STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055307	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Canyon Post Acute, LLC	1642 West Avenue J Lancaster, CA 93534

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to honor the resident's right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and support for daily living safely for two of five sampled residents (Residents 46 and 85) reviewed under environment facility task by failing to ensure the hot water in the residents` bathroom sink was between 105 to 120 degrees Fahrenheit (F, a temperature scale commonly used in the United States to measure how hot or cold it is).^ The deficient practice had violated the resident's right to a safe, clean, comfortable and homelike environment that resulted to residents being unable to bathe comfortably. Findings: 1. During a review of Resident 46's admission Record (AR), the AR indicated the facility admitted the resident on 9/18/2025, and readmitted the resident on 12/25/2025, with diagnoses including anxiety disorder (mental health conditions characterized by excessive, persistent, and uncontrollable fear or worry that interferes with daily life), anemia (a condition where the body does not have enough healthy red blood cells), and history of falling. During a review of Resident 46's History and Physical (H&P), dated 9/19/2025, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 46's Minimum Data Set (MDS, a resident assessment tool), dated 12/21/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's mental processes-such as thinking, memory, learning, and decision-making-are functioning normally without any significant impairment or decline). During an interview on 2/23/2026 at 9:31 a.m., with Resident 46, Resident 46 stated that the water in the bathroom is cold and it is very uncomfortable for them to take a bath, because the water does not get warm enough and it takes time to warm up. Resident 46 stated this has been going on for a while now and the facility is aware of the issue. During a concurrent observation and interview on 2/23/2026 at 9:35 a.m., with the Maintenance Director (MD), inside Resident 46's bathroom, the hot water temperature at the bathroom sink was measured. The bathroom sink faucet ran for five (5) minutes and started to warm up. The water temperature was measured with the MD using a thermometer and registered at 81 degrees F. The MD stated it was caused by the building setup, and hot water gets pulled to the laundry room when they use the washers. The MD stated he (MD) is aware of the issue, and he cannot do anything about it. The MD stated the water temperature should be maintained between 105 to 120 degrees F to ensure residents have a comfortable hot water temperature for bathing. During an interview conducted at the Resident Council meeting (RCM, make recommendations to facility administrators to improve the quality of daily living and care in the facility and to promote and protect residents' rights) on 2/24/2026 at 2 p.m., five (5) out of five (5) residents who attended confirmed that the hot water temperature in the facility was not warm enough and it is very uncomfortable for them to do their ADLs such as bathing since the water was cold for bathing. The Resident Council attendees stated the facility is aware of the concerns for months now. During a review of the facility-provided Resident Council Meeting Minutes, dated 12/30/2025, the RCM indicated under the maintenance section that hot water was lacking in the majority of residents rooms. During an interview on 2/25/2026 at 3:30 p.m., with the (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assistant Director of Nursing (ADON), the ADON stated the hot water temperature in Resident 46's bathroom sink should be within 105 to 120 degrees F for residents to take a bath comfortably. The ADON stated she will escalate the issue to the governing body chair (GBC- the leader of a group of individuals with the authority to set policies, direct, and oversee an organization). During an interview on 2/26/2026 at 11:50 a.m., with the GBC, the GBC stated the hot water in the facility should be within 105 to 120 degrees F to promote comfort to residents to perform their ADLs. The GBC stated the issue should be fixed regardless of the issue of the age of the building and the hot water getting pulled to the washers when they are doing laundry. The GBC stated he (GBC) will instruct the MD to fix them right away as it affects the resident's ADLs and they are failing to provide a homelike environment to the resident. During an interview on 2/26/2026 at 12:10 p.m., with the Head Maintenance (HD), the HD stated they found the issues with the hot water temperature in the facility and all they needed to do was to shut a valve off and now the water temperature in Resident 46's room is in between 105 to 120 degrees F. During a review of the facility's recent policy and procedure (P&P) titled, Homelike Environment, last reviewed on 10/23/2025, the P&P indicated the facility strives to provide a personalized, homelike environment which recognizes the individuality and autonomy of the resident, provides an opportunity for self-expression, and encourages links with the past and family members. During a review of the facility's recent P&P titled, Maintenance Services-Water Temperature, last reviewed on 10/23/2025, the P&P indicated to control water temperature in resident-use fixtures to prevent scalding and ensure resident comfort while meeting regulatory standards. Policy - Water temperatures at resident-use fixtures shall be maintained between 105 degrees F and 120 degrees F in accordance with state and federal regulatory requirements. - Temperature variances shall be documented and corrected promptly to maintain compliance. 2. During a review of Resident 85's AR, the AR indicated the facility admitted the resident on 6/16/2025, and readmitted the resident on 6/21/2025, with diagnoses including hypothyroidism (when the thyroid gland does not make enough thyroid hormones to meet the body's needs), depression (a serious, long-lasting mental health condition-not just a temporary sad mood-characterized by a persistent feeling of sadness, emptiness, and loss of interest in daily life), and overactive bladder (OAB, a common condition causing a sudden, uncontrollable need to urinate, often resulting in frequent trips (8+ times/day) and waking up at night). During a review of Resident 85's H&P dated 6/22/2025, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 85's MDS dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition. During an interview on 2/23/2026 at 10:55 a.m., with Resident 85, Resident 85 stated the water in the bathroom is cold and it is very uncomfortable for them to take a bath because it does not get warm enough and the water takes time to warm up. Resident 85 stated it had been going on for a while now and the facility is aware of the issue and he reported them to the diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a concurrent observation and interview on 2/23/2026, at 9:35 a.m., with the MD, inside Resident 85's bathroom, measured the water temperature at the bathroom sink. The bathroom sink faucet was ran for five (5) minutes and started to warm up. The water temperature was measured with the MD using a thermometer and registered at 81 degrees F. The MD stated it was caused by the building setup, and hot water gets pulled to the laundry room when they use the washers. The MD stated he (MD) is aware of the issue, and he (MD) cannot do anything about it. The MD stated the water temperature should be maintained between 105 to 120 degrees F to ensure residents have a comfortable hot water temperature for bathing. During an interview conducted at the Resident Council meeting on 2/24/2026 at 2 p.m., five (5) out of five (5) residents who attended confirmed that the hot water temperature in the facility was not warm enough and it is very uncomfortable for them to do their ADLs such as bathing since the water was cold for bathing. The Resident Council attendees stated the facility is aware of the concerns for months now. During a review of the facility-provided Resident Council Meeting Minutes, dated 12/30/2025, the RCM (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated under the maintenance section that hot water was lacking in the majority of residents rooms. During an interview on 2/25/2026 at 3;30 p.m., with the ADON, the ADON stated the hot water temperature on Resident 85's bathroom sink should be within 105 to 120 degrees for residents to take a bath comfortably. The ADON stated she will escalate the issue to the GBC. During an interview on 2/26/2026 at 11:50 a.m., with the GBC, the GBC stated hot water in the facility should be within 105 to 120 degrees F to promote comfort to residents to perform their ADLs. The GBC stated the issue should be fixed regardless of the issue of the age of the building and the hot water getting pulled to the washers when they are doing laundry. The GBC stated he (GBC) will instruct the MD to fix them right away as it affects the resident's ADLs and they are failing to provide a homelike environment to the resident. During an interview on 2/26/2026 at 12:10 p.m. with the HD, the HD stated they found the issues with the hot water temperature in the facility and all they needed to do was to shut a valve off and now the water temperature in Resident 46's room is in between 105 to 120 degrees F. During a review of the facility's recent P&P titled, Homelike Environment, last reviewed on 10/23/2025, the P&P indicated the facility strives to provide a personalized, homelike environment which recognizes the individuality and autonomy of the resident, provides an opportunity for self-expression, and encourages links with the past and family members. During a review of the facility's recent P&P titled, Maintenance Services- Water Temperature, last reviewed on 10/23/2025, the P&P indicated to control water temperature in resident-use fixtures to prevent scalding and ensure resident comfort while meeting regulatory standards. Policy - Water temperatures at resident-use fixtures shall be maintained between 105 degrees F and 120 degrees F in accordance with state and federal regulatory requirements. - Temperature variances shall be documented and corrected promptly to maintain compliance.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) for five of five sampled residents (Residents 63, 41, 3, 76, and 56) reviewed for physical restraints by failing to ensure: 1. Resident 63's physician's order for Bilateral Bolsters ([often called roll-control bolsters or bed wedges] are long, firm, cushioned pads placed on both sides of a resident's body while they are in bed) had appropriate indication as a restraint and was not tucked under the sheets. 2. Resident 41's physician's order for low air loss mattress (LALM, a medical bed system designed to prevent and treat bedsores) w/bolster had an appropriate indication and was not tucked under the sheets. 3. Resident 3's use of pommel wedge cushion (a specialized, often foam or gel-filled, wheelchair accessory with a tapered shape and a front center protrusion) had a physician order, restraint assessment, and informed consent prior to use. 4. Resident 76's physical restraint assessment was completed prior to application of bilateral bolsters, the physician's order had an appropriate indication for use, and the bilateral bolters were not tucked under the fitted sheet. 5. Resident 56's physical restraint assessment was completed prior to application of bilateral bolsters and the physician's order had an appropriate indication for use. These deficient practices had the potential to result in the restriction of residents' freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from the resident climbing up on the bolsters and falling on a higher ground causing injuries such as fractures (a broken or cracked bone). Findings: 1. During a review of Resident 63's admission Record (AR), the AR indicated the facility admitted the resident on 2/5/2024, with diagnoses including muscle weakness, dementia (a progressive state of decline in mental abilities), and altered mental status. During a review of Resident 63's Minimum Data Set (MDS - a resident assessment tool), dated 12/16/2025, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (a significant, advanced decline in mental abilities—such as memory, reasoning, and language—that makes it impossible to live independently). The MDS indicated the resident was dependent to needing setup assistance on mobility and activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 63's Order Summary Report (OSR), dated 6/11/2025, the OSR indicated an order for bilateral bolsters to bed to define parameters of bed. During a review of Resident 63's Fall Risk Evaluation (FRE), dated 12/17/2025, the FRE indicated the resident was high risk for falls. During a review of Resident 63's Informed Consent (IC)- Devices & Physical Restraints, dated 6/11/2025, the IC indicated restraint type of bilateral bolsters with a target behavior of sliding off the bed for fall risk. During a review of Resident 63's Devices/Physical Restraint Assessment/Re-evaluation, dated 2/18/2026, the Assessment indicated the resident had medical symptoms of climbing out of bed, confusion, and sliding or leaning. The physician order indicated bilateral landing mat, bilateral (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bolsters. During a review of Resident 63's Care Plan (CP) Report regarding the resident being at risk for falls related to gait (the specific pattern or manner in which a person or animal walks or runs)/balance problems, ., last revised on 2/13/2026, the CP indicated an intervention of bilateral bolsters to bed to define parameters of bed. During a concurrent observation and interview on 2/23/2026, at 10:21 a.m., with Certified Nursing Assistant (CNA) 9, inside Resident 63's room, observed Resident 63 with bilateral bolsters tucked under the sheet. CNA 9 stated the bolster was applied to prevent the resident from getting out of bed and fall. CNA 9 stated tucking the bolster under the sheet will prevent the resident from removing them and it will be hard for the resident to get out of the bed. During a concurrent interview and record review on 2/25/2026 at 3:30 p.m. with the Assistant Director of Nursing (ADON), Resident 63's Medical Diagnoses, OSR, FRE, IC, Restraint Assessment, and CP were reviewed. The ADON stated the physician's order and consent does not match. The ADON stated the physician's order and the IC should match to ensure the consent is obtained for what it is being intended for. The ADON stated the order is just to define the parameter of the bed but the behavior and medical indication was not indicated. The ADON stated if the bolster is just for repositioning it should not be tucked under the sheet because it becomes a restraint. The ADON stated the use of the bilateral bolsters for the resident is to prevent the resident from getting out of the bed to prevent a fall, which is a restraint. 2. During a review of Resident 41's AR, the AR indicated the facility admitted the resident on 4/5/2021, and readmitted the resident on 7/2/2025, with diagnoses including muscle weakness, difficulty in walking, and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 41's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's mental abilities—thinking, memory, reasoning, and judgment—are functioning normally and without significant impairment or decline). The MDS indicated the resident was dependent to needing setup assistance on mobility and ADLs. During a review of Resident 41's OSR, dated 7/14/2025, the OSR indicated an order for low air loss mattress with bolsters every shift for skin maintenance. During a review of Resident 41's FRE, dated 1/2/2026, the FRE indicated the resident was high risk for falls. During a review of Resident 41's CP Report regarding the resident being at risk for falls related to gait /balance problems, . muscle weakness, and history of falls, last revised on 11/3/2025, the CP indicated an intervention of low air loss mattress with bolsters. During an interview on 2/23/2026, at 9:22 a.m., with Resident 41, Resident 41 stated she was on a LALM w/ bolsters because she is high risk for falls. During a concurrent observation and interview on 2/23/2026 at 9:26 a.m. with the Minimum Data Set Coordinator (MDSC), inside Resident 41's room, observed Resident 41 had LALM w/ bolsters tucked (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	under the sheets. The MDSC stated the resident had LALM w/ bolsters tucked under the sheets because the resident was high risk for falls. The MDSC stated tucking the bolsters under the sheet will make it harder for the resident to remove them. During a concurrent interview and record review on 2/25/2026 at 3:30 p.m. with the ADON, Resident 41's Diagnoses, OSR, FRE, Restraint Assessment, IC, and CP were reviewed. The ADON stated there is an order for low air loss mattress with bolsters every shift for skin maintenance, however, there was no informed consent, restraint assessment, and a care plan on its use. The ADON stated they are using the LALM w/bolster for fall prevention as reflected on the care plan. The ADON stated the use of the LALM w/bolster was a restraint. The ADON stated it was important to have a physician's order for the restraint, informed consent, restraint assessment, and a care plan on the use of LALM w/ bolster for its safe use and to honor the resident's right to agree or disagree with the proposed treatment after explaining the risk and benefits of its use. During a review of the facility-provided Bolster (B) 1 Information, undated, the Information indicated the roll-control bolsters are not substitutes for bed side rails. If you plan to use the Roll-Control Bolsters and leave one or both side rails in the lowered position, it is the responsibility of the facility and its qualified healthcare professionals to evaluate the resident to determine if that resident should be permitted to leave the bed at his/her discretion. Roll-Control Bolsters are not as effective as side rails for preventing a resident from rolling off or leaving the bed. 3. During a review of Resident 3's AR, the AR indicated that the facility admitted the resident on 12/21/2025 with diagnoses including dementia, anxiety disorder (a condition characterized by persistent and excessive worries that interfere with daily activities), and chronic obstructive pulmonary disease (COPD - chronic lung disease causing difficulty in breathing). During a review of Resident 3's H&P, dated 12/22/2025, the H&P indicated that the resident has the capacity to make decisions. During a review of Resident 3's MDS, dated [DATE], the MDS indicated the resident had severe impaired cognitive function. The MDS indicated that the resident required substantial/maximal assistance with mobility including roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer. During an observation on 2/23/2026 at 9:29 a.m., in Resident 3's room, Resident 3 sat up in wheelchair with a pommel wedge cushion. During an observation on 2/23/2026 at 3:09 p.m., in the main activity/dining room, Resident 3 sat up in wheelchair with a pommel wedge cushion, asleep. During an observation on 2/24/2026 at 8:48 a.m., in Resident 3's room, Resident 3 sat up in wheelchair with a pommel wedge cushion. During a concurrent observation and interview on 2/26/2026 at 8:27 a.m. with Licensed Vocational Nurse (LVN) 4, inside Resident 3's room, LVN 4 confirmed and stated Resident 3 sat on a wheelchair with a pommel wedge cushion. During a concurrent interview and record review on 2/25/2026 at 8:28 a.m. with LVN 4, Resident 3's physician orders, informed consents, and restraint assessments were reviewed. LVN 4 stated there (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was no order, restraint assessment, and informed consent done prior to the use of the pommel wedge cushion. LVN 4 stated it should have been completed to ensure that the device is appropriate for the resident. LVN 4 stated without an order, assessment, and informed consent the resident can potentially fall and injure herself. LVN 4 stated the resident has a responsible party and should have been informed of the risk and benefits of the use of the wedge cushion because it is a restraint. During an interview on 2/26/2026 at 12:39 p.m. with the ADON, the ADON stated that the pommel wedge cushion is a restraint and is applied to fall risk residents. The ADON stated the resident should be assessed if the resident is a candidate. The ADON stated the facility should inform the responsible party/family and ask the MD for an order if the responsible party/family want the pommel wedge cushion for the resident. The ADON stated that the care plan should be developed. The ADON stated that the restraint assessment is done to see if the resident really needs the pommel cushion because the resident's movement could be restrained and not be able to move freely, which can make the resident agitated and can possibly fall because of the agitation. The ADON stated that when the informed consent is not obtained from the responsible party, then the responsible party would not be able to know the care plan and the staff may be doing interventions that is not part of the resident's care plan. The ADON stated it is the residents' right to be informed and not informing them would violate their rights. During a review of the facility provided Manufacturer Instruction (MI) 1 titled, [MI 1] Wedge Foam Pommel Cushions, dated year 2007, the MI 1 indicated that the MI 1's Wedge Foam Pommel Cushions are designed to keep hip and knees in alignment, while minimizing patient forward sliding. Can be used to help prevent hip dislocation following surgery and allow patients to exercise their knees and lower legs. 4. During a review of Resident 76's admission Record, the admission Record indicated the facility admitted the resident on 11/29/2022 with diagnoses including dementia, major depressive disorder, and generalized muscle weakness. During a review of Resident 76's H&P, dated 7/18/2025, the H&P indicated Resident 76 did not have the capacity to understand and make decisions. During a review of Resident 76's MDS, dated [DATE], the MDS indicated Resident 76 had severely impaired cognition was sometimes able to understand others and make her needs known. The MDS further indicated Resident 76 required setup or clean-up assistance with eating, supervision or touching assistance with oral hygiene and substantial/maximal assistance to totally dependent on staff with all other ADLs. During a review of Resident 76's OSR dated 2/26/2026, the OSR indicated the following physician's orders: - 4/23/2025: May use an alternating pressure pump (APP – a therapeutic, inflating mattress overlay designed to prevent and treat bed sores [pressure ulcers] in bedridden individuals) from Hospice Provide (HP) 1. - 10/14/2025: Bilateral bolster as per family request. During a review of Resident 76's fall risk evaluations, dated 9/4/2025, 12/1/2025, and 2/22/2026, the fall risk evaluations indicated the resident was at a high risk for falls. