident 273's controlled drug record, the resident's Endocet was last given on 5/27/2026 at 5:07 AM but it should indicate 5/27/2026 at 1:11 AM. LVN 6 stated the previous nurse should have signed both the MAR and the Controlled Drug Record right after giving the Endocet to ensure the correct time the medicine was given is documented in the record because having two different times can cause confusion for the next nurse. During an interview on 5/29/2026 at 11:09 AM with the Assistant Director of Nursing (ADON), the ADON stated the nurse should document in both the MAR and the Controlled Drug Record right after giving a controlled medication. The DON also stated accurate time of giving the medications should be documented to know when doses of the pain medication were given and if timing is not accurately documented, it may cause confusion. During a review of the facility's P&P titled, Documentation-Nursing, dated 6/1/2017, the P&P indicated the nursing staff to provide documentation of resident status and care given. The P&P indicated nursing documentation will be concise, clear, pertinent, and accurate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055293	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Anita Convalescent Hospital	5522 Gracewood Ave. Temple City, CA 91780

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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on interview and record review, the facility failed to ensure one of three sampled Residents (Resident 45) was informed and understood the concept of the proposed arbitration (solving disputes with a neutral third party instead of the court) and the Arbitration Agreement (a binding agreement by the parties to submit to arbitration all or certain disputes between them in respect of a defined legal relationship, whether contractual or not) Form before having the resident/ Resident Representative (RP) enter into a binding arbitration agreement. The deficient practice had the potential to result in Resident 45 unknowingly giving up their right to resolve any disputes with the facility through a court of law before a jury.During a review of Resident 45's admission Record (AR), the AR indicated the facility admitted Resident 45 on 3/20/2026 and readmitted him on 3/31/2026 with diagnoses that included heart failure (a condition in which the heart muscle cannot pump enough blood to meet the body's needs) and diabetes mellitus (a diseases that affect how the body uses blood sugar and results in high blood sugar). During a review of Resident 45's History and Physical (H&P), dated 3/21/2026, the H&P indicated Resident 45 had the capacity to understand and make decisions. During an interview on 5/27/2026 at 1:17 PM with Resident 45, Resident 45 stated when he had a dispute with the facility, he wanted to hire his own attorney to sue the facility in court. Resident 45 stated he did not know about the arbitration agreement with the facility. During a concurrent interview and record review on 5/28/2026 at 9:09 AM with the admission Assistant (AA), Resident 45's signed Arbitration Agreement, dated 4/28/2026, was reviewed. The AA stated she explained to Resident 45 that he would still have the choice to talk to his own legal counsel outside of the facility and proceed through the legal court process if he was dissatisfied with the result of the arbitration when there was a dispute with the facility. The AA stated even though Resident 45 signed the Arbitration Agreement, Resident 45 still had his constitutional right to have any dispute decided in a court of law before a jury. During a concurrent interview and record review on 5/28/2026 at 9:18 AM with Director of admission (DA), Resident 45's signed Arbitration Agreement, dated 4/28/2026, was reviewed. DA stated Resident 45 had signed the arbitration, and he would resolve a dispute through the arbitration process first, however, the resident could go through the legal court process if he was not happy with the result of the arbitration. The DA stated the residents can rescind the agreement at any time. During an interview on 5/29/2026 at 8:53 AM with the Administrator (ADM), the ADM stated the explanation to the residents regarding Arbitration Agreement was incorrect. The ADM stated after the residents signed the Arbitration Agreement, the residents gave up their right to resolve a dispute in a court of law before a jury. The ADM stated the residents who signed the Arbitration Agreement only had 30 days to rescind the Arbitration Agreement from the date of signature. The ADM stated the facility staff should provide correct explanation regarding Arbitration Agreement to the residents and responsible parties to ensure they were well informed and making right decisions. During a review of the facility's policy and procedure (P&P) titled, Arbitration Agreement, dated 10/24/2022, the P&P indicated The person tasked with obtaining signatures for Arbitration Agreements will know how to explain the Agreement to residents/responsible parties. The terms and conditions of the Arbitration Agreement must be clearly explained to the resident/responsible party. The P&P also indicated The Arbitration Agreement may be cancelled by any signatory within 30 calendar days of its execution.