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 76's CP on risk for falls, initiated on 12/6/2026 and last revised on 11/4/2025, the CP indicated bilateral bolsters to the bed to facilitate resident's awareness of the edge of the mattress for repositioning as one of the interventions to minimize Resident 76's risk of injury from fall. During a review of Resident 76's device/physical restraint assessment form, dated 11/17/2025, the device/physical restraint assessment form indicated bilateral bolster to define the parameters of bed and for proper positioning. During an observation on 2/23/2026 at 11:22 a.m., inside Resident 76's room, observed Resident 76 not in bed but observed an APP mattress with bilateral bolsters with the straps looped around the side rails. During a follow up concurrent observation and interview on 2/25/2026 at 8:39 a.m., inside Resident 76's room, with CNA 6, observed Resident 76 up on the Geri chair (also known as a geriatric chair, a specialized, comfortable, and mobile reclining chair with wheels, designed for elderly individuals or residents with limited mobility). CNA 6 stated he just made Resident 76's bed, and the bilateral bolsters are usually placed under the fitted sheet bilateral bolsters to prevent the bolsters from sliding out of the bed and to prevent the resident from sliding out as well and fall. During a concurrent interview and record review on 2/26/2026 at 9:05 a.m. with the ADON, Resident 76's diagnoses, physician's orders, fall risk evaluations, device/physical restraint assessment form, informed consent, and CP were reviewed. The ADON stated Resident 76 had a physician's order for bilateral bolsters per family request, however the order did not specify the indication for the use of the bolsters, and there was no device/physical restraint assessment completed prior to the application of the bolsters. The ADON stated the facility is using the bilateral bolsters for the resident to be aware of the edges of the bed to minimize risk of injury from falls as reflected on the care plan. The ADON stated the bolsters should not have been tucked under the fitted as it was restricting Resident 76's freedom of movement and can be considered a restraint. The ADON stated that if the use of bilateral bolsters was to minimize the risk of injury from falls, a device/physical restraint assessment should have been complete prior to application of the bolsters and that the physician's order was complete with the indication for the use to ensure the use of the device was appropriate and safe. 5. During a review of Resident 56's admission Record, the admission Record indicated the facility admitted the resident on 3/25/2025, with diagnoses including dementia, history of falling, and generalized muscle weakness. During a review of Resident 56's H&P, dated 2/28/2025, the H&P did not indicate Resident 56's capacity to understand and make decisions. During a review of Resident 56's MDS, dated [DATE], the MDS indicated Resident 56 had severely impaired cognition and rarely understands others and make her needs known. The MDS indicated Resident 56 required setup or clean-up assistance with eating; partial/moderate assistance to substantial/maximal assistance with all other ADLs. During a review of Resident 56's OSR, dated 2/26/2026, the OSR indicated a physician's order dated 4/11/2025 for LALM with bolsters. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 56's fall risk evaluation, dated 2/10/2025, the fall risk evaluation indicated the resident was at a high risk for falls. During a review of Resident 56's CP on use of LALM with bolsters for safety, initiated on 4/23/2025, the CP indicated monitor/document/report to the physician as needed changes regarding the effectiveness of the device, less restrictive device, if appropriate; any negative of adverse effects noted including decline in mood, change in behavior, decrease in ADL performance, decline in cognitive ability or communication contracture formation, skin breakdown, signs and symptoms of delirium, falls/accidents/injuries, agitation and weakness as one of the interventions so Resident 56 will remain free of complications related to the device use. During a review of Resident 56's device/physical restraint assessment form, dated 4/23/2025, the device/physical restraint assessment form did not indicate the use of LALM with bolsters. During a concurrent observation and interview on 2/23/2026 at 11:24 a.m., inside Resident 56's room, with CNA 10, CNA 10 stated Resident 56 was in the small dining room, but the resident's LALM has bolsters inside on both sides and closed with a zipper. CNA 10 stated Resident 56 cannot remove the bolsters freely as it zippered inside the LALM. CNA 10 stated that Resident 56 just fell recently and had the tendency to slide on the bed, so the bolsters protect the resident from sliding off the bed and fall. During an interview on 2/24/2026 at 8:30 a.m. with LVN 5, LVN 5 stated that the LALM with bolsters were ordered for residents who were at a high risk for falls. LVN 5 stated that due to the height of the LALM, the residents had the tendency to slide off the mattress. LVN 5 stated the bolsters are for the residents' safety to prevent falls. During an interview on 2/24/2026 at 9:30 a.m. with the ADON, the ADON stated the facility is using the bilateral bolsters for the residents to be aware of the edges of the bed and for safety to minimize risk of injury from falls. The ADON stated that due to the height of the LALM, the residents have the tendency to slide and can fall. During a follow-up concurrent interview and record review on 2/26/2026 at 9:15 a.m. with the ADON, Resident 56's diagnoses, physician's order, fall risk evaluations, device/physical restraint assessments, and CP were reviewed. The ADON stated Resident 56 had a physician's order for LALM with bolsters, however, the order did not specify the indication for the use of the bolsters, there was no device/physical restraint assessment completed prior to the application of the bolsters. The ADON stated the facility is using the bilateral bolsters for Resident 56 to be aware of the edges of the bed and for safety to minimize the risk of injury from falls, the bolsters were restricting Resident 56 to move freely. The ADON stated if the bolsters were inside the LALM and zippered, Resident 56 would not be able to remove the device and can be considered a restraint if there was no device use/physical restraint assessment completed prior to use and that the physician's order should be complete with the indication for the use to ensure the use of the device was appropriate and safe. During a review of the facility's recent policy and procedure (P&P) titled, Nursing Service - Restraints, last reviewed on 10/23/2025, the P&P indicated the Facility shall adhere to California Code of Regulations, Title 22, Section 72319 regarding the use of restraints. Restraints shall only be used when permitted by law, under physician order, and never for punishment, staff convenience, or as substitute for a care. All subsections (a) through (j) of this regulation are included herein. (continued on next page)

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Desert Canyon Post Acute, LLC	1642 West Avenue J Lancaster, CA 93534

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Definitions Restraint: Any physical or mechanical device or chemical agent that restricts the patient's freedom of movement or access to their body. - Restraints shall only be used upon the written order of a physician or other person lawfully authorized to give such an order, which specifies the duration and circumstances under which the restraints are to be used. - Restraints shall not be used for punishment, for the convenience of staff, or as a substitute for more effective patient care. During a review of the facility's recent P&P titled, Patient Rights - Informed Consent Requirements, last reviewed on 10/23/2025, the P&P indicated the facility shall comply with California Code of Regulations, Title 22, Section 72528, which requires that informed consent be obtained prior to the administration of psychotherapeutic drugs, medical treatment, or procedures that carry significant risk. Informed consent shall be obtained voluntarily from the resident or their authorized representative after disclosure of relevant information. During a review of the facility's P&P titled, Respect and Dignity – Physical Restraints, last reviewed on 10/23/2025, the P&P indicated, the facility does not use physical restraint imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. The P&P further indicated: - Physical restraints: any manual method or physical or mechanical devices, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. - Removes easily: the manual method, device, material, or equipment can be removed intentionally by the resident in the same manner as it was applied by the staff considering the resident's physical condition and ability to accomplish objective. - Convenience: any action taken by the facility to control a resident's behavior or manage a resident's behavior with a lesser amount of effort by the facility and not in the resident's best interest. - Freedom of movement: any change in place or position of the body or anby pat of the body that the person is physically able to control. - The following practices shall be considered a physical restraint including but not limited to tucking in a sheet tightly so that the resident cannot get out of bed or fastening fabric or clothing so that a resident's freedom of movement is restricted. - Physical restraints may increase the risk decline in physical functioning, respiratory complications and accidents such as falls, strangulation, or entrapment. - Psychosocial impact related to the use of physical restraints may include feelings of imprisonments or restriction of freedom of movement - The licensed nurse shall obtain a physician's order for the use and specific type of restraint. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The interdisciplinary team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the patients) shall complete a physical restraint assessment to identify the potential risks associated with the restraint use, specifically to the resident. - The facility does not implement the use of a restraint at the resident or resident representative request in the absence of an evaluation and identification of a medical symptom that must be treated and includes the practitioner in the review and discussion.

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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 ensure the resident environment was free of accident hazards for four of eight sampled residents (Residents 63, 77, 41, and 21) reviewed for accidents by failing to ensure: 1. Resident 63 did not have a furniture or equipment on top of the floor mat (specially designed mats provide cushioning and support to patients who are at risk of falling, helping to prevent serious injuries). 2. Resident 77 did not have medications or biologicals (medicines derived from living organisms-such as humans, animals, or microorganisms-rather than being created from chemicals) left at the bedside. 3. Resident 41 did not have frayed wires (a condition where electrical cables become worn or damaged, exposing the internal wires) on the resident's call light button. 4. Resident 21 did not push a trolley (a small vehicle with wheels that can be pushed or pulled along and is used for carrying things) used by the maintenance department without supervision along the hallway. These deficient practices increase the risk of accidents such as electrocution (the injury or killing of someone by electric shock), falls with injuries, and ingested poisoning on residents. Findings: 1. During a review of Resident 63's admission Record (AR- front page of the chart that contains a summary of basic information about the resident), the AR indicated the facility admitted the resident on 2/5/2024, with diagnoses including muscle weakness, dementia (a progressive state of decline in mental abilities), and altered mental status. During a review of Resident 63's Minimum Data Set (MDS, a resident assessment tool), dated 12/16/2025, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (a state where a person's ability to think, reason, remember, and communicate has declined to a point where they can no longer live independently and require full-time care). The MDS indicated the resident was dependent to needing set-up assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 63's Order Summary Report (OSR), dated 5/25/2025, the OSR indicated an order for landing mat on both sides every shift. During a review of Resident 63's Fall Risk Evaluation (FRE), dated 12/17/2025, the FRE indicated the resident was at high risk for falls. During a review of Resident 63's Care Plan (CP) Report regarding the resident use of devices/bilateral bolsters (are firm, cylindrical pillows or foam cushions placed on both sides of a resident in bed) and bilateral landing mats/floor mats., last revised on 4/29/2025, the CP indicated an intervention the resident needs a safe environment with adequate glare-free light; floors that are even and free from spills or clutter, call light within reach, and personal items within reach. During a concurrent observation and interview on 2/23/2026 at 10:21 a.m., with Certified Nursing Assistant (CNA) 11, inside Resident 63's room, observed Resident 63 had bilateral floor mats and there were a side table and a wheelchair on top of the floor mat on the right side. CNA 11 stated there should be no objects or equipment on top of the floor mats as it defeats the purpose of its use. CNA 11 stated that when the resident falls, they will land on the hard objects or equipment on top of the floor mat causing injuries such as a broken bone. During an interview on 2/25/2026 at 3:30 p.m., with the Assistant Director of Nursing (ADON), the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ADON stated the floor mat of Resident 63 should not have any equipment or furniture on top of them because it defeats the purpose of using a floor mat. The ADON stated the floor mat serves as a soft-landing area for residents to fall to. The ADON stated if there is an object on top of the floor mat, the resident could fall on them and it can cause bruises, bumps, or even fracture (break in bone) to the resident. During a review of the facility's recent policy and procedure (P&P) titled, Other Environmental Conditions, last reviewed on 10/23/2025, the P&P indicated the facility should provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Guidelines: 2. The functions of the maintenance personnel include but are not limited to: g. Maintaining the paging system in good working order. j. Others that may become necessary or appropriate. During a review of the facility's recent P&P titled, Accident Physical Plant Hazards, last reviewed on 10/23/2025, the P&P indicated the facility ensures the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. During a review of the facility's recent P&P titled, Fall Management Program, last reviewed on 10/23/2025, the P&P indicated the facility strives to provide each resident with adequate supervision and assistance devices to minimize the risks associated with falls; and to provide an environment which remains as free from accident hazards as possible.ˆ Definitions Avoidable Accident: An accident which occurred because the facility failed to: - Identify environmental hazards and/or assess individual resident risk of an accident, including the need for supervision and/or assistive devices; and/or - Implement interventions, including adequate supervision and assistive devices; consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and if not, reduce the risk of an accident. During a review of the facility-provided Landing Mat (LM) 1 Owner's Manual (OM), printed date 2016, the OM indicated the Direct Choice Bedside Mat may be placed next to a resident's bed to help reduce the impact of a fall should a resident fall from the bed. Storage When product is stored: 4. Do not place objects on the product during storage. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 77's AR, the AR indicated the facility admitted the resident on 2/10/2026, with diagnoses including dementia, depression (a serious, long-lasting mood disorder—more than just temporary sadness—characterized by a persistent feeling of hopelessness, emptiness, or loss of interest in activities), and cerebral infarction (also calledˆischemic stroke, a cerebral infarction occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it). During a review of Resident 77's History and Physical (H&P), dated 2/14/2026, the H&P indicated the resident was well nourished and not in acute distress. The H&P indicated the resident's cranial nerves (a set of 12 nerves that send electrical signals between your brain and different parts of your head, face, neck and torso) two through seven are gross motor intact (specifically indicates no obvious signs of paralysis, severe weakness, or severe droop in the face, eyes, or tongue). During a review of Resident 77's Order Summary Report (OSR), dated 2/26/2026, the OSR did not indicate an order for vitamin A&D ointment (is a thick, petroleum-based skin protectant designed to soothe, moisturize, and heal irritated or damaged skin). During a review of Resident 77's Self-Administration of Medication Assessment ([NAME]), dated 2/10/2026, the [NAME] indicated the resident did not express desire to self-administer medications and mentally the resident is not able to administer own medications. During a review of Resident 77's CP Report regarding the resident being at risk for falls related to confusion., last revised on 2/23/2026, the CP indicated an intervention to promote a safe environment. During a concurrent observation and interview on 2/23/2026 at 12:29 p.m., with Licensed Vocational Nurse (LVN) 1, inside Resident 77's room, observed Resident 77 had an opened A&D ointment at the resident's side table. LVN 1 stated there should be no medications or biologicals left at the resident's side table because if used wrongly the resident can develop skin issues and when ingested can be harmful to the resident and other confused resident as well. During an interview on 2/25/2026 at 3:30 p.m., with the ADON, the ADON stated Resident 77 should not have any medications or biologicals left at the bedside as it can be accidentally ingested by the resident or other confused residents in the facility and cause poisoning. During a review of the facility's recent P&P titled, Labeling of Biologicals and Storage of Biologicals, last reviewed on 10/23/2025, the P&P indicated the facility, in coordination with the licensed pharmacist, provides accurate labeling to facilitate precaution and safe administration of medications, and safe and secure storage. Storage of Drugs and Biologicals 4. The facility has procedures for the control and safe storage of medications for those residents who can self-administer medications. Access to Medications 6. During a medication pass, medications must be under the direct observation of the person administering the medications or locked in the medication storage area/cart. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recent P&P titled, Resident Self-Administer Medications, last reviewed on 10/23/2025, the P&P indicated the interdisciplinary team supports the right of each resident to self-administer medications when this practice is clinically appropriate. During a review of the facility-provided Vitamin A and D- vitamin a and d ointment, undated, the information indicated warnings of: External Use Only. When using this product.: Avoid contact with eyes. Do not apply over deep or punctured wounds, infections or lacerations. If Condition Worsens or Does not improve within 7 days stop use and consult a physician. Keep out of reach of children. In event of accidental ingestion contact a Poison Control Center right away. 3. During a review of Resident 41's AR, the AR indicated the facility admitted the resident on 4/5/2021, and readmitted the resident on 7/2/2025, with diagnoses including psychosis (a mental health symptom—not a specific illness—where a person loses touch with reality, causing them to struggle with what is real and what is not) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 41's MDS dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). During a review of Resident 41's CP Report regarding the resident being at risk for falls related to psychosis and depression., last revised on 11/3/2025, the CP indicated an intervention to promote a safe environment. During a concurrent observation and interview on 2/23/2026 at 9:20 a.m., with Maintenance Director (MD), inside Resident 41's room, observed Resident 41's call light button cable had frayed/exposed wires near the call button console. The MD stated the call light is a low voltage electricity carrier, he (MD) will replace the call light button immediately. During a concurrent observation and interview on 2/23/2026 at 9:29 a.m., with the Minimum Data Set Coordinator (MDSC), inside Resident 41's room, observed Resident 41's call light button with frayed/ exposed electrical wires near the call light button console. The MDSC stated there should be no exposed electrical wires on the resident's call light button because it can cause accidents such as electrocution. During an interview on 2/25/2026 at 3:30 p.m., with the ADON, the ADON stated there should be no exposed/frayed wires on Resident 41's call light because it can cause electrocution on the resident. The ADON stated the staff should report all hazards that they see at the resident's bedside to prevent accidents to residents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recent P&P titled, Other Environmental Conditions, last reviewed on 10/23/2025, the P&P indicated the facility should provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Guidelines: 2. The functions of the maintenance personnel include but are not limited to: g. Maintaining the paging system in good working order. j. Others that may become necessary or appropriate. During a review of the facility's recent P&P titled, Accident Physical Plant Hazards, last reviewed on 10/23/2025, the P&P indicated the facility ensures the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. During a review of the facility's recent P&P titled, Fall Management Program, last reviewed on 10/23/2025, the P&P indicated the facility strives to provide each resident with adequate supervision and assistance devices to minimize the risks associated with falls; and to provide an environment which remains as free from accident hazards as possible.ˆ Definitions Avoidable Accident: An accident which occurred because the facility failed to: - Identify environmental hazards and/or assess individual resident risk of an accident, including the need for supervision and/or assistive devices; and/or - Implement interventions, including adequate supervision and assistive devices; consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and if not, reduce the risk of an accident. During a review of the facility-provided Call Light (CL) 1 Installation & Operating Instructions ([NAME]), undated, the [NAME] indicated to read the following instructions concerning system equipment and determine installation methods before proceeding and to check wires. Connections Checkout re-check all connections to equipment. If all wires and connections are satisfactory, connect the primary coil of the SS106 Transformer to a source of 117 VAC 60 Hz (30 VA max). 4. During a review of Resident 21's AR, the AR indicated the facility admitted Resident 21 on 9/15/2025, with diagnoses including cerebral infarction (also known as stroke, loss of blood flow to a part of the brain), difficulty in walking, and aphasia (a disorder that makes it difficult to speak). During a review of Resident 21's History and Physical (H&P) dated 9/21/2025, the H&P indicated Resident 21 had the capacity to understand and make decisions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 21's MDS, dated [DATE], the MDS indicated Resident 21 had an intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand and able to make his needs known. The MDS further indicated Resident 21 required setup or clean-up assistance with eating, oral hygiene, and rolling left and right; supervision or touching assistance with toileting, sit to lying, lying to sitting, and walking ten (10) feet (ft – a unit of distance); partial or moderate assistance from staff with all other activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 21's fall risk evaluation forms dated 9/15/2025, and 12/18/2025, the fall risk evaluation forms indicated that Resident 21 was not at a high risk for falls. During a review of Resident 21's care plan (CP) on risk for falls initiated on 9/16/2025 and last revised on 12.12.2025, the CP indicated maintain a clear pathway free of obstacles, promote a safe environment, provide visual prompts to ask for help, and provide activities that minimize the potential for falls while providing diversion and distraction as a few of the interventions to minimize risk of injury from falls. During an observation on 2/24/2026 at 2:03 p.m., observed Resident 21 walking on the hallway with a slight limp (a mild unevenness in gait) past the maintenance department office pushing a trolley. Observed Certified Nursing Assistant (CNA) 3, who was standing by the door outside Room (RM) 1, spoke with Resident 21 and CNA 3 continued going inside RM [ROOM NUMBER]. During an interview with CNA 3 on 2/24/2026 at 2:04 p.m., CNA 3 stated she (CNA 3) told Resident 21 not to push the trolley as it was not safe to do so. CNA 3 stated Resident 21 was not supposed to be pushing the trolley as he (Resident 21) was a little unsteady while walking. CNA 3 stated she (CNA 3) was not attending to a resident at the time of observation and that she (CNA 3) should have stopped what she (CNA 3) was doing and taken the trolley away from Resident 21. CNA 3 stated if Resident 21 continued to walk in the hallway with the trolley, Resident 21 can slip or trip and fall causing injury such as broken bone. During an interview on 2/24/2026 at 2:08 p.m. with the Assistant Director of Nursing (ADON), the ADON stated Resident 21 was normally ambulatory but walks with a slight limp and can be unsteady on his feet. The ADON stated that all residents are supposed to be supervised regardless of their ambulatory status. The ADON stated if residents push any equipment unsupervised, they can potentially fall and get injured. The ADON stated CNA 3 should have stopped what she (CNA 3) was doing if she (CNA 3) was not attending to another resident and taken the trolley from Resident 21 while the resident was walking in the hallway pushing the trolley as it placed the resident at risk to trip and fall and get injured from the fall. During a review of the facility's policy and procedure (P&P) titled, Fall Management Program, last reviewed on 10/23/2025, the P&P indicated the facility ensures to provide an environment that is free from accident hazards over which the facility has control and provide supervision and assistive devices to each resident to prevent avoidable accidents. The P&P further indicated: - Avoidable accident: an accident which occurred because the facility failed to: - Identify environmental hazards and/or assess individual resident risk of an accident, including the need for supervision. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Evaluate and analyze the hazards and risks and eliminate them. - Implement interventions, including adequate supervision and assistive devices, consistent with as resident's needs, goals, care plan and current professional standards of practice; and/or eliminate the risk, if possible, and if not, reduce the risk of an accident. - Environment: any environment or area in the facility that is frequented by or accessible to residents, including but not limited to the resident's rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas, and activity areas. - Hazards: elements of the resident environment that have the potential to cause injury or illness. Hazards over which the facility has control; hazards in the resident environment where reasonable efforts by the facility could influence the risk for resulting injury of illness.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility failed to ensure residents were free of any significant medication errors (the observed or identified preparation or administration of medications or biologicals which are not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) by failing to: 1. Rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (sq, beneath the skin) insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) administration sites for one of one sampled resident (Resident 6). 2. Rotate subcutaneous enoxaparin (an injectable prescription medicine that acts as a powerful blood thinner [anticoagulant]) administration sites for one of three sampled residents (Resident 94) observed during Medication Pass Facility Task. The deficient practices had the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Findings: 1. During a review of Resident 6's admission Record (AR), the AR indicated the facility admitted the resident on 8/26/2021, and readmitted the resident on 5/9/2024, with diagnoses including type two diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), end stage renal disease (ESRD, irreversible kidney failure), and encephalopathy (any disease, damage, or malfunction that causes the brain to stop working properly). During a review of Resident 6's History and Physical (H&P), dated 11/2/2025, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 1/25/2026, the MDS indicated the resident usually had the ability to make self-understood and understand others and had intact cognition (a person's brain is functioning normally, without any significant decline or impairment in their mental abilities). The MDS indicated the resident was on a high-risk drug class hypoglycemic medication (a type of medicine used toˆlower high blood sugar (glucose) levels, primarily in people with type two diabetes). During a review of Resident 6's Order Summary Report (OSR), dated 2/12/2026, the OSR indicated an order for Insulin Lispro Subcutaneous Solution Cartridge 100 unit per milliliter (unit/ml, in insulin refers to theˆconcentrationˆor strength of the medication-essentially, how much insulin is packed into every one milliliter of liquid) (Insulin Lispro). Inject as per sliding scale (a flexible, customized plan that tells you how much rapid-acting insulin to take before meals or at bedtime based on your current blood sugar reading): if 0 - 179 = 0; 180 - 200 = 2 units; 201 - 230 = 4 units; 231 - 260 = 6 units; 261 - 290 = 8 units CALL MD for blood sugar (BS) less than (<) 70 OR greater than (>) 350; 291 - 320 = 10 units; 321 - 350 = 12 units. Give 12 u and call MD for BS >350, subcutaneously before meals and at bedtime for DM Notify MD below 70 hold insulin or above 350, subcutaneously before meals and at bedtime for DM 2 If resident can eat or drink give fruit juice or glucose 15 grams (g, a unit of weight). If resident can't eat or drink. Give intramuscular (IM, means delivering medication directly into a muscle, typically via injection, allowing for faster absorption into the bloodstream compared to fat-layer injections) glucagon 1 milligram (mg, a unit of weight). Rotate site. During a review of Resident 6's Care Plan (CP) Report titled, On insulin (insulin glargine, insulin lispro) therapy related to DM, last revised on 3/20/2025, the CP indicated an intervention of insulin administration as ordered. During a review of Resident 6's Location of Administration Report (LAR) from 2/12026 thru 2/28/2026, the LAR indicated insulin Lispro subcutaneous solution cartridge 100 unit/ ml was given on: 2/4/2026 at 06:58 a.m. on the Arm - Upper arm (rear) (left) 2/4/2026 at 11:55 a.m. on the Arm - Upper arm (rear) (left) 2/17/2026 at 5:39 a.m. on the Arm - forearm (left) 2/18/2026 at 5:53 a.m. on the Arm - forearm (left) 2/20/2026 at 8:44 p.m. on the Arm - left 2/22/2026 at 5:45 a.m. on the Arm - left During a concurrent interview and record review on 2/25/2026 at 3:30 p.m., with the Assistant Director of Nursing (ADON), reviewed Resident 6's Medical Diagnoses, H&P, MDS, OSR, CP, and LAR. The ADON stated there were (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	multiple instances that the licensed staff did not rotate the insulin administration of the resident as reflected in the LAR. The ADON stated there was an order to rotate the administration sites of insulin the physician's order. The ADON stated the insulin is a significant medication and the licensed staff did not follow the physician's order by not rotating them constituting a medication error. The ADON stated the failure of the licensed staff to rotate the sites of injection of insulin can lead to lipodystrophy. During a review of the facility's recent policy and procedure (P&P) titled, Insulin Administration, last reviewed on 10/23/2025, the P&P indicated the facility develops protocol to provide guidelines for the safe administration of insulin. Procedure 16. Select an injection site. 17. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. 18. Injection sites should be rotated to reduce the risk of damaging the skin tissue. During a review of the facility's recent P&P titled, Medication Errors, last reviewed on 10/23/2025, the P&P indicated the facility ensures that its residents are free of any significant medication errors; and that its medication error rates are not 5 percent or greater. Definitionsˆ Medication Error: The observed or identified preparation or administration of medications or biologicals which are not in accordance with: a. the prescriber's order. b. Manufacturer's specifications regarding the preparation and administration of the medication or biological; or c. Accepted professional standards and principles which apply to professionals providing services. d. Accepted professional standards and principles include various practice regulations in each State, and current commonly accepted health standards established by national organizations, boards, and councils. During a review of the facility-provided Highlights of Prescribing Information (HPI) on Admelog (insulin lispro) injection, for subcutaneous or intravenous use, with initial U.S. approval on 2017, the HPI indicated rotate injection sites to reduce of lipodystrophy and localized cutaneous amyloidosis. 2. During a review of Resident 94's AR, the AR indicated the facility admitted the resident on 2/16/2026, with a diagnosis of displaced fracture (a broken bone in which the pieces on either side of the break have moved out of their normal, straight alignment) of greater trochanter of right femur (the large, bony bump on the outer side of your upper right thigh, just below the hip joint), subsequent encounter for closed fracture (a broken bone that does not break or pierce through the skin) with routine healing. During a review of Resident 94's H&P, dated 2/17/2026, the H&P indicated the resident had the capacity to make decisions. During a review Resident 94's OSR, dated 2/16/2026, the OSR indicated an order for enoxaparin sodium solution 40 mg/0.4 ml. Inject 40 milligram subcutaneously one time a day for post hemi-arthropathy (a partial joint replacement surgery, most commonly performed on the hip, where only one half of the joint-the ball (femoral head)-is replaced with a prosthetic, while the original socket is left intact) prophylaxis (ppx, any action, treatment, or measure taken beforehand to prevent diseases or infections before they occur) rotate sites. During a review of Resident 94's LAR from 2/1/2026 to 2/28/2026, the LAR indicated enoxaparin sodium solution 40 mg/0.4 ml was administered subcutaneously on: 2/24/2026 at 9:10 a.m. at the Arm-right 2/25/2026 at 8:29 a.m. at the Arm-right During a review of Resident 94's CP Report titled, Black box warning for use of Lovenox for deep vein thrombosis (DVT, is a serious medical condition that occurs when aˆblood clot forms in a deep vein) prophylaxis, last revised on 2/17/2026, the CP indicated a goal of the resident will not experience side effects/interactions with the use of Lovenox (Enoxaparin Sodium). During a concurrent observation, interview, and record review on 2/25/2026, at 8:11 a.m., with Licensed Vocational Nurse (LVN) 1, observed LVN 1 preparing administration of Enoxaparin Sodium sq to Resident 94. LVN 1 checked the medication compared the dosage against the Medication Administration Record (MAR) in Point Click Care (PCC, an electronic healthcare record) and prepared the supplies for administration. LVN 1 knocked at the door of Resident 94, sanitized hands with antiseptic solution. LVN 1 checked the resident using two identifiers, asked for resident's name and birthdate comparing them on Resident 94's arm band. LVN 1 sanitized the right arm shoulder of Resident 94 with alcohol wipes. LVN 1 administered the enoxaparin sodium solution 40 mg/0.4 ml subcutaneously at the right shoulder of Resident 94. LVN 1 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	activated the safety latch of the enoxaparin sodium solution 40 mg/0.4 injection and discarded the syringe with needle in sharps container. LVN 1 washed hands and proceeded to document the administration site. Asked LVN 1 where the last administration site of the enoxaparin was on Resident 94. LVN 1 opened the PCC and checked the history and found out the last site was on the right arm too. LVN 1 stated he should have checked the PCC for last administration site of the enoxaparin sq to prevent repetition of sites. LVN 1 stated there was an order to rotate sites and he did not follow the physician's order which is a medication error. LVN 1 stated not rotating sites of injection for enoxaparin could cause excessive bruising or calluses which will affect the medication absorption. During an interview on 2/25/2026, at 3:30 p.m., with the ADON, the ADON stated Resident 94's enoxaparin sq administration should have been rotated to prevent excessive bruising to the resident. The ADON stated the enoxaparin sodium sq is a significant medication and the licensed staff did not follow the physician's order to rotate the insulin administration site which constitutes a medication error. The ADON stated they should always check for history of last site of administration of sq medications that needed to be rotated in the PCC before administering them to the residents. During a review of the facility's recent P&P titled, Medication and Treatment Orders, last reviewed on 10/23/2025, the P&P indicated orders for medications and treatments will be consistent with principles of safe and effective order writing. During a review of the facility-provided HPI on the use of Lovenox (enoxaparin sodium) injection, for subcutaneous and intravenous use, with initial U.S. approval in 1993, the HPI indicated under subcutaneous injection technique: - Alternate injection sites between the left and right anterolateral and left and right posterolateral abdominal wall.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. The facility failed to ensure sufficient kitchen staff had the appropriate skills and competencies to carry out the functions of the food and nutrition service when the Dietary Supervisor (DS), [NAME] 1, [NAME] 2, and [NAME] 3 did not demonstrate knowledge of and / or competency for following International Dysphagia Diet Standardization Initiative (IDDSI - a standardized framework used to classify food textures and liquid thickness for people with dysphagia) testing (methods to confirm the flow or textural characteristics of a particular food or liquid) of mechanically altered diets on 2/23/2026 for one of four residents (Resident 25) on puree diet (a texture modified diet that consists of smooth, pudding-like consistencies that are easy to swallow). This deficient practice resulted in Resident 25's lunch plate on 2/23/2026 containing broccoli that wept (release of moisture, forming liquid on the surface) potentially resulting in the resident choking (when food gets stuck in your airway, blocking the flow of the air to your lungs) on the food.^^^ Findings:^ During a review of Resident 25's admission Record (AR - front page of the chart that contains a summary of basic information about the resident), the AR indicated the facility admitted the resident on 11/6/2025 with diagnoses including dysphagia, chronic respiratory failure (serious condition that slowly develops when the lungs cannot get enough oxygen into the blood) with hypoxia (low oxygen in the tissues), and chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs). During a review of Resident 25's Minimum Data Set (MDS - a resident assessment tool), dated 2/4/2026, the MDS indicated Resident 25 had the ability to understand others and had the ability to make herself understood. The MDS further indicated Resident 25 required supervision or touching assistance with eating and oral hygiene, and substantial/maximal assistance to total assistance dressing and personal hygiene, and was dependent on staff for toileting and bathing. The MDS further indicated Resident25 was on mechanically altered (requires change in texture of food) and therapeutic diet. During a review of Resident 25's Order Summary Report, dated 2/26/2026, the Order Summary Report indicated a physician's order dated 2/23/2026 for consistent carbohydrate (CCHO - a nutritional approach that involves eating a similar, measured amount of carbohydrates at each meal to maintain stable blood sugar levels) no added salt (NAS - eliminating the use of salt during cooking and at the table) diet pureed texture, mildly thick consistency, fortify diet (practice of adding vitamins and minerals to commonly consumed foods during processing to increase the nutritional value). During a review of the facility's Diet Spreadsheet - Spring/Summer 2025, the Diet Spreadsheet indicated the following menu for lunch on 2/23/2026 for Pureed (PU4) / (texture): - Pureed Penne with mushroom sauce 1 and one half (1/2 - a unit of measurement) cups - Pureed seasoned fresh broccoli florets, number twelve (12) scoop - Pureed garlic bread (PU4) - number 12 scoop - Pureed key lime pie - number 12 scoop - Choice of beverage During a kitchen tray line (specialized, assembly-line food service system) observation on 2/23/2026 at 12:02 p.m., observed [NAME] 1 plating the resident lunch meals. Observed Resident 25's tray prepared with the plate covered, and sitting on the tray line. Just prior to being placed in the meal cart, the surveyor asked to see the plate. Resident 25's plate cover was removed and observed puree broccoli, puree pasta, and puree bread. Observed a green tinted, water like liquid surrounding the broccoli. [NAME] 1 stated the broccoli was separating and should not have water, but it did. [NAME] 1 stated he needed to stir the broccoli more. Observed cook 1 stirred the broccoli and replated Resident 25's meal. Observed [NAME] 1 did not perform IDDSI standardized testing on the prepared puree foods during tray line. [NAME] 1 stated the process for making pureed broccoli was to measure the cooked broccoli and puree in the blender, then add water or a commercial thickener (food additive designed to increase the thickness of liquids and food items) to make sure it was not lumpy and was an applesauce like texture. [NAME] 1 stated [NAME] 3 prepared the puree broccoli. [NAME] 3 then stated she prepared the broccoli by placing an unmeasured amount of cooked broccoli from the (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	regular recipe in the blender with an unmeasured amount of cooking water. The Dietary Supervisor (DS) stated there is a recipe for puree broccoli. The Surveyor asked to see the recipe and observed the DS walk to the recipe binder. The DS stated the puree broccoli recipe was not with the printed recipes and the DS would now print the recipe. The DS, [NAME] 1, [NAME] 2, and [NAME] 3 stated they were not familiar with the term IDDSI spoon tilt test (method used to determine the stickiness of puree foods and the ability of the food to hold its shape and easily fall off a spoon when tilted). During a follow-up concurrent interview and record review on 2/23/2026 at 1:42 p.m. with [NAME] 1, [NAME] 3, and the DS, [NAME] 1 reviewed the recipe titled, Pureed Seasoned Fresh Broccoli Florets, dated 2026. [NAME] 1 stated the recipe indicated to place the broccoli from the regular recipe into a blender and blend until smooth and if the consistency needed thinning, then gradually add water or if it needs thickening then add commercial thickener. [NAME] 1 stated the recipe indicated to perform appropriate IDDSI testing to ensure texture standards are met. [NAME] 1 stated he did not know the term IDDSI testing, but puree should be smooth and not separate with liquid. The DS and [NAME] 2 stated they did not know the term IDDSI testing. During an interview on 2/23/2026 at 1:59 p.m. with the DS, the DS stated the facility implemented Menu and Recipe System (MS) 1 about a year prior that includes IDDSI. The DS stated he completed an on-line training at that time. The DS stated he did not provide an in-service for kitchen staff when MS 1 was implemented. The DS stated the kitchen staff have never been given in-services on IDDSI or IDDSI testing or had competency evaluations for IDDSI testing of mechanically altered diets. The DS stated the DS works with the Registered Dietician (RD) and RD has never provided and in-service or completed a competency evaluation for the DS on IDDSI. During an interview on 2/24/2026 at 3:58 p.m. with the Speech-Language Pathologist (SLP), the SLP stated IDDSI is a diet level system for modified diets for residents that are at risk of choking and possible aspiration (accidentally inhaling food or liquid into the lower airway) from food or liquids that are too thin or too thick. The SLP stated puree is level 4 and like a pudding texture. The SLP stated the kitchen staff should have a diet manual for testing of puree texture. The SLP stated the IDDSI testing for puree is to visually make sure there are no lumps, to use the spoon tilt test, or to use the fork drip test (puree food should not drip or continuously flow through the tines of the fork). During a concurrent interview and record review on 2/24/2026 at 4:32 p.m. with the DS, the MS 1 Diet Manual (MS1DM), last revised 9/26/2025, was reviewed. The DS stated the MS1DM is a kitchen resource for any questions regarding the MS 1 diets, menu, and recipes. The DS stated he assembled the MS1DM but did not thoroughly read it. The DS stated the MS1DM indicates the IDDSI framework uses standardized testing methods for evaluation of modified food and liquid consistencies. The DS stated the MS1DM indicates level 4 puree foods must pass the IDDSI Appearance Test (no lumps), Fork Drip Test, and Spoon Tilt Test. The DS stated on 2/23/2026 during the lunch service the kitchen staff did not perform IDDSI testing on the puree broccoli and it resulted in broccoli being watery that could potentially cause liquid going to the lungs, coughing, and aspiration when served to residents. The RD stated he was responsible for making sure the kitchen staff was competent. The DS stated he did not provide an in-service to kitchen staff or evaluate the staff for competency with IDDSI standards and testing. During an interview on 2/25/2026 at 2:11 p.m. with the RD, the RD stated that the proper consistency for a pureed diet is that it slides off the spoon, maintains its shape and form, not sticky, and not watery. The RD further stated the cook should follow the recipe and the recipe has instructions on what to do. The RD stated the cook should test the consistency of the pureed diet during tray line and adjust as needed using water or thickener depending on the consistency. The RD stated the pureed diet served should have been the correct consistency for the residents to be able to swallow the food without any choking which may lead to aspiration pneumonia (a lung infection caused by inhaling something other than air into the lungs such as food, liquid, saliva or stomach contents). The RD stated the facility staff should have known how to test the puree broccoli based on IDDSI testing. The RD stated the kitchen staff did not display competence when Resident 25's puree broccoli wept and the staff did not perform puree testing on (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the trayline. The RD stated she did not provide an in-service regarding IDDSI and she did not perform a competency evaluation for the DS. The RD stated she was not sure who was responsible for ensuring the DS was evaluated for competencies. During a concurrent interview and record review on 2/26/2026 at 9:58 a.m. with the Assistant Director of Nursing (ADON), a photograph of Resident 25's lunch tray contents, dated 2/23/2026, was reviewed. The ADON stated that the liquid was separating from the puree broccoli. The ADON stated liquid should not separate from the broccoli because it was the wrong consistency to serve to residents. The ADON stated on 2/23/2026 during the lunch service when the DS, [NAME] 1, [NAME] 2, and [NAME] 3 did not follow puree recipes, did not perform IDDSI testing, and prepared broccoli that wept. The ADON stated they did not demonstrate competency with IDDSI standards used in the MS 1 system potentially resulting in Resident 25 choking and aspirating when the puree broccoli wept. During an interview on 2/26/2026 at 10 a.m. with the DS, the DS stated when IDDSI was first starting to be implemented in the facility, about four years ago, he (DS) learned about IDDSI on the old computer menu system. The DS stated his competency on IDDSI was never evaluated. The DS stated the implementation of IDDSI should have been more organized to ensure all the kitchen staff were knowledgeable regarding IDDSI levels and testing. During an interview on 2/26/2026 at 12:13 p.m. with the ADON, the ADON stated she had worked in the facility for about five years and didn't really know the diet levels and IDDSI terminology. The ADON stated it was really the responsibility of the Administrator (ADM) to ensure the DS was provided with competency evaluations regarding IDDSI standards and implementation. During a concurrent interview and record review on 2/26/2026 at 12:22 p.m. with the Governing Body Chair (GBC), the Facility Assessment and policy and procedures regarding administrator duties were reviewed. The GBC stated if the DS does not know the terminology and procedures of the Diet Manual then it is a problem. The GBC stated it is the responsibility of the ADM to ensure that the DS is competent. The GBC stated if the DS did not demonstrate competence and stated he was never provided a competency evaluation then it ultimately falls on the ADM. The GBC stated the facility assessment indicates the dietary staff should have competence to provide care to residents on mechanically altered diets that require specialized aspiration and choking prevention. The GBC stated there was no documentation that the ADM provided competency evaluations for the DS. During a review of the facility's policy and procedure (P&P) titled, Therapeutic Diet, last reviewed on 10/23/2025, the P&P indicated, The facility ensures residents receive and consume food in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the patients) to support the resident's treatment, plan of care, in accordance with his or her goals and preferences. During a review of the facility's P&P titled, Staffing Food and Nutritional Services, last reviewed on 10/23/2025, the P&P indicated, The facility ensures there are sufficient and qualified staff with the appropriate competencies and skill sets to carry out food and nutrition services. The facility should employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment. When the qualified dietitian or other clinically qualified nutrition professional is not employed full time, the facility shall designate a person to serve as the director of food and nutrition services. Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. The Registered Dietitian/designated person(s) shall: . Participate in developing and evaluating regular and therapeutic diets, including texture of foods and liquids, to meet the specialized needs of residents. Develop and implement the person-centered education programs involving food and nutrition services for all facility staff. A qualified dietitian or other clinically qualified nutrition professional may delegate activities to the director of food and nutrition services. During a review of the facility's P&P titled, Administrators Duties and Responsibilities, last reviewed (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facilityˆfailed toˆprepare food in a form designed to meet individual needs for:ˆ 1. One (1) of four (4) residents (Resident 25) on puree diet (a texture modified diet that consists of smooth, pudding-like consistencies that are easy to swallow) when the resident`s lunch plate did not contain broccoli that wept (release of moisture, forming liquid on the surface) because International Dysphagia Diet Standardization Initiative (IDDSI, a standardized framework used to classify food textures and liquid thickness for people with dysphagia) testing (methods to confirm the flow or textural characteristics of a particular food or liquid) was not performed to ensure appropriate texture standards for residents with dysphagia (difficulty swallowing). 2. One (1) of one (1) resident (Resident 7) on Minced and Moist diet (MM5 -ˆconsists of soft, moist, and cohesive food with small, 4ˆmillimeter [mmˆ- a unit of measurement]ˆlumps that are easily mashed with the tongue or fork, noˆseparate liquids should be present, and requires minimal chewing) was served pureedˆgarlic bread andˆpenne pasta with mushroom sauceˆthat was notˆrunny and did not holdˆitsˆshapeˆduring dining observation.ˆˆ 3. One (1) of one (1) resident (Resident 42)ˆon soft bite sized (SB6- soft, tender foods that are appropriate for oral processing skills with no more than 15 millimeters [mm, a unit of length], for adults)ˆdiet wasˆgivenˆpasta withˆmushroom sauceˆthat was finely chopped and minced.ˆ These deficient practices had potential to cause the residents to not be able to eat their food and/or choke (when food gets stuck in your airway, blocking the flow of the air to your lungs) on the food.ˆˆˆ Findings:ˆ a. During a review of Resident 25's admission Record (AR, front page of the chart that contains a summary of basic information about the resident), the AR indicated the facility admitted the resident on 11/6/2025, with diagnoses including dysphagia, chronic respiratory failure (serious condition that slowly develops when the lungs cannot get enough oxygen into the blood) with hypoxia (low oxygen in the tissues), and chronic obstructive pulmonary disease (COPD, is a chronic inflammatory lung disease that causes obstructed airflow from the lungs). During a review of Resident 25's Minimum Data Set (MDS, a resident assessment tool), dated 2/4/2026, the MDS indicated Resident 25 had the ability to understand others and had the ability to make herself understood. The MDS further indicated Resident 25 required supervision or touching assistance with eating and oral hygiene, and substantial/maximal assistance to total assistance dressing and personal hygiene and was dependent on staff for toileting and bathing. The MDS further indicated Resident 25 was on mechanically altered (requires change in texture of food or) and therapeutic diet. During a review of Resident 25's Order Summary Report dated 2/26/2026, the Order Summary Report indicated a physician's order dated 2/23/2026 for consistent carbohydrate (CCHO – a nutritional approach that involves eating a similar, measured amount of carbohydrates at each meal to maintain stable blood sugar levels) no added salt (NAS - eliminating the use of salt during cooking and at the table) diet pureed texture, mildly thick consistency, fortify diet (practice of adding vitamins and minerals to commonly consumed foods during processing to increase the nutritional value). During a review of the facility's Diet Spreadsheet – Spring/Summer 2025, the Diet Spreadsheet indicated the following menu for lunch on 2/23/2026 for Pureed (PU4) / (texture): - Pureed Penne with mushroom sauce one and one half (1/2 – a unit of measurement) cups (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Pureed seasoned fresh broccoli florets, number twelve (12) scoop - Pureed garlic bread (PU4) – number 12 scoop - Pureed key lime pie - number 12 scoop - Choice of beverage During a kitchen tray line (specialized, assembly-line food service system) observation on 2/23/2026 at 12:02 p.m., observed [NAME] 1 plating the resident lunch meals. Observed Resident 25's tray prepared with the plate covered, and sitting on the tray line. Just prior to being placed in the meal cart, the surveyor asked to see the plate. Resident 25's plate cover was removed and observed puree broccoli, puree pasta, and puree bread. Observed a green tinted, water like liquid surrounding the broccoli. [NAME] 1 stated the broccoli was separating and should not have water, but it did. [NAME] 1 stated he (Cook 1) needed to stir the broccoli more. Observed [NAME] 1 stirred the broccoli and replated Resident 25's meal. Observed [NAME] 1 did not perform IDDSI standardized testing on the prepared puree foods during tray line. [NAME] 1 stated the process for making pureed broccoli was to measure the cooked broccoli and puree in the blender, then add water or a commercial thickener (food additive designed to increase the thickness of liquids and food items) to make sure it was not lumpy and was an applesauce like texture. [NAME] 1 stated [NAME] 3 prepared the puree broccoli. [NAME] 3 then stated she (Cook 3) prepared the broccoli by placing an unmeasured amount of cooked broccoli from the regular recipe in the blender with an unmeasured amount of cooking water. The Dietary Supervisor (DS) stated there is a recipe for puree broccoli. The Surveyor asked to see the recipe and observed the DS walk to the recipe binder. The DS stated the puree broccoli recipe was not with the printed recipes and the DS would now print recipe. The DS, [NAME] 1, [NAME] 2, and [NAME] 3 stated they were not familiar with the term IDDSI spoon tilt test (method used to determine the stickiness of puree foods and the ability of the food to hold its shape and easily fall off a spoon when tilted). During a follow-up interview and record review on 2/23/2026 at 1:42 p.m. with [NAME] 1, [NAME] 3, and the DS, [NAME] 1 reviewed the recipe titled, Pureed Seasoned Fresh Broccoli Florets, dated 2026. [NAME] 1 stated the recipe indicated to place the broccoli from the regular recipe into a blender and blend until smooth and if the consistency needed thinning, then gradually add water or if it needs thickening then add commercial thickener. [NAME] 1 stated the recipe indicated to perform appropriate IDDSI testing to ensure texture standards are met. [NAME] 1 stated he (Cook 1) did not know the term IDDSI testing, but puree should be smooth and not separate with liquid. The DS and [NAME] 2 stated they did not know the term IDDSI testing. During an interview on 2/23/2026 at 1:59 p.m. with the DS, the DS stated the facility implemented Menu and Recipe System (MS) 1 about a year prior that includes IDDSI. The DS stated he (DS) completed an on-line training at that time. The DS stated he did not provide an in-service for kitchen staff when MS 1 was implemented. During an interview and record review on 2/24/2026 at 3:58 p.m. with the Speech-Language Pathologist (SLP), the SLP stated IDDSI is a diet level system for modified diets for residents that are at risk of choking and possible aspiration (accidentally inhaling food or liquid into the lower airway) from food or liquids that are too thin or too thick. The SLP stated puree is level 4 and like a pudding texture. The SLP stated the IDDSI testing for puree is to visually make sure there are no lumps, to use the spoon tilt test, or to use the fork drip test (puree food should not drip or (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	standardized dietary guidelines for planning and implementing patient diets. Diet Manual: A current reference manual containing nutritional standards and therapeutic diet descriptions, approved annually. The manual must include descriptions of therapeutic diets and serve as a guide for prescribing and serving patient diets. Procedures / Standards . Staff use the manual for guidance in prescribing and serving diets. During a review of the MS1DM document titled, Common Ground between National Dysphagia Diet (NDD) and IDDSI, dated 2025, the MS1DM document indicated, The National Dysphagia Diet (NDD) of 2002 was replaced with the International Dysphagia Diet Standardization Initiative (IDDSI) Framework. This document explores the development of the IDDSI framework and the identification of diet levels. IDDSI is the only professionally recognized and supported diet framework as of October 2021. IDDSI framework consists of 8 more clearly defined levels (0-7) of drinks through foods. Drinks and foods are tested using IDDSI Testing Methods. Testing Methods such as the Spoon Tilt Test to ensure safety of a pureed food product. During a review of the MS1DM document titled, IDDSI Texture-Modified Diets, dated 2025, the MS1DM document indicated, texture-modified diets are prepared and served by the physician or community speech language pathologist when a resident has difficulty chewing and/or swallowing. The residents' acceptance and tolerance of the diet determine the extent of texture modification and meals need to be modified to suit individual resident preferences. Use the IDDSI testing methods to evaluate the final consistency.Testing Info. Level 4 – Pureed PU 4. sits in a mound or pile above the fork, does not dollop or drip continuously through a fork. Holds its shape on a spoon, falls off easily if the spoon is tilted or lightly flicked, must not be firm or sticky, should be smooth with no lumps, no chewing ability needed, and can be eaten with a spoon. During a review of the MS1DM document titled, Pureed (PU4), dated 2025, the MS1DM document indicated, This modification is designed for people who have severe chewing and/or swallowing problems. Properly pureed foods eliminate the chewing phase. Pureed diet menus follow the foods on the regular menu as closely as possible and differ primarily in consistency. Puree all foods to a smooth, lump-free, Extremely Thick (EX4) consistency (not firm or sticky). Use an appropriate recipe. This diet is also appropriate for Dysphagia Pureed (Level 1). Use of commercial thickeners (used according to the resident's tolerance) when preparing pureed foods is recommended. Always refer to the recipe and spreadsheet for directions . Foods on this level must pass the IDDSI Appearance Test, Fork Drip Test and Spoon Tilt Test. Food is smooth, with no lumps. Food sits in a mound on a fork, does not drip continuously through the tines of a fork, holds its shape on a spoon, slides off spoon easily (not sticky). Pureed food must pass both tests! During a review of the facility's P&P titled, Staffing Food and Nutritional Services, last reviewed on 10/23/2025, the P&P indicated, The facility ensures there are sufficient and qualified staff with the appropriate competencies and skill sets to carry out food and nutrition services. The facility should employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment. When the qualified dietitian or other clinically qualified nutrition professional is not employed full time, the facility shall designate a person to serve as the director of food and nutrition services. Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. The Registered Dietitian/designated person(s) shall: . Participate in developing and evaluating regular and therapeutic diets, including texture of foods and liquids, to meet the specialized needs of residents. Develop and implement the person-centered (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	education programs involving food and nutrition services for all facility staff. A qualified dietitian or other clinically qualified nutrition professional may delegate activities to the director of food and nutrition services. During a review of the facility provided Job Description for Cook, dated 10/2016, the Job Description indicated, Job Title: Cook. Reports to. Dietary Manager. Prepares and cooks for the regular and modified diets for the resident population. Reviews menus prior to preparation of food. Prepares meals in accordance with planned menus, standardized recipes and production sheets. Prepares food for therapeutic diets in accordance with planned menus. Prepares meals in accordance with planned menus, standardized recipes and production sheets. Prepares food for therapeutic diets in accordance with planned menus. To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed are representative of the knowledge, skill, and/or ability required. During a review of the facility provided Job Description for Dietary Manager, dated 10/2016, the Job Description indicated, Job Title: Dietary Manager. Reports to. Administrator. Responsible for supervision of both the kitchen and dining room staff in. serving food Completes evaluations on dietary staff. Ensures food is handled in accordance with applicable standards. b.ˆDuring a review of Residentˆ7's admission Record, the admission Record indicated the facility originally admitted the resident on 1/20/2023,ˆand readmitted in the facility onˆ11/4/2025, with diagnoses includingˆdysphagia,ˆadult failure to thrive (a condition in older adults marked by physical and mental declineˆsuch as loss of appetite and weight loss), generalized muscle weakness).ˆ During a review of Residentˆ7's History and Physical (H&P) datedˆ11/6/2025, the H&PˆindicatedˆResidentˆ7ˆdid not have theˆcapacity to understand and make decisions.ˆ During a review of Residentˆ7's MDS, dated [DATE], the MDS indicated Residentˆ7ˆhadˆseverely impairedˆcognition (mental action or process ofˆacquiringˆknowledge and understanding) and was able to understand and make herˆneeds known. The MDS further indicated Residentˆ7ˆrequired supervision or touching assistance with eating,ˆpartial/moderate assistance with oral hygiene, and substantial/maximal assistance to total assistanceˆwith allˆotherˆactivities of daily livingˆ(ADLs-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).ˆThe MDS furtherˆindicatedˆResident had a diagnosis of dysphagiaˆand was on mechanically altered and therapeutic diet.ˆ Duringˆa review of Resident 7'sˆOrder Summary Report dated 2/26/2026, the Order Summary Report indicated a physician's order dated 2/13/2026ˆforˆconsistentˆcarbohydrate NASˆdiet Minced and Moist texture, moderately thick consistency, fortify diet.ˆˆ During anˆobservation on 2/23/2026ˆat 12:40 p.m.ˆwith Certified Nursing Assistant (CNA) 8,ˆobservedˆResident 7 eating lunch in the small dining room. CNA 8 statedˆResident 7'sˆmeal ticketˆindicated CCHOˆMinced and Moistˆ(MM5) textureˆmoderately thick honey liquidˆfortify dietˆandˆResidentˆ7 was served withˆpureed bread, pureed pasta, and finely chopped broccoli. CNA 8ˆstatedˆthe pureedˆbread and pasta were runny andˆdidˆnot hold their shape. CNA 8ˆstatedˆtheˆliquid was separating from the broccoli.ˆˆCNAˆstatedˆif theˆfood is too runnyˆand thin,ˆit placed Residentˆ7 at riskˆfor choking.ˆ During aˆconcurrentˆinterviewˆand record reviewˆon 2/25/2026ˆat 2:11 p.m.,ˆphotograph of (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 7's lunch trayˆand meal ticketˆfor 2/23/2026 was reviewedˆwith the RD.ˆThe RD stated the meal ticket indicated thatˆResident 7's dietˆwasˆCCHO Minced and Moist (MM5) texture moderately thick honey liquid fortify dietˆˆand the resident was servedˆpureed pasta and bread that is too thin and did not hold its shapeˆand that theˆliquid was separating from theˆfinely chopped broccoli.ˆThe RDˆstatedˆthat the proper consistency forˆa pureed dietˆis that it slides off the spoon,ˆmaintainsˆits shape and form,ˆnot sticky, and not watery. The RD furtherˆstatedˆthe cook should follow the recipe and theˆrecipe has instructions on what to do. The RDˆstatedˆthe cookˆshould test the consistency of the pureed diet duringˆtray line and adjust as needed using water or thickener depending on the consistency.ˆThe RD stated the pureed dietˆserved should have been the correct consistency for the residents to be able to swallow the food without anyˆchoking which may lead to aspiration pneumonia (aˆlungˆinfection caused by inhaling something other than air intoˆtheˆlungsˆsuch asˆfood, liquid, saliva or stomach contents).ˆ During a concurrent interview and record review on 2/26/2026 atˆ9:29 a.m., Resident 7's Order Summary Report,ˆmedical diagnosis,ˆand photographˆof Resident 7's lunch tray contents and meal ticket dated 2/23/2026 were reviewed with the ADON.ˆThe ADON stated that Resident 7 had a diagnosis of dysphagia.ˆThe ADON statedˆthe meal ticket indicated that Resident 7's diet was CCHO Minced and Moist (MM5) texture moderately thick honey liquid fortify diet andˆthatˆthe resident was served pureed pasta and bread that is too thin and did not hold its shape and that the liquid was separating from the finely chopped broccoli.ˆThe ADON stated that the pureed dietˆserved to Resident 7ˆshouldˆhave beenˆmore formedˆand not too thin as it placed Resident 7 at risk for choking and aspirationˆas the resident had a diagnosis of dysphagia.ˆ During a review of the facility'sˆDiet Spreadsheet – Spring/Summer 2025, dated 2025, the Diet Spreadsheetˆindicatedˆthe following menu for lunch for Minced and Moist (MM5)ˆtexture:ˆ - Penne withˆmushroomˆsauce 1 and one half (1/2ˆ– a unit of measurement) cupsˆ - Mincedˆseasonedˆfreshˆbroccoliˆflorets withˆthickˆbrothˆnumber eight (8) scoop with thick brothˆ - Pureed garlic breadˆ(PU4) – number 12 scoopˆ - Pureed key limeˆpie - number 12 scoopˆ - Choice of beverageˆ During a review of the facilityˆprovided document titled,ˆDiet Descriptions, dated 2025, the Diet Descriptionsˆindicatedˆthe following:ˆ 3. Texture-Modified Diets and Thickened liquids – texture-modified diets are prepared and served by the physician or community speech language pathologist when a resident has difficulty chewing and/or swallowing. Texture-modified diets and thickened liquid consistencies are based on theˆInternational Dysphagiaˆ Standardizationˆ Initiative (IDDSI, aˆframeworkˆmade up of levels and describes food textures and drink thickness)ˆframework. Texture modifications and thickened liquid consistenciesˆinclude the following:ˆ - Minced and Moist (MM5);ˆalsoˆappropriate forˆdysphagia mechanically altered (level 2)ˆ–ˆused in the dietary management ofˆdysphagiaˆwith food texture described as s soft, tender, moist foods with no separateˆthin liquids. Food should be no greater than 4 mm by 15 mm (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Residents receive foodˆin the amount, type, consistency, and frequencyˆtoˆmaintainˆnormal body weight and acceptable nutritional values.ˆ - Menus meet basic nutritional needs by providingˆmeals based on individual nutritional assessment, the individualized plan of care, andˆestablishedˆnational guidelines and are periodicallyˆupdated to mitigate the risk of menu fatigue.ˆ c.ˆDuring a review of Residentˆ42's admission Record, the admission Record indicated the facility admitted the resident onˆ10/30/2025, with diagnoses including dysphagia,ˆdementia (a progressive state of decline in mental abilities),ˆandˆgeneralized muscle weakness.ˆ During a review of Residentˆ42's History and Physical (H&P) dated 11/2/2025, the H&PˆindicatedˆResidentˆ42 did not have theˆcapacity to understand and make decisions.ˆ During a review of Residentˆ42's MDS dated [DATE], the MDS indicated Residentˆ42ˆhad severely impaired cognition (mental action or process ofˆacquiringˆknowledge and understanding) and wasˆunable to understand and make hisˆneeds known. The MDS further indicated Residentˆ42ˆrequiredˆsupervision or touching assistance with rollingˆto left and right and sit to lying;ˆpartial/moderate assistanceˆwith eatingˆand lying to sitting;ˆpartial/moderate assistance with oral hygiene, and substantial/maximal assistance to total assistance with all other activities of daily living. The MDS furtherˆindicatedˆResident had a diagnosis of dysphagia and was on mechanically altered and therapeutic diet.ˆ During a review of Residentˆ42's Order Summary Report dated 2/26/2026, the Order Summary Report indicatedˆaˆphysician's order dated 2/22/2026 forˆno added salt dietˆsoftˆandˆbite sized (SB6- soft, tender foods that are appropriate for oral processing skills with no more than 15 millimeters [mm, a unit ofˆmeasurement], for adults)thin liquids consistency, fortify diet.ˆˆ During aˆconcurrentˆobservationˆand interviewˆon 2/23/2025 at 12:46ˆp.m.ˆinside Resident 42's room withˆCNA 6ˆand CNA 7,ˆCNA 6 stated Resident 42's meal ticketˆindicatedˆNASˆsoftˆand bite sized (SB6)ˆthin liquids consistency, fortify diet. CNAˆ7ˆstatedˆthe pastaˆnoodles served to Resident 42ˆwereˆsoft but were not bite sized.ˆCNA 6ˆand CNA 7 bothˆstatedˆthat they just cut the noodles in small bite sized pieces before giving it to the residentˆbutˆwere unableˆto tell the approximate measurement for bite-sized food.ˆCNA 6 stated that he (CNA 6) will send the tray back to the kitchen and request a replacement with bite-sized pasta. CNA 7ˆstatedˆthat the lunch tray served to theˆresident should have been the correct one. CNA 7ˆstatedˆthat if Resident 42 ateˆthe big pieces of pasta on the plate, the resident canˆend upˆchoking.ˆ During a concurrent interview and record review on 2/25/2026 at 2:11 p.m.,ˆaˆphotograph of Residentˆ42's lunch tray and meal ticket for 2/23/2026 was reviewed with the RD, the RD stated the meal ticket indicated that Residentˆ42's diet wasˆNAS soft and bite sized (SB6) thin liquids consistency, fortify dietˆand the resident was served pastaˆand the noodles were not bite-sized pieces. The RDˆstatedˆthat the proper consistency for aˆsoft and bite-sizedˆdietˆisˆat leastˆ1/2 of an inchˆfor the pasta pieces and should not be biggerˆthan that.ˆThe RD furtherˆstatedˆthe cook should follow the recipe and the recipe has instructions on what to do. The RDˆstatedˆthe cook shouldˆprepare the soft and bite-sizedˆaccording to the recipeˆand should have been chopped in bite-sized pieces.ˆThe RD stated theˆsoft and bite-sized dietˆservedˆto Resident 42ˆshould have been the correct consistency for the resident to be able to swallow the food without any choking which may lead to aspiration pneumonia (a lung infection caused by inhaling something other than air (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Canyon Post Acute, LLC	1642 West Avenue J Lancaster, CA 93534

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	into the lungs such as food, liquid, saliva or stomach contents).ˆ During a concurrent interview and record review on 2/26/2026 at 9:29 a.m., Residentˆ42's Order Summary Report, medical diagnosis, and photograph of Residentˆ42's lunch tray contents and meal ticket dated 2/23/2026 were reviewed with the Assistant Director of Nursing (ADON). The ADON stated that Residentˆ42ˆhad a diagnosis of dysphagia. The ADON stated the meal ticketˆindicatedˆthat Residentˆ42's diet wasˆNAS soft and bite sized (SB6) thin liquids consistency, fortify dietˆand that the resident was served pastaˆnoodles that wereˆnot bite-sized pieces.ˆThe ADON stated thatˆmost of theˆpasta noodlesˆserved to Resident 42 on the plateˆwere at leastˆ1 inch in lengthˆwhich is not a bite-sized length.ˆThe ADON stated that theˆsoft and bite-sized pastaˆserved to Residentˆ42ˆshould have beenˆcut by the cook in bite-sized piecesˆas it placed Residentˆ42ˆat risk for choking and aspirationˆif consumedˆas the resident had a diagnosis of dysphagia.ˆ During a review of the facility's Diet Spreadsheet – Spring/Summer 2025, dated 2025, the Diet Spreadsheetˆindicatedˆthe following menu for lunch forˆsoft and bite-sizedˆ(SB6) texture:ˆ - Chopped penne with mushroom sauce 1 1/2 cupsˆ - Bite-sized seasoned fresh broccoliˆflorets (SB6)ˆnumber 8 scoopˆ - Pureed garlic bread (PU4) numberˆ12ˆscoopˆ - Pureed key lime pieˆ(PU 4)ˆnumber 12ˆscoopˆ - Choice of beverage 1 cupˆ During a review of the facility provided doc

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen reviewed during the Kitchen task by failing to: 1. Ensure used towels were stored in sanitation buckets or dirty towel bins and not left unattended in the sink, at the trayline (a specialized, assembly-line food service system), and in the dirty dish washing area. 2. Ensure food items in the Dry Food Storage Area were labeled with the date per facility policy and procedure (P&P). 3. Ensure perishable fruits and vegetables were stored in the refrigerator and according to facility P&P. 4. Ensure frozen items in the Ice Cream Freezer were labeled with the contents and date. 5. Ensure food items in the Dry Can Storage Area were properly covered with tight sealed lids. 6. Ensure expired foods in the Dry Can Storage Area were discarded and not readily available to be served. These deficient practices had the potential to result in harmful bacterial growth and cross contamination (the process by which bacteria, chemicals, or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs) in 87 of 89 medically compromised residents who received food and drinks from the kitchen. Findings: a. During an Initial Kitchen Tour on 2/23/2026 at 7:53 a.m., with the Dietary Supervisor (DS), observed the Food Preparation Area, the Dishwashing Area, and Trayline Area. The DS stated the facility uses white towels to clean and sanitize the kitchen. The DS stated all towels should only be stored in red sanitizer buckets when in use or dirty towel bins after use. The DS stated no towels should be left out on kitchen surfaces to prevent cross contamination from one surface to another while staff is performing tasks in the kitchen. Observed the following: 1.A damp white towel was placed in the kitchen prep sink. The DS stated the towel was dirty and should not be left in the sink. The DS stated the staff should have placed the used towel in the dirty towel area and they did not. 2.A soiled, white towel was placed under a plate of parsley on the tray line. The DS stated towels should not be left under a plate of food on the trayline to prevent cross contamination from the towel to the food. 3.A damp, soiled towel was left on top of dirty dishes in the dirty dish area. The DS stated the used towel should not have been left in the dirty dish area, but staff left it there. During an interview on 2/25/2026 at 2:11 p.m. with the Registered Dietician (RD), the RD stated kitchen towels are kept in the sanitation solution buckets and then used only one time and then placed in the dirty towel bin. The RD stated the kitchen towels should not be left on kitchen surfaces to ensure staff does not grab and re-use dirty towels. The RD stated she (RD) has previously corrected the practice of leaving used towels on kitchen surfaces and has provided in-services to staff. The RD stated when dirty towels were left out in the kitchen there was the potential to spread bacteria in the kitchen resulting in cross contamination and food poisoning in residents. During a review of the facility P&P titled, Safe Food Preparation, last reviewed 10/23/2025, the P&P indicated, POLICY. The facility follows proper sanitation and food handling practices to prevent the outbreak of foodborne illness. PURPOSE: To provide guidelines for the safe preparation of meals. DEFINITIONS: The following definitions are provided to clarify terms related to professional standards for food service safety, sanitary conditions, and the prevention of foodborne illness. Foodborne illness refers to illness caused by the ingestion of contaminated food or beverages. Cross-Contamination. 2. Cross-contamination can occur when harmful substances. i.e . chemical or disease-causing microorganisms are transferred to food by hands (including gloved hands), food contact surfaces, sponges. cloth towels. or utensils that are not adequately cleaned. 3. Examples of ways to reduce cross-contamination include. but are not limited to:. b. Between uses, store towels/cloths used for wiping surfaces during the kitchen's daily operation in containers filled with sanitizing solution at the appropriate concentration per manufacturer's specifications. b. During an Initial Kitchen Tour on 2/23/2026 at 7:53 a.m., with the DS, observed the Dry Food Storage Area, Ice Cream Freezer, and Dry (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Can Storage Area. The DS stated the facility uses the First-In, First-Out method (FIFO, an inventory management and food safety system where the oldest stock [first in] is used before newer stock [last in]) and labels and dates all food with the food item, date of arrival, and open date to ensure staff knows what they are serving and to ensure no expired or old food is served to residents. The DS stated food is used or discarded by a date determined by the Product Shelf-Life guidelines and the expiration date on packaging. The DS stated when items are removed from the original packaging, they are labeled with the food item and date. Observed the following: 1. In the Ice Cream Freezer, observed a clear plastic bag containing two frozen pizzas. The DS stated the frozen pizzas were removed from the original container and were not labeled with the contents or the date. The DS stated all frozen foods should be labeled and have the date removed from the original box or an expiration date to track quality and freshness of the food, but the kitchen staff did not label the frozen pizzas. 2. In the Dry Can Storage Area observed a clear plastic bin containing dry cereal. Observed the lid to the bin was not secured and cereal was exposed. The DS stated bins containing cereal should be properly covered with tight sealed lids, but it was not. The DS stated it was important to keep food covered to preserve the quality of the food and ensure nothing got inside that may contaminate the food and result in illness in residents. 3. In the Dry Can Storage Area observed a package of English Muffins labeled with a best if used by date of 2/11/2026. The DS stated the muffins should have been discarded and not available to be served, but they were not. The DS stated expired food items should not be served to residents to ensure quality and prevent food borne illness. 4. In the Dry Food Storage Area, observed there was no thermometer in the room. Observed a box containing sprouting potatoes. The DS stated the box was not labeled with the date and the potatoes were growing roots. The DS stated he (DS) was not sure when the potatoes arrived in the facility because the box was not labeled with a date. The DS stated kitchen staff should have labeled the box of potatoes but did not. The DS stated he (DS) would discard the potatoes. 5. The DS stated the Dry Food Storage Area was used to store food that does not need to be refrigerated and / or food that will be used within a day. The DS stated there was no thermometer in the Dry Food Storage Area and there were no temperature monitoring logs maintained. In the Dry Food Storage Area: - Observed on the shelf a box of cabbage dated 2/23/2026. The DS stated the cabbage was mislabeled because it was delivered on 2/21/2026. The DS stated cabbage was stored in the Dry Food Storage area and can be stored outside the refrigerator for up to five days. - Observed on the shelf a box of green bell peppers. The DS stated some of the bell peppers were wilting. The DS stated bell peppers were stored in the Dry Food Storage area and did not require refrigeration. - Observed on the shelf a box of cantaloupes labeled 2/21/2026. The DS stated cantaloupes were stored in the Dry Food Storage area and did not require refrigeration. - Observed on the shelf a box of cucumbers labeled 2/19/2026. The DS stated cucumbers were stored in the Dry Food Storage area and did not require refrigeration. - Observed on the shelf a box containing honey dew melons labeled 2/19/2026. The DS stated honey dew melons were stored in the Dry Food Storage area and did not require refrigeration. During a follow-up concurrent interview and record review on 2/24/2026 at 2:23 p.m. with the DS, the DS reviewed the facility P&P regarding food storage. The DS stated the Dry Food Storage Area did not have a thermometer and was not monitored for temperature. The DS stated the P&P indicates all vegetables and fruits, except potatoes, onions, and bananas should be stored at 41 degrees Fahrenheit (F, a measurement of temperature) in the refrigerator. The DS stated all the vegetables and fruit in the Dry Food Storage Area, except the potatoes, onions, and bananas, should have been stored in the refrigerator to keep them fresh and to prevent spoiling, but they were not. The DS stated when spoiled food is served to residents it could result in harm to the residents. During an interview on 2/25/2026 at 2:11 p.m. with the RD, the RD stated fruits and vegetables should be stored per the P&P. The RD stated when fruits and vegetables are not stored per the facility P&P there is the potential that the food would not maintain the nutrients for residents or there could be bacteria growth resulting in resident illness. The RD stated all foods in the freezer need to be labeled with the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contents and dated. The RD stated it was important to label the contents because some residents have allergies and it was important to know the exact ingredients of the food. The RD stated the frozen pizza should have been labeled, but it was not. The RD stated lids should be secured on the food bins to ensure the food does not become stale or contaminated. The RD stated she (RD) has noticed and reported to the DS that the lids were not secured on the food bins in the facility kitchen in the past. The RD stated the cereal bin lid should have been secured, but it was not. The RD stated expired English muffins and sprouting potatoes should have been discarded, but they were not. The RD stated expired food should not be available to be served to residents because it could potentially result in food born illness. During a review of the facility P&P titled, Food Storage, last reviewed 10/23/2025, the P&P indicated, Purpose. To establish guidelines for storing, thawing, and preparing food. Procedure. Foods should be stored in their original containers if designed for freezing. Foods to be frozen should be store in airtight containers. Label and date all food items. Fresh Fruits Storage Guidelines. Store at a temperature of 41 For less, except bananas, which should be stored at 60 F to 70 F. Fresh Vegetable Storage Guidelines. Fresh vegetables should be checked and sorted for ripeness.Store at a temperature of 41 F or less, except potatoes and onions, which should be stored in a cool and dry place at 60 F to 70 F. Fresh vegetables should be ordered and delivered frequently to ensure freshness. Dry Storage Guidelines . The area should be well lit and ventilated with a temperature of 50 F to 70 F. Any opened products should be placed in storage containers with tight fitting lids. Label and date storage products. During a review of the facility P&P titled, Food Receiving and Storage, last reviewed 10/23/2025, the P&P indicated, PURPOSE STATEMENT.When food, food products or beverages are delivered to the nursing home, facility staff must inspect these items for safe transport and quality upon receipt and ensure their proper storage, keeping track of when to discard perishable foods and covering, labeling, and dating all foods stored in the refrigerator or freezer as indicated. DRY FOOD STORAGE GUIDELINES.1. Dry storage may be in a room or area designated for the storage of dry goods, such as single service items, canned goods, and packaged or containerized bulk food that is not Potentially Hazardous Foods. 4. Dry foods and goods should be handled and stored in a manner that maintains the integrity of the packaging until they are ready to use. It is recommended that foods stored in bins (e.g., flour or sugar) be removed from their original packaging. Desirable practices include managing the receipt and storage of dry food, removing foods not safe for consumption, keeping dry food products in closed containers, and rotating supplies. REFRIGERATED STORAGE GUIDELINES. Potentially hazardous foods shall be maintained at or below 41 degrees F, unless otherwise specified by law. 3. Refrigeration prevents food from becoming a hazard by significantly slowing the growth of most microorganisms. Inadequate temperature control during refrigeration can promote bacterial growth. Adequate circulation of air around refrigerated products is essential to maintain appropriate food temperatures. During a review of the facility provided guidelines document titled, Product Shelf Life, undated, the guidelines indicated, TV dinners purchased frozen. frozen for three to four months. Commercial muffins. pantry stored three to seven days. Vegetables. refrigerator three to five days. During a review of Food Code 2022, the Food Code 2022 indicated, 3-501.16 Time/Temperature for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as a public health control as specified under 3-501.19, and except as specified under (B) and in (C) of this section, Time/Temperature Control for safety food shall be maintained: (2) At 5 C (41 F) or less.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility failed to maintain documentation and demonstrate evidence of ongoing Quality Assurance and Performance Improvement (QAPI - a data driven proactive approach to improvement used to ensure services are meeting quality standards) program by: 1. Failing to provide documentation of the written QAPI plan (guides the nursing home's quality efforts and serves as the main document to support implementation of QAPI). 2. Failing to provide documentation of data collection and analysis at regular intervals to include falls, which was identified by the facility as a problem issue in the facility. These deficient practices had the potential for systemic failures to go uncorrected and no improvement to the facility's delivery of care for all residents. Findings: During the Entrance Conference conducted on 2/23/2026 at 8:09 a.m. with the Assistant Director of Nursing (ADON), the ADON was provided the Entrance Conference Worksheet (information needed from the facility, including the QAPI Plan). During a concurrent interview and record review on 2/26/2026 at 3:11 p.m. with the ADON, the Entrance Conference Worksheet and survey binder (binder used to collect and organize requested documents from the Entrance Conference Worksheet) were reviewed. The ADON stated the QAPI Plan that was in the survey binder was not the correct one and was dated 1/26/2023. The ADON stated she does not have access to the current QAPI Plan. The ADON stated the Administrator (ADM) is unable to be reached and the Director of Nursing (DON) is not available. The ADON stated the QAPI Plan is to identify the problem care areas of the facility for them to discuss and fix it. The ADON stated the QAPI plan is a written plan, and it contains data, logs, in-services, meeting minutes and analyzed during the QAPI meeting by the DON. The ADON stated by not having a QAPI plan, the facility would not have a goal and would not know when to meet and would not know what quality care areas to improve.^ During a review of the facility's policy and procedure (P&P) titled, Quality Assurance Performance Improvement (QAPI), last reviewed 10/23/2025, the P&P indicated the purpose of the P&P is to provide facility staff with a plan that describes the process for conducting QAPI/QAA activities, such as identifying and correcting quality deficiencies as well as opportunities for improvement, which will lead to improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life, and resident safety. PROCEDURE 1. The facility maintains documentation and demonstrates evidence of its ongoing QAPI program. 3. The facility shall present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request. 5. The facility QAPI plan is a written plan containing the process that will guide the nursing home's efforts in assuring care and services are maintained at acceptable levels of performance and continually improved. 6. The QAPI plan describes in detail the scope the QAA committee's responsibilities and activities, and the process addressing how the committee will conduct the activities necessary to identify and correct quality deficiencies. 7. The QAPI plan described how the facility will ensure care and services delivered meet accepted standards of quality, identify problems and opportunities for improvement, and ensure progress toward correction or improvement is achieved and sustained. 8. The facility QAPI plan described the process for identifying and correcting quality deficiencies, including but not limited to: - Tracking and measuring performance. - Establishing goals and thresholds for performance measurement. - Identifying and prioritizing quality deficiencies. - Systematically analyzing underlying causes of systemic quality deficiencies. - Developing and implementing corrective action or performance improvement activities; and - Monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed.

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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 maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases (a disease that is spread from one person to another through a variety of ways that include: contact with blood and bodily fluids; breathing in an airborne virus; or by being bitten by an insect), and infections by failing to ensure: 1. Resident 41's call light (a button, cord, or remote device in a hospital or nursing home room that allows a patient or resident to electronically alert nurses or staff that they need assistance) that was inside the trash can was sanitized before handing it off to the resident for use observed during random screening of residents.ˆ 2. Resident 37's call light that was on the floor was sanitized before handing them off to the resident for use during random screening of residents.ˆ 3. Certified Nursing Assistant (CNA) 10 was wearing a gown while providing activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive) care to the resident who was on enhanced barrier precautions (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO, microorganisms, mainly bacteria, that are resistant to one or more classes of antibiotics] that uses targeted gown and glove use during high contact resident care activities) for one (1) out of three (3) sampled residents (Resident 4) reviewed under infection control. The deficient practices had the potential to cause cross-contamination (a mechanical device used by caregivers to safely move people with limited mobility from one place to another) of infection among residents and staff. Findings: 1. During a review of Resident 41's admission Record (AR), the AR indicated the facility admitted the resident on 4/5/2021, and readmitted the resident on 7/2/2025, with diagnoses including muscle weakness, difficulty walking, and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 41's Minimum Data Set (MDS, a resident assessment tool), dated 1/19/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's mental abilities—such as memory, thinking, reasoning, and learning—are working normally, without any significant decline, impairment, or loss of function). The MDS indicated the resident was dependent to needing set-up assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 41's Order Summary Report (OSR), dated 7/21/2025, the OSR indicated an order of EBP due to left heel peripheral vascular disease (PVD, a slow, progressive circulation disorder caused by narrowed, blocked, or damaged blood vessels (arteries or veins) outside the heart and brain, most commonly affecting the legs and feet) ulcer every shift. During a review of Resident 41's Care Plan (CP) Report titled, Enhanced barrier precaution related to left heel PVD ulcer, last revised on 7/21/2025, the CP indicated an intervention of environmental cleaning on resident's room, equipment and devices. During a concurrent observation and interview on 2/23/2026 at 9:26 a.m., with the Minimum Data Set Coordinator (MDSC), inside Resident 41's room, observed Resident 41's call light button dangling inside the trash can. The MDSC stated the call light button should not be dangling inside the trash can as it will contaminate the call light. The MDSC stated she (MDSC) should have sanitized the call light button before handing them off to the resident to prevent cross-contamination of infection to the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/25/2026 at 3:30 p.m., with the Assistant Director of Nursing (ADON), reviewed Resident 41's OSR and CP. The ADON stated Resident 41 was on an enhanced barrier precaution due to the residents OPVD and the care plan indicated to clean the environment of the resident including the equipment and devices. The ADON stated the MDSC should have sanitized the call light button that was inside the trash before handing it to the resident to prevent the spread of infection, especially if the resident had an open wound. During a review of the facility's recent policy and procedure (P&P) titled, Infection and Prevention and Control, last reviewed on 10/23/2025, the P&P indicated the facility has an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 2. During a review of Resident 37's AR, the AR indicated the facility admitted the resident on 9/18/2025, and readmitted the resident on 10/5/2025, with diagnoses including cellulitis (a skin infection that causes swelling and redness) of the left and right lower limb, local infection of the skin and subcutaneous tissue (the deepest layer of the skin, located just beneath the dermis), and depression (a common, serious mood disorder characterized by persistent feelings of sadness, emptiness, or loss of interest in activities for at least two weeks). During a review of Resident 37's MDS dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition. The MDS indicated the resident was dependent to needing set-up assistance on mobility and activities of daily living (ADLs). During a concurrent observation and interview on 2/23/2026 at 10:09 a.m., with Certified Nursing Assistant (CNA) 4, inside Resident 37's room, observed Resident 37's Call light was resting on the floor at the right side of the bed. CNA 4 stated the call light should always be within the reach of the resident so they can call for help when needed. CNA 4 picked the call light from the floor and handed it to Resident 37 without wiping the call light button with an antiseptic wipe. CNA 4 stated she (CNA 4) should have wiped the call light button with an antiseptic wipe prior to handing it to the resident to prevent the spread of infection among staff and resident. During a concurrent interview and record review on 2/25/2026 at 3:30 p.m., with the ADON, reviewed Resident 37's Medical Diagnoses and MDS. The ADON stated the call light of Resident 37 should not be resting on the floor as it will be hard for the resident to reach them and will not be able to call for help when needed and it can be a source of infection to the resident since the floor is contaminated. The ADON also stated CNA 4 should have wiped the call light button with an antiseptic wipe prior to handing the call light button of the resident to prevent the spread of infection to the resident. During a review of the facility's recent P&P titled, Infection and Prevention and Control, last reviewed on 10/23/2025, the P&P indicated the facility has an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 3. During a review of Resident 4's admission Record, the admission Record indicated the facility originally admitted the resident on 8/26/2018 and readmitted in the facility on 2/9/2022 with diagnoses including gastrostomy (GT - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), dementia (a progressive state of decline in mental abilities), and generalized muscle weakness. (continued on next page)

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	055307	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Canyon Post Acute, LLC	1642 West Avenue J Lancaster, CA 93534

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 4's History and Physical (H&P) dated 11/19/2025, the H&P indicated Resident 4 did not have the capacity to understand and make decisions. During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) was sometimes able to understand others and make his needs known. The MDS further indicated Resident 4 was on GT feeding and totally dependent on staff with all ADLs. During a review of Resident 4's Order Summary Report dated 2/26/2026, the Order Summary Report indicated the following physician's orders: - 11/7/2024: GT: cleanse with normal saline (NS – a saltwater solution), pat dry, cover with split sponge dressing, secure with tape. - 11/17/2025: Enteral feed order: every shift Tube Feeding (TF) 1; set pump at 73 milliliters (ml – a unit of measurement) per hour for 20 hours to provide 1460 ml per 2190 kilocalories (Kcal – a unit of measurement). Start infusion at 2 p.m. and continue for 20 hours or until total volume is complete. - 12/23/2025: EBP due to GT and ulcer on the right third toe. During a review of Resident 4's care plan (CP) on EBP initiated on 5/1/2024, and last revised on 1/16/2026, the CP indicated health teaching to resident, family members and staff about importance of EBP including proper hand hygiene and wearing of personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) as one of the interventions to minimize risk and complications of infection. During a concurrent observation and interview on 2/23/2026 at 11:10 a.m. inside Resident 4's room with CNA 10, observed Resident 4 lying in bed, alert, and verbally responsive. Observed outside the room by the doorway a sign for EBP and a personal protective equipment (PPE- wearable gear and clothing designed to protect individuals from safety hazards, injuries, or infectious diseases) caddie (a portable storage). Observed CNA 10 used hand sanitizer prior to putting on gloves but did not put on a gown. CNA 10 stated she (CNA 10) will start providing ADL care to Resident 4. During a follow up observation and concurrent interview and review of EBP signage on 2/23/2026 at 11:35 a.m. outside Resident 4's room by the doorway, with CNA 10, observed CNA 10 only wearing gloves and stated she (CNA 10) just finished providing ADL care to Resident 4. CNA 10 stated there was a signage posted by Resident 4's doorway for EBP. CNA 10 stated the EBP signage indicated the staff have to observe proper hand hygiene and put on gloves and gown during high contact resident activities. CNA 10 stated she (CNA 10) did not observe the EBP by not putting on gown while providing care to Resident 4. CNA 10 stated Resident has a GT, and she (CNA 10) should have put on a gown while providing ADL care to Resident 4 as it placed Resident 4 at risk for acquiring infection and the infection can spread to other staff and residents. CNA 10 stated they get in-services and reminders regarding observing EBP during high contact activities, but she (CNA 10) forgot to put on gown before providing care to Resident 4. During an interview on 2/25/2026 at 9:37 a.m. outside Resident 4's room with the Assistant Director of Nursing (ADON), the ADON stated Resident 4 has a GT and there was a signage posted by the doorway for EBP to perform proper hand hygiene using hand sanitizer, then put on gown and gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The ADON stated that PPE caddies are inside the room by the doorway or a PPE cart outside the room by the doorway if there is no caddie inside the room. The ADON stated the staff are supposed to perform proper hand hygiene, put on gown and gloves prior to providing care to residents with wounds and indwelling medical devices (instruments placed inside the body either temporarily or permanently to assist with diagnostic, monitoring, or therapeutic functions) such as GT. The ADON stated that CNA 10 should have put on a gown while providing care to Resident 4 as it placed Resident 4 at risk of acquiring infection and the infection can potentially spread to other residents and staff. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precaution, last reviewed on 10/23/2025, the P&P indicated the facility established infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The P&P further indicated: - EBP are indicated for residents with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with and MDRO. - An indwelling medical device examples include central lines (a long flexible tube inserted into a vein in the neck, chest, arm or groin, up to the large vein near the heart for the patient to receive medications, fluids or additional blood), urinary catheters (a hollow tube inserted into the bladder to drain or collect urine), feeding tubes, and tracheostomies (a surgical opening in the neck into the trachea [also known as windpipe] to facilitate the passage of air and removal of secretions). - The staff will implement EBP for residents who are indicated when performing the following high contact resident care activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care (any skin opening requiring a dressing). - The facility alerts staff when EBP is necessary and for which residents require the use of EBP prior to staff providing high-contact care activities.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 keep the call light (an alerting device for nurses or other nursing personnel to assist a patient when in need) within reach of the residents for two of four sampled residents (Residents 41 and 37) reviewed under environment task. The deficient practice had the potential for residents unable to summon health care worker for help as needed. Findings: 1. During a review of Resident 41's admission Record (AR), the AR indicated the facility admitted the resident on 4/5/2021, and readmitted the resident on 7/2/2025, with diagnoses including muscle weakness, difficulty walking, and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 41's Minimum Data Set (MDS, a resident assessment tool), dated 1/19/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). The MDS indicated the resident was dependent to needing set-up assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 41's Fall Risk Evaluation (FRE), dated 1/2/2026, the FRE indicated the resident was at high risk for falls. During a review of Resident 41's Care Plan (CP) Report regarding the resident being at risk for fall related to gait (the specific pattern or manner in which a person or animal walks or runs)/balance problems, peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs) . muscle weakness, and history of falls, last revised on 11/3/2025, the CP indicated an intervention to keep the call light within reach and encourage the resident to use it for assistance as needed. During a concurrent observation and interview on 2/23/2026 at 9:26 a.m., with the Minimum Data Set Coordinator (MDSC), inside Resident 41's room, observed Resident 41's call light button dangling inside the trash can. The MDSC stated the call light button should not be dangling inside the trash can as it will make it hard for the resident to reach the call light button to call for help when needed. The MDSC stated the resident can also fall while reaching for the call light and sustain an injury. During a concurrent interview and record review on 2/25/2026 at 3:30 p.m., with the Assistant Director of Nursing (ADON), reviewed Resident 41's FRE and CP. The ADON stated the resident was at high risk for falls as indicated on the 1/2/2026 FRE. The ADON stated the call light of Resident 41 should not be dangling on the trash can as it will be hard for the resident to reach them and will not be able to call for help when needed. The ADON also stated the resident can slide down from the bed while reaching for the call light in the trash can and fall sustaining an injury. The ADON stated it is everyone's responsibility in the facility to keep the call light within the reach of the resident. During a review of the facility's recent policy and procedure (P&P) titled, Resident Call System, last reviewed on 10/23/2025, the P&P indicated the facility is adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from the resident's bedside, floor, or toileting facilities. Procedure: 8. Resident call system shall be accessible to residents while in their bed or other sleeping accommodations within the resident's room. 11. The Environmental Services Department completes routine audits and maintenance to ensure all portions of the system are functioning, including but not limited to . 2. During a review of Resident 37's AR, the AR indicated the facility admitted the resident on 9/18/2025, and readmitted the resident on 10/5/2025, with diagnoses including muscle weakness, difficulty in walking, and depression (a serious, long-lasting mental health condition-not just a temporary sad mood-characterized by persistent sadness, hopelessness, and a loss of interest in daily life for at least two weeks). During a review of Resident 37's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition. The MDS indicated the resident was dependent to needing (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	set-up assistance on mobility and ADLs. During a review of Resident 37's FRE, dated 1/2/2026, the FRE indicated the resident was not at risk for falls. During a review of Resident 37's CP Report regarding the resident being at risk for falls related to limited mobility. muscle weakness, last revised on 9/26/2025, the CP indicated an intervention to anticipate and meet the resident's needs and call light is within reach and encourage the resident to use it for assistance as needed. During a concurrent observation and interview on 2/23/2026, at 10:09 a.m. with Certified Nursing Assistant (CNA) 4, inside Resident 37's room, observed Resident 37's call light was resting on the floor at the right side of the bed. CNA 4 stated the call light should always be within the reach of the resident so they can call for help when needed. CNA 4 stated their failure to keep the call light within reach will prevent the resident from asking for help when needed and can fall. During a concurrent interview and record review on 2/25/2026 at 3:30 p.m., with the ADON, reviewed Resident 37's FRE and CP. The ADON stated the resident was not high risk for falls as indicated on the 1/2/2026 FRE. The licensed staff placed the resident on fall risk per nursing judgement. The ADON stated the call light of Resident 37 should not be resting on the floor as it will be hard for the resident to reach them and will not be able to call for help when needed. The ADON also stated the resident can slide down from the bed while reaching for the call light in the trash can and fall sustaining an injury. The ADON stated it is everyone's responsibility in the facility to keep the call light within the reach of the resident. During a review of the facility's recent P&P titled, Resident Call System, last reviewed on 10/23/2025, the P&P indicated the facility is adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from the resident's bedside, floor, or toileting facilities. Procedure: 8. Resident call system shall be accessible to residents while in their bed or other sleeping accommodations within the resident's room. 11. The Environmental Services Department completes routine audits and maintenance to ensure all portions of the system are functioning, including but not limited to .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents rights to request, refuse, and / or discontinue treatment for one of two sampled residents (Resident 2) reviewed under the Advance Directives (AD - a legal document that outlines an individual's wishes regarding medical care in the event they become incapacitated and unable to communicate their preferences) care area by failing to ensure medical records were updated with a current copy of the resident's Durable Power of Attorney (DPOA or POA, a type of AD). This deficient practice had the potential to violate the resident's right to have their wishes honored regarding health care decisions. Findings: During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted the resident on [DATE] with diagnoses that included metabolic encephalopathy (an alteration in consciousness due to brain dysfunction), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), major depressive disorder (persistent feelings of sadness and loss of interest that can interfere with daily living), epilepsy (chronic disorder that causes recurrent seizures [abnormal electrical activity in the brain]), and diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). The AR further indicated Friend 1 was Resident 2's POA. During a review of Resident 2's Minimum Data Set (MDS - resident assessment tool), dated [DATE], the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated that the resident required partial / moderate assistance from staff for toileting, bathing, dressing, personal and oral hygiene and mobility. During a review of Resident 2's History and Physical (H&P), dated [DATE], the H&P indicated the resident had the capacity to make decisions. During a review of Resident 2's Care Plan (CP) titled, Resident / responsible party (RP) / surrogate decision maker has chosen full code status (a medical directive indicating that in the event of cardiac or respiratory arrest, healthcare teams will use all available measures to revive the resident), full treatment, initiated [DATE], the CP indicated a goal to honor and remain full code unless rescinded by resident / RP / surrogate decision maker. The CP indicated an intervention that included to review code status / advance care directives per resident / RP request and as needed. During a review of Resident 2's Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life), dated [DATE] and signed by Resident 2, the POLST indicated the resident did not have an AD. During a review of Resident 2's Psychosocial Assessment / Social History / Discharge Planning (PASHDP) form, dated [DATE], the PASHDP form indicated Resident 2 had completed an AD. The PASHDP indicated the type of AD completed was a POA. During a concurrent interview and record review on [DATE] at 8:55 a.m., with Registered Nurse (RN) 1, Resident 2's AR was review and RN 1 stated the AR indicated the resident had a POA. RN 1 stated Resident 2's electronic health record (EHR) did not have any documented evidence of Resident 2's POA documentation. RN 1 stated the Social Services (SS) department keeps the residents' POA documentation. During a concurrent interview and record review on [DATE] at 8:57 a.m., with the Social Services Coordinator (SSC), Resident 2's EHR was review and the SSC stated when a resident indicates that they have a POA, the POA documentation should be uploaded into the EHR. The SSC stated Friend 1 had not provided Resident 2's POA documents, so the POA was not in the EHR. The SSC stated there was no documented evidence that the facility had followed up or requested to obtain Resident 2's POA document, but there should be. The SSC stated when a POA document is not followed up on and provided, there is no way to verify that a resident actually has a POA or what the exact role of the POA would be if the resident was not able to make their wishes known. During an interview on [DATE] at 9:08 a.m. with Friend 1, Friend 1 stated he was Resident 2's POA. Friend 1 stated the POA documents were already provided to the facility, and the (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility should have them. Friend 1 stated he (Friend 1) was never contacted by the facility to provide another copy of the POA documents. During a concurrent interview and record review on [DATE] at 11:39 a.m. with the Assistant Director of Nursing (ADON), facility's policy and procedure (P&P) regarding AD was reviewed. The ADON stated the POA document is a type of AD that communicates a resident's wishes when they are no longer able to do so. The ADON stated the SS department follows up to ensure a copy of the resident's POA is obtained and placed in the resident's chart. The ADON stated there are different kinds of POAs and it is important that the facility is aware of the POA responsibilities to ensure the POA is appropriately included in the resident's plan of care. The ADON stated that when Resident 2's POA was not followed up on and placed in the resident's EHR, there was a potential that staff would not follow the resident's desires with the POA. The ADON stated the facility P&P was not followed. During a review of the facility P&P titled, Advance Directives, last reviewed [DATE], the P&P indicated, POLICY STATEMENT.Residents have the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. DEFINITIONS.Advance Care Planning: A process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals cannot make their own healthcare decisions.Advance Directive: A written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. Health Care Decision-Making Capacity: Possessing the ability (as defined by State law) to make decisions regarding health care and related treatment choice. GUIDELINES. 3. The facility honors residents' choices for care and does not treat the resident against his or her wishes. 4. If a resident is unable to make a health care decision, a decision by the resident's legal representative to forgo treatment may, subject to State requirements, be equally binding on the facility. 13. The ability of a dying person to control decisions about medical care and daily routines has been identified as one of the key elements of quality care at the end of life. 17. Advance care planning is an integral aspect of the facility's comprehensive care planning process and assures re-evaluation of the resident's desires on a routine basis and when there is a significant change in the resident's condition. 18. The medical record has documentation indicating whether the resident has an advance directive.19. The facility will request a copy of the resident's advance directive, if applicable, at the time when the resident states they have formulated an advance directive and periodically during care conferences when the resident or their representative have not provided a copy to the facility for inclusion in the medical record. 20. The facility is required to establish, maintain, and implement written policies and procedures regarding the residents' right to formulate an advance directive, refuse medical or surgical treatment. 21. In addition, the facility management is responsible for ensuring that staff follow those policies and procedures.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document a significant change of condition (COC, isˆthe formal written record of any significant, non-temporary change in a resident's physical, mental, or emotional healthˆ[e.g., sudden confusion, falls, weight loss]) on a resident's physical condition that had deteriorated for one of one sampled resident (Resident 5) by failing to inform the resident's representative/family member when the resident fell at the facility on 10/31/2025.ˆ This deficient practice had violated the resident's responsible party's right to be informed of the resident's accident and the facility's intervention to mitigate the situation. Findings: During a review of Resident 5's admission Record (AR), the AR indicated the facility admitted the resident on 2/2/2024, and readmitted the resident on 11/11/2025, with diagnoses including metabolic encephalopathy (a broad term for temporary or permanent brain dysfunction caused by chemical imbalances in the body, rather than direct physical injury), cerebral infarction (also calledˆischemic stroke, a cerebral infarction occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 5's History and Physical (H&P), dated 11/12/2025, the H&P indicated the resident was transferred to general acute care hospital (GACH) for worsening confusion and fall. The H&P also indicated the resident had the capacity to make decisions. During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 11/18/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (a noticeable decline in memory, thinking, or language skills that is greater than normal aging, yet not severe enough to interfere with daily independence). The MDS indicated the resident was dependent to needing supervision assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 5's Fall Risk Evaluation (FRE), dated 9/24/2025, the FRE indicated the resident was at high risk for falls. During a review of Resident 5's Change of Condition (COC) form, dated 10/3/2025, the COC indicated Resident 5 had a witnessed fall at around 8 p.m. Certified Nursing Assistant (CNA) 5 lowered down Resident 5 while sliding off from the bed. Registered Nurse (RN) assessed the resident and found sitting on the floor, denied any pain. RN stated the resident's range of motion (ROM, the full distance and direction a joint (like the knee, shoulder, or elbow) can move, measured in degrees or by its ability to bend and straighten) was within normal limits, vital signs (reflect essential body functions, including your heartbeat rate, breathing rate, temperature, and blood pressure) was baseline, and no injuries noted, and the resident denied any pain. RN and CNA 5 assisted the resident to bed and notified PMD and will continue to monitor the resident. The COC form indicated that the Family/Health Care Agent Notified Name was recorded as Self-monitoring. During a review of Resident 5's Care Plan (CP) Report titled, Initial goal based on admission, last revised on 1/29/2026, the CP indicated an intervention of interdisciplinary team (IDT, the group of professionals from different specialties who come together to plan, coordinate, and review the care of a resident) to continue to identify resident goals and support and IDT, Resident Representative and physician involvement to support initial goals. During an interview on 2/23/2026 at 12:40 p.m., with Resident Representative (RR) 1, on the phone, RR 1 stated she (RP 1) was upset because she (RP 1) was not notified when Resident 5 fell in the facility on 10/31/2025 at around 8 p.m. RP 1 stated after Resident 5`s fall, the resident was transferred to a GACH for altered mentation suspecting urinary tract infection (UTI, an infection in the bladder/urinary tract) on 11/1/2025, and they later found out that the resident had a broken hip in the hospital. During an interview on 2/24/2026, at 11:42 a.m. with CNA 5, on the phone, CNA 5 stated she (CNA 5) was the CNA assisting Resident 5 when she (Resident 5) fell on [DATE] at around 8 p.m. CNA 5 stated she (CNA 5) was trying to scoot the resident up in (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Canyon Post Acute, LLC	1642 West Avenue J Lancaster, CA 93534

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed by herself and the resident stood up and tried to scoot herself up. CNA 5 stated Resident 5 cannot bear her weight and started to descend on the floor; the bed was close to the resident and the resident slid on the bed with her trying to lessen the impact of the fall. CNA 5 stated she (CNA 5) was holding Resident 5`s arm while she (CNA 5) tried to lower the resident to the floor. CNA 5 stated the resident did not complaint of any pain after the fall and she (CNA 5) informed RN 2 regarding the resident's fall. CNA 5 cannot remember if the resident representative was informed of the resident's fall. During an interview on 10/26/2025 at 10:52 a.m., with RN 2, RN 2 stated she (RN 2) was the RN supervisor that night (10/31/2025) at around 8 p.m. RN 2 stated she (RN 2) got a report from CNA 5 that Resident 5 fell while being assisted by CNA 5 in bed. RN 2 stated she (RN 2) immediately went to the resident`s room and assessed the resident. RN 2 stated the resident did not complain of pain or tenderness in any part of the body and had no indication of the resident having a fracture (break in bone) of limbs. RN 2 stated she (RN 2) cannot remember calling the family member about the fall and she (RN 2) knew the RR 1 is very involved in the care of the resident. RN 2 stated she (RN 2) should have informed RR 1 of the resident's accidents as it is their policy to inform family members or resident reps when they have accidents in the facility. RN 2 stated their failure to report the incident to RR 1 resulted in the family getting upset and worried about the resident. During a review of the facility's recent policy and procedure (P&P) titled, Notification of Changes, last reviewed on 10/23/2025, the P&P indicated the facility informs the resident, the resident's physician, and the resident's representative when there is an accident resulting in injury, changes involving life threatening conditions, adverse treatment consequences or transfer or discharge the resident. Guidelines: 1. The facility shall immediately or as soon as practicable inform the resident, consult with the resident's physician, and notify, consistent with his or her authority, the resident representative(s) when there is: b. A significant change in the resident's physical, mental, or psychosocial status.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's drug regimen was free from unnecessary drugs (any medication in excessive dose, excessive duration, without adequate indication for its use and monitoring) use of psychotherapeutic drug (any medication capable of affecting the mind, emotions, and behavior) in accordance with facility policy and procedures for one (1) of five (5) sampled resident (Resident 12) reviewed for unnecessary medications by failing to ensure there was a physician's order for the behavior manifestations monitoring, adverse side effects (unwanted or dangerous medication-related side effects) monitoring, and non-pharmacological approach attempted for the use of clonazepam (also known as Klonopin, a medication used to treat panic attacks and control seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] by slowing down the overexcited brain). This deficient practice had the potential for Resident 12 to experience the adverse effects related to psychotropic medication (medications that affect brain activities associated with mental processes and behavior) therapy such as drowsiness, dizziness, constipation, or increased risk of fall, possibly leading to impairment or decline in their mental or physical condition or functional or psychosocial status. Findings: During a review of Resident 12's admission Record, the admission Record indicated the facility admitted Resident 12 on 10/15/2025, with diagnoses including cerebral infarction (also known as stroke, loss of blood flow to a part of the brain), epilepsy (a long-term condition that causes repeated seizures [burst of uncontrolled electrical activity within brain cells] due to abnormal electrical signals produced by damaged brain cells), and generalized muscle weakness. During a review of Resident 12's History and Physical (H&P) dated 10/29/2025, the H&P indicated Resident 12 had the capacity to make decisions. During a review of Resident 12's Minimum Data Set (MDS, a resident assessment tool) dated 1/30/2026, the MDS assessment indicated Resident 12 was able to understand others and make his needs known and had an intact cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 12 required setup or clean-up assistance with eating and oral hygiene; supervision or touching assistance with rolling to left and right; partial/moderate assistance with toileting, personal hygiene, upper body dressing, and sit to lying; substantial/maximal assistance with lower body dressing and lying to sitting; and total assistance from staff with all other activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS further indicated that Resident 12 received antianxiety medication (A drug used to treat symptoms of anxiety, such as feelings of fear, uneasiness, and muscle tightness, that may occur as a reaction to stress). During a review of Resident 12's Order Summary Report dated 2/26/2026, the Order Summary Report indicated a physician's order dated 1/12/2026 for clonazepam oral tablet one milligram (mg - a unit of measurement) give one tablet by mouth three (3) times a day for anxiety manifested by restlessness. The Order Summary Report did not physician's order to monitor episodes of anxiety manifested by restlessness, monitor for adverse side effects, and non-pharmacological interventions attempted every shift for the use of clonazepam. During a review of Resident 12's informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered), the informed consent indicated Resident 12's responsible party gave a consent via telephone call for the resident to receive clonazepam for anxiety manifested by restlessness. During a review of Resident 12's care plan (CP) on use of clonazepam for behaviors of restlessness initiated on 1/31/2025 and last revised on 2/4/2026, the CP indicated to give anti-anxiety medication as ordered. The care plan interventions were to review the medication use for gradual dose reduction (the systematic, stepwise tapering of a medication's dosage to determine if the patient's symptoms can be managed on a lower dose or if the (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	drug can be discontinued entirely) , monitor and document side effects and effectiveness, and use [NAME]-pharmacological approaches. The CP indicated that Resident 12 will not experience any side effects from the medication use. During a concurrent interview and record review on 2/26/2026 at 8:41 a.m., Resident 12's physician's order, informed consents, summary of episodes of anxiety, and care plans were reviewed with the Assistant Director of Nursing (ADON). The ADON stated Resident 12 had a physician's order for the use clonazepam dated 1/12/2026 and had a CP in place for the use of the medication for anxiety manifested by restlessness. The ADON there was no physician's order to monitor Resident 12 for behavior manifestations of anxiety manifested by restlessness. The ADON stated there was no physician's order to monitor the adverse side effects for the use of clonazepam, and there was no physician's order for non-pharmacological interventions/approaches implemented during every shift. The ADON stated that when a psychotropic medication is ordered for a resident, there should be a physician's order to monitor the behavior manifestation, adverse side effects, and non-pharmacological approaches every shift. The ADON stated there should have been a physician's order for the monitoring for episodes of restlessness every shift, monitoring for adverse side effects every shift, and non-pharmacological approaches attempted every shift for Resident 12's use of clonazepam so the physician, pharmacist, and the interdisciplinary team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the patients) would be able to know if the medication use was effective, if Resident 12 was tolerating the use of clonazepam without any adverse side effects, and if the non-pharmacological approaches were effective to address Resident 12's behavior of restlessness. The ADON stated if there was no monitoring in place, Resident 12 could have developed adverse side effects or the medication not being effective that the nurses were not aware of which could result in a delay in notification of the physician and cause delay in providing the care Resident 12 needed. During a review of the facility's policy and procedure (P&P) titled, Unnecessary Drugs, last reviewed on 10/23/2025, the P&P indicated that each resident's drug regimen shall be free from unnecessary drugs. The P&P further indicated the facility ensures that each resident ?s entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental. Physical, and psychosocial well-being. - Unnecessary drugs include but may not be limited to medications used: a. In excessive dose (including duplicate therapy); or b. For excessive duration; or c. Without adequate monitoring; or d. Without adequate indication for its use; or e. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or f. Any combinations of aforementioned reasons. - Monitoring and Adverse Consequences: 1. The facility is responsible for the resident's medication management including but not limited to: a. Recognition or identification of the problem/need. b. Assessment, c. Diagnosis/cause identification, d. Management/treatment, e. Monitoring, and f. Revising interventions. 2. The IDT are responsible for documenting medication management steps including monitoring and documenting the resident's response to any treatment such as lab results, vital signs, progress notes, behavior flow sheets, medication administration records, and the consultant pharmacist's drug regimen review. During a review of the facility's P&P titled, Nursing Service - Restraints, last reviewed on 10/23/2025, the P&P indicated that restraints shall only be used when permitted by law, under physician's order, and never for punishment, staff convenience, or as a substitute for care. - Definitions: - Chemical Restraint: a drug used to control behavior or restrict freedom of movement, not a standard treatment for a patient's condition. - Use of chemical restraints: 1. The specific behavior or manifestation for which the drug is given must be documented on the health record. 2. The care plan must define the data to be collected to evaluate the effectiveness of the drug and adverse reactions.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to follow its policy and procedure regarding transfers and discharge by failing to ensure that necessary medical information was communicated to the receiving hospital for one (1) of one (1) sampled resident (Resident 90) reviewed for hospitalization. This deficient practice placed Resident 90 at risk for a delay in the continuity of care and receiving the services and treatment the resident needed. Findings: During a review of Resident 90's admission Record, the admission Record indicated the facility admitted the resident on 1/14/2026, with diagnoses including sepsis (a life-threatening blood infection), acute respiratory failure (a condition that occurs when the lungs cannot release oxygen into the blood resulting to shortness of breath, confusion, drowsiness, and bluish discoloration of the lips, skin, or extremities), and congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 90's Minimum Data Set (MDS, a resident assessment tool), dated 1/30/2026, the MDS indicated Resident 90 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) was unable to understand others and make his needs known. The MDS further indicated Resident 90 was totally dependent on staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 90's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Change of Condition (COC) form dated 1/21/2026, the SBAR COC form indicated that Resident 90 had abnormal laboratory result for blood urea nitrogen (BUN - a blood test that measures how much urea [a waste product of protein breakdown] and determines how well the kidneys are working; normal level is 7 to 30 milligrams per deciliter [mg/dl - a unit of measurement]) of 202 mg/dl. The SBAR COC further indicated that the physician was notified with an order to transfer Resident 90 to the emergency room via non-emergent transportation. The SBAR COC form indicated that the responsible party was made aware on 1/21/2026 at 10 p.m. During a review of Resident 90's Health Status Notes dated 1/21/2026 at 11:39 p.m., 1/22/2026 at 4:48 a.m., and 1/22/2026 at 11:42 a.m., the Health Status Notes indicated: - 1/21/2026 at 11:39 p.m.: Nurse Practitioner (NP) ordered to transfer Resident 90 via non-emergency transportation to the hospital due to elevated BUN and that the medical transportation company will pick up Resident 90 at 3 a.m. The health status notes further indicated that handoff report was given to oncoming shift. - 1/22/2026 4:48 a.m.: Resident 90 left the facility via gurney at 4:35 a.m. for evaluation of abnormal lab oratory results, elevated BUN and left a message for the responsible party. - 1/22/2026 11:42 a.m. Resident 90 was sent to emergency room and left the facility at 4:35 a.m. Responsible party was made aware. During a concurrent interview and record review on 2/25/2026 at 7:01 a.m., Resident 90's SBAR COC form dated 1/21/2026, and Health status Notes dated 1/21/2026 at 11:39 p.m., 1/22/2026 at 4:48 a.m., and 1/22/2026 at 11:42 a.m. were reviewed with the Assistant Director of Nursing (ADON). The ADON stated that Resident 90's SBAR COC dated 1/21/2026 at 11:39 p.m. indicated that the NP was made aware of Resident 90's abnormal BUN with an order to send the resident to the hospital via non-emergency transportation. The ADON stated that Resident 90's Health Status Notes indicated that the resident left the facility at 4:35 a.m. on 1/22/2026. However, there was no documentation that the facility nurse provided the hospital with the necessary medical information upon transferring Resident 90. The ADON stated that the facility practice when transferring residents to the hospital via non-emergent transportation is that the resident will be sent out with the admission Record and the current physician's orders. The ADON stated then licensed staff will give a telephone report to the receiving hospital and document in the electronic health record under the Health Status Notes. The ADON stated the licensed nurse who transferred Resident 90 should have called the hospital to provide the necessary medical information when Resident 90 was transferred and documented in the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Health Status Notes. The ADON stated the importance of giving the proper handoff report to the receiving facility or hospital is for the members of the healthcare team taking care of Resident 90 would be aware of what was going on with the resident for continuity of care and if it was not done, it placed Resident 90 at risk for a delay in receiving the care and services the resident needed in the hospital. During a review of the facility's policy and procedure (P&P) titled, Transfers and Discharge, last reviewed on 10/23/2025, the P&P indicated that the facility transfers or discharges residents in a safe manner. The P&P further indicated that the facility documents the resident's transfer or discharge in the medical record and communicates appropriate information to the receiving healthcare institution or provider when a resident is transferred from the facility.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, the facility failed to ensure the PASRR was completed accurately for one of four sampled residents (Resident 10) reviewed under Preadmission Screening and Resident Review (PASARR - a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) when Resident 10 was admitted with a serious mental illness and was taking a psychotropic medication (medication that alters brain chemistry to manage mental health conditions by affecting mood, thoughts, behavior, or perception). This deficient practice had the potential to result in inappropriate placement and unidentified specialized services for Resident 10. Findings: During a review of Resident 10's admission Record (AR), the AR indicated that the facility admitted the resident on 2/11/2025 with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a condition characterized by persistent and excessive worries that interfere with daily activities), post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event). During a review of Resident 10's History and Physical (H&P), dated 2/15/2025, the H&P indicated the resident has the capacity to make decisions. During a review of Resident 10's Minimum Data Set (MDS - a resident assessment tool), dated 2/18/2025, the MDS indicated that the resident was cognitively intact (a person's thinking, learning, and memory abilities are functioning normally and are not impaired). The MDS indicated the resident with active diagnoses including anxiety disorder, depression, and PTSD. The MDS indicated the resident was taking an antidepressant medication since admission to the facility. During a review of Resident 10's Order Summary Report (OSR), dated 2/11/2025, the OSR indicated escitalopram oxalate (medication used to treat major depressive disorder) tablet 10 milligrams (mg - a unit of measurement), Give one tablet by mouth one time a day for depression manifested by persistent feeling of worthlessness. During a review of Resident 10's PASARR Level I Screening, dated 2/13/2025, the PASARR indicated that the resident does not have a diagnosed serious mental illness and has not been prescribed psychotropic medications for serious mental illness. During a concurrent interview and record review on 2/26/2026 at 10:22 a.m. with Licensed Vocational Nurse (LVN) 4, Resident 10's PASARR Level I Screening, admitting diagnoses, and physician orders were reviewed. LVN 4 stated the resident had admitting diagnoses including anxiety disorder, major depressive disorder, and PTSD and was taking escitalopram. LVN 4 stated the PASARR Level I Screening was not completed accurately. LVN 4 stated there was no correction or second PASARR Level I Screening submitted after 2/13/2025. During an interview on 2/26/2026 at 1:40 p.m. with the Assistant Director of Nursing (ADON), the ADON stated she was made aware about Resident 10's PASARR not being completed accurately. The ADON stated it should be accurately completed to ensure the outcome is correct and the resident is evaluated and receives specialized services if required. The ADON stated that when the PASARR is not completed accurately the resident could experience delay in care and treatment. During a review of the facility's policy and procedure (P&P) titled, Preadmission Screening and Resident Review (PASRR), dated 10/23/2025, the P&P indicated that the PASRR requires that: 1. All applicants to a Medicaid-certified nursing facility are evaluated for a serious mental disorder and/or intellectual disability. 2. Are offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting); . Guidelines 1. The PASARR process requires that all applicants to Medicaid-certified nursing facilities be screened for possible serious mental disorders. 2. The initial screening is referred to as Level I identification of individuals with Mental Disorder (MD) or Intellectual Disability (ID) and is completed prior to admission to a nursing facility. 3. The purpose of the Level I pre-admission screening is to identify individuals who may have or may have MD/ID or a related condition, who would then require PASARR Level II evaluation and determination prior to admission to the facility. 6. Failure to pre-screen residents prior to admission to the facility may (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	result in failure to identify residents who have or may have MD, ID, or a related condition. 7. At the time of admission, the facility will review the admission documentation to identify the presence of the PASARR Level I and Level II recommendations as applicable.

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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 observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan (is a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for one of 21 sampled residents (Resident 5) reviewed for accidents by failing to develop and implement a care plan when the resident fell on [DATE].ˆ This deficient practice had the potential to result in a delay of nursing care and medical interventions for the residents. Findings: During a review of Resident 5's admission Record (AR), the AR indicated the facility admitted the resident on 2/2/2024, and readmitted the resident on 11/11/2025, with diagnoses including metabolic encephalopathy (a broad term for temporary or permanent brain dysfunction caused by chemical imbalances in the body, rather than direct physical injury), cerebral infarction (also calledˆischemic stroke, a cerebral infarction occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 5's History and Physical (H&P), dated 11/12/2025, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 5's Minimum Data Set (MDs, a resident assessment tool), dated 11/18/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had moderately impaired cognition (a stage of thinking decline that is more severe than mild memory loss but not yet full-blown dementia). The MDS indicated the resident was dependent to needing supervision assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 5's Fall Risk Evaluation (FRE), dated 9/24/2025, the FRE indicated the resident was at high risk for falls. During a review of Resident 5's Change of Condition (COC), dated 10/3/10225, the COC indicated Resident 5 had a witnessed fall at around 8 p.m. Certified Nursing Assistant (CNA) 5 lowered down Resident 5 while sliding off from the bed. Registered Nurse (RN) 2 assessed the resident and found sitting on the floor, denied any pain. RN stated the resident's range of motion (ROM, the full distance and direction a joint (like a knee or shoulder) can move, often measured in degrees) was within normal limits, vital signs (reflect essential body functions, including your heartbeat rate, breathing rate, temperature, and blood pressure) was baseline, and no injuries noted, and the resident denied any pain. RN 2 and CNA 5 assisted the resident to bed and notified Primary Medical Doctor (PMD) and will continue to monitor the resident. The COC form indicated that the Family/Health Care Agent Notified Name was recorded as Self-monitoring. During a concurrent interview and record review on 2/25/2026 at 3:30 p.m., with the Assistant Director of Nursing (ADON), reviewed Resident 5's Medical Disgnosis, COC, and CP. The ADON stated the COC indicated the resident had an accident on 10/31/2025, and she (ADON) was not able to see an actual care plan for the resident`s fall. The ADON stated the licensed staff should have developed and implemented a care plan on the resident's actual fall on 10/31/2025, to ensure the resident got all the care needed and prevent delays of care. During a review of the facility's recent policy and procedure (P&P) titled, Develop-Implement Comprehensive Care Plans, last reviewed on 10/23/2025, the P&P indicated the facility develops a person-centered comprehensive care plan that is culturally competent and trauma-informed, developed and implemented to meet each resident's preferences and goals; and address the resident's medical, physical, mental, and psychosocial needs.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary services to maintain good grooming and personal hygiene for two of two sampled residents (Resident 13 and 19) by failing to: 1. Ensure Resident 13's nails were trimmed per family requests and plan of care. 2. Ensure Resident 19's right hand fingernails were cleaned as dirt and dead skin had accumulated under the free edge of the nails from the resident scratching himself. These deficient practices had the potential to result in resident infections caused by abrasions from long fingernails and uncleaned free edge fingernails. Findings: a. During a review of Resident 13's admission Record (AR), the AR indicated the facility admitted the resident on 3/24/2015, with diagnoses including vascular dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), major depressive disorder (persistent feelings of sadness and loss of interest that can interfere with daily living), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 13's Minimum Data Set (MDS – resident assessment tool) dated 1/29/2026, the MDS indicated the resident was rarely / never able to understand others or to make herself understood. The MDS further indicated that the resident was completely dependent on staff for eating, toileting, bathing, dressing, personal and oral hygiene and mobility. During a review of Resident 13's Care Plan (CP) titled, (Resident 13) has impaired cognitive function/dementia or impaired thought processes related to Alzheimer's, dementia, initiated 6/29/2021 and last reviewed 1/30/2026, the CP indicated interventions that included to communicate with the family regarding the resident's needs. During a review of Resident 13's CP titled, (Resident 13) has an activity of daily living (ADL) self-care performance deficit related to Alzheimer's dementia, limited range of motion, ., initiated 4/8/2021, and last reviewed 1/30/2026, the CP indicated interventions to be provided by Certified Nursing Assistants (CNA) and licensed nurses (LN) that included to check nail length and trim and clean on bath day and as necessary. During a concurrent observation and interview on 2/23/2026 at 11:45 a.m., with the Assistant Director of Staff Development (ADSD) and CNA 2, observed the ADSD at Resident 13's bedside holding fingernail clippers and trimming the resident's fingernails. Resident 13 did not verbally respond. Observed Resident 13's left hand with two trimmed nails and three remaining. Observed the untrimmed nails were white colored, overgrown to approximately one inch in length past the tip of the finger and curling inward. The ADSD stated she (ADSD) was making rounds and noticed the resident's fingernails were long. The ADSD stated she (ADSD) had never seen a resident's fingernails grown out that long. The ADSD stated the LN or CNA is responsible to trim a resident's fingernails and Resident 13's nails were not trimmed. CNA 2 entered the room and stated that she (CNA 2) had not cared for Resident 13 in over a week and did not notice the Resident's fingernails were long. During an interview on 2/23/2026 at 4:19 p.m., with Family Member (FM) 1, FM 1 stated Resident 13's fingernail length is an ongoing issue that (FM 1) discusses with the facility staff every time he (FM1) speaks with them. FM 1 stated he (FM1) would like the nail issue addressed. FM 1 stated Resident 13's nails are long and her hands are atrophied (weakened due to disease or lack of use) and the nails press into the palm of the resident's hands. (continued on next page)

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Desert Canyon Post Acute, LLC	1642 West Avenue J Lancaster, CA 93534

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/25/2026 at 7:39 a.m. with CNA 1, CNA 1 stated she (CNA 1) was caring for Resident 13. CNA 1 stated she (CNA 1) has never cut Resident 13's fingernails because the resident has diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and CNAs do not cut the nails of residents with DM. CNA 1 stated a couple of weeks prior, CNA 1 reported to the LN that the resident's fingernails were very long. CNA 1 stated CNA 1 could not remember which LN she (CNA 1) reported to. CNA 1 stated Resident 13's nails should not have been so long because it was dangerous and the resident could scratch herself. CNA 1 stated resident fingernails should be kept trimmed and the LN did not follow up. During an interview on 2/25/2026 at 7:57 a.m. with the Director of Staff Development (DSD), the DSD stated Resident 13 did not have DM and the CNAs are responsible for cutting Resident 13's fingernails. The DSD stated Resident 13's fingernails did not grow over night, and the CNAs should have been trimming her fingernails and they were not. The DSD stated when Resident 13's nails were not clipped there was the potential that the resident could cut herself. The DSD stated a cut in Resident 13 could result in an infection in the resident. During an interview and record review on 2/26/2026 at 9:08 a.m. with the Assistant Director of Nursing (ADON), the ADON reviewed the facility policy and procedure (P&P) regarding ADLs. The ADON stated the facility is responsible for cutting resident fingernails and Resident 13's nails should not have been kept long unless the family wanted them that way. The ADON stated long nails can potentially cause a skin issue resulting in infection in Resident 13. The ADON stated the facility P&P was not followed. During a review of the facility P&P titled, Activities of Daily Living Maintain Abilities, last reviewed 10/23/2025, the P&P indicated, POLICY STATEMENT. The facility provides each resident with care and services to maintain activities of daily living. INTENT. To ensure facility staff provide necessary care and services, based on the resident's comprehensive assessment, to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. GUIDELINES. 1. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility provides care and services needed to assist the resident' to maintain or improve his or her ability to carry out activities of daily living, including: a. Hygiene -bathing, dressing, grooming, and oral care. b. During a review of Resident 19's admission Record (AR), the AR indicated that the facility originally admitted the resident on 10/22/2020, and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), anemia (a condition where the body does not have enough healthy red blood cells), and hypertension (HTN-high blood pressure). During a review of Resident 19's MDS dated [DATE], the MDS indicated the resident had clear speech, able make self-understood and had the ability to understand others. The MDS indicated the resident was dependent on staff with toileting hygiene and personal hygiene and with mobility including sit to lying, lying to sitting, chair/bed-to-chair transfer and tub/shower transfers. During a review of Resident 19's Care Plan titled, ADL: [Resident 19] requires assistance in. personal hygiene, revised 12/19/2025, the CP indicated the resident with goals of increased ADL participation and minimizing functional decline which included interventions assist with maintaining good personal hygiene every shift and as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/23/2026 at 10 a.m., inside Resident 19's room, Resident 19 was observed lying in bed awake. The free edges of the right –hand fingernails were noted to have accumulated dirt that was black in color. During a concurrent observation and interview on 2/24/2026 at 8:49 a.m. with CNA 13, inside Resident 19's room, CNA 13 delivered Resident 19's breakfast meal tray. Resident 19 was about to eat breakfast. CNA 13 stated underneath the resident's fingernails, along the free edges, there was dirt that was black in color. CNA 13 stated the dirt is from the resident scratching himself and when he (Resident 19) wheels himself on a wheelchair he (Resident 19) uses his right hand. CNA 13 stated the resident's left hand is contracted (when your muscles, tendons, joints, or other tissues tighten or shorten causing a deformity) and the resident is not able to move it. CNA 13 stated she will clean the resident's hands now before he eats. During an interview on 2/26/2026 at 1:30 p.m. with the ADON, the ADON stated residents are provided with nail care per resident request. The ADON stated the CNAs should check the resident's fingernails before the resident eats and offer to clean it. The ADON stated when the resident's fingernails are not clean the resident could use his dirty hands and eat it. The ADON stated the resident could have an infection and experience abdominal pain, nausea, vomiting, and diarrhea from eating with unclean hands. During a review of the facility's P&P titled, Activities of Daily Living Maintain Abilities, last reviewed 10/23/2025, the P&P indicated, POLICY STATEMENT. The facility provides each resident with care and services to maintain activities of daily living. INTENT. To ensure facility staff provide necessary care and services, based on the resident's comprehensive assessment, to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. GUIDELINES. 1. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility provides care and services needed to assist the resident' to maintain or improve his or her ability to carry out activities of daily living, including: a. Hygiene -bathing, dressing, grooming, and oral care.

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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 residents who were incontinent of bladder received services and assistance for one (1) of one (1) sampled resident (Resident 40) reviewed for urinary tract infection (UTI- an infection in the bladder/urinary tract) by: 1. Failing to ensure Resident 40's urinal bottle (portable container for collecting urine) was labeled with the name of the resident and the date it was last changed. 2. Failing to ensure Resident 40's urinal bottle was changed per facility practice. These deficient practices had the potential for the resident to experience cross-contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another) and to develop UTI due to potentially contaminated urinal bottle and switching of urinal bottle with other residents. Findings: During a review of Resident 40's admission Record, the admission Record indicated the facility admitted the resident on 8/20/2022, with diagnoses including bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), cognitive communication deficit (a condition that affects how individuals think and communicate), and generalized muscle weakness. During a review of Resident 40's History and Physical (H&P), dated 11/19/2025, the H&P did not indicate Resident 40's capacity to understand and make decisions. During a review of Resident 40's Minimum Data Set (MDS, a resident assessment tool) dated 1/9/2026, the MDS indicated Resident 40 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and was able to understand others and make his needs known. The MDS further indicated Resident 40 required supervision or touching assistance to partial/moderate assistance with toileting hygiene and personal hygiene and that the resident was always incontinent of urine and occasionally incontinent with the bowels. During a review of Resident 40's Order Summary Report, dated 2/26/2026, the Order Summary Report indicated the following physician's orders: - 7/29/2023: furosemide tablet 40 milligrams (mg - a unit of measurement) give one tablet by mouth one time a day for both lower extremities (BLE) edema (swelling caused by extra fluid buildup in the tissues often in the feet, ankles, legs, or hands). - 11/4/2023: spironolactone oral tablet 25 mg give one tablet by mouth one time a day for BLE edema. During a review of Resident 40's care plan (CP) on preference to hang personal urinal on the trash can initiated 10/16/2025, the CP indicated to observed urinal frequently for cleanliness ensuring it is emptied, disinfect after each use and replace as needed if soiled as one of the interventions to maintain urinary hygiene and environment free from cross-contamination while respecting personal preferences and dignity. During a concurrent observation and interview on 2/23/2025 at 11:28 a.m., inside Resident 40's room with Certified Nursing Assistant (CNA) 12, CNA 12 stated Resident 40 had two (2) urinal bottles at the bedside. CNA 12 stated one urinal that was hanging at the bed headboard did not have a label and the other urinal bottle inside the urinal holder hanging on the right side of the bed was labeled with the date 1/12/2026. CNA 12 stated she (CNA 12) was not sure on the frequency of changing the urinal bottles but usually it is at least every week. CNA 12 stated when changing the urinals, it should be labeled with Resident 40's name or room number and the date it was last changed. CNA 12 stated that Resident 40's urinal should have indicated Resident 40's name or room number and the date it was changed to prevent being switched with other residents' urinals in the room and prevent cross contamination and potentially acquiring infection. CNA 12 stated Resident 40's urinal dated 1/12/2026 was very old and should have been changed as it could have been contaminated and the resident can get urine infection from a dirty urinal. During an interview on 2/25/2026 at 9:32 a.m. with the Assistant Director of Nursing (ADON), the ADON stated that she (ADON) was not sure about the frequency of changing the urinals but the date of 1/12/2026 indicated in Resident 40's urinal was very old and the urinal should have been changed. The ADON stated the facility practice is to change the (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	urinals at least every week as it was an infection control issue. The ADON stated the urinal could have been dirty and contaminated and placed Resident 40 at risk for acquiring infection due to the contaminated urinal bottle. The ADON stated Resident 40's other urinal bottle hanging at the bed headboard should have been labeled with the resident's name or room number and the date it was last changed. The ADON stated that if Resident 40's urinal was not labeled, the urinal could be switched and result to cross-contamination. During a review of the facility's policy and procedure (P&P) titled, Cleaning and Disinfection of Resident Care Items and Equipment, the P&P indicated resident-care equipment including reusable items will be cleaned and disinfected. The P&P further indicated: - Staff will be provided with guidelines to clean and disinfect resident equipment to reduce the risk of transmitting infectious agents. - Single resident-use items are cleaned and/or disinfected between uses by a single resident and disposed of when no [NAME] in use such as bedpans, and urinals. During a review of the facility's P&P titled, Infection and Prevention and Control, last reviewed on 10/23/2025, the P&P indicated that the facility has an infection prevention and control program designed to provide safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The P&P further indicated: - The staff apply standard precautions to infection prevention measures that apply to all resident care, regardless of suspected or confirmed infection status of the resident, in any setting where healthcare is being delivered. - Standard precautions include hand hygiene, selection and use of PPE, respiratory hygiene and cough etiquette, safe injection practices, environmental cleaning and disinfection, and cleaning and disinfection of reusable resident medical equipment.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure the staff providing care and services to a resident who had a feeding tube (are soft plastic tubes through which liquid nutrition travels through the gastrointestinal tract [the series of organs that food and liquids pass through as they are digested, absorbed, and leave the body as feces]) were aware of, competent in, and utilized facility protocols regarding feeding tube nutrition and care for one of one sampled resident (Resident 6) reviewed for tube feeding by failing to ensure Resident 6's old piston syringe (is a large, reusable plastic syringe used to deliver formula, water, or medication directly into the stomach through a feeding tube) for gastrostomy tube (g-tube, a soft, flexible tube surgically inserted through a small opening in the skin of the abdomen directly into the stomach) medication administration and feeding dated 2/22/2026 was discarded after 24 hours of use. The deficient practices had the potential to result in altered nutritional status that can lead gastrointestinal (GI, relating to stomach and intestines) infection to the resident. Findings: During a review of Resident 6's admission Record (AR), the AR indicated the facility admitted the resident on 8/26/2021, and readmitted the resident on 5/9/2024, with diagnoses including gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), gastro-esophageal reflux disease (GERD, a chronic condition where stomach acid frequently flows back (refluxes) into the esophagus, the tube connecting the mouth and stomach), and dysphagia (difficulty swallowing). During a review of Resident 6's History and Physical (H&P), dated 11/2/2025, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 1/25/2026, the MDS indicated the resident usually had the ability to make self-understood and understand others and had intact cognition (a person's mental abilities are functioning normally, without any significant impairment, decline, or brain-related confusion). The MDS indicated the resident was dependent to needing partial assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident had a feeding tube. During a review of Resident 6's Order Summary Report (OSR), dated 1/18/2026, the OSR indicated enteral feed order every day shift. Change syringe daily. During a review of Resident 6's Care Plan (CP) Report regarding the resident requiring enteral feeding and must maintain nutritional status via tube feeding, last revised on 5/17/2024, the CP indicated an intervention to discard continuous enteral feeding containers and administration sets every 24 hours. During a concurrent observation and interview on 2/23/2026 at 8:14 a.m., with the Minimum Data Set Coordinator (MDSC), inside Resident 6's room, observed Resident 6's piston syringe hanging on the feeding pole stand on a plastic pouch dated 2/22/2026. The MDSC stated the piston syringe should have been discarded by the night shift licensed nurses and a new one should have been utilized dated 2/23/2026. The MDSC stated the failure of the staff to provide a new piston syringe for medication administration and feeding could lead to gastric infections to Resident 6. During an interview on 2/25/2026 at 3:30 p.m., with the Assistant Director of Nursing (ADON), the ADON stated the night licensed nurses should have discarded the piston syringe dated 2/22/2023 and replaced them with a new piston syringe dated 2/23/2026. The ADON stated their policy and procedure titled, Enteral Feeding- Syringe was not followed as it should be replaced every 24 hours to prevent gastric infections and gastric symptoms such as diarrhea, stomachache, and vomiting. During a review of the facility's recent policy and procedure (P&P) titled, Enteral Feeding- Syringe, last reviewed on 10/23/2025, the P&P indicated the purpose of this procedure is to guide the proper sanitizing of reusable enteral feeding syringes.^ Guidelines 7. Enteral feeding syringes are replaced every 24 hours.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure parenteral fluids (liquids, such as medication or nutrition, that are administered to the body by bypassing the digestive system) were administered consistent with professional standards of practice to one of one sampled resident (Resident 5) reviewed for hydration by failing to ensure that Resident 5's peripheral intravenous (IV, within a vein) line (a small, flexible plastic tube (catheter) inserted through the skin into a small vein-usually in the hand, arm, or foot-to deliver fluids and medications directly into the bloodstream) had the date and initials of the licensed nurse who inserted the IV line or changed the IV dressing.ˆ The deficient practices had the potential for complications associated with intravenous therapy (a medical technique that delivers fluids, medication, or nutrients directly into a person's bloodstream through a vein) and catheter-related infections. Findings: During a review of Resident 5's admission Record (AR), the AR indicated the facility admitted the resident on 2/2/2024, and readmitted the resident on 11/11/2025, with diagnoses including type two (2) diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), extended spectrum beta lactamase (ESBL) resistance (aˆtype of bacteria that has developed the ability to produce enzymes (chemicals) capable of destroying many common, frontline antibiotics), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 5's History and Physical (H&P), dated 11/12/2025, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 11/18/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had moderately impaired cognition (a brain-based decline in memory, thinking, or judgment that is noticeable to others and disrupts daily life, but is not as severe as dementia). During a review of Resident 5's Order Summary Report (OSR), dated 2/16/2026, the OSR indicated an order for: - IV Peripheral Active Therapy Orders #4: Monitor peripheral IV site. Observe for reactions during infusion. Observe for signs and symptoms of infiltration (the accidental leakage of IV fluids or medication into the surrounding tissue instead of the vein, often caused by the needle dislodging) or phlebitis (the inflammation of a vein caused by irritation from the catheter, the medication being given, or bacteria) before and after medication administration. Document as follow: 0 = None 1 = Redness 2 = Swelling 3 = Infiltration. every shift AND as needed. -IV Peripheral Active Therapy Orders #2: Flush with five (5) cubic centimeters (cc, a metric unit of volume equal to the space inside a cube with sides measuring 1 cm) normal saline (NS, a mixture of salt and water) before & after meds and/or every (Q) shift & if needed (PRN). Every shift and as needed. During a review of Resident 5's Care Plan (CP) Report titled, Risk for infection related to IV site, initiated on 1/27/2026, the CP indicated an intervention of site dressing changes per protocol. During an interview on 2/23/2026 at 10:15 a.m., with Resident 5, Resident 5 stated the peripheral IV on her right arm was inserted in GACH. Resident 5 stated she (Resident 5) came back from GACH to the facility on 2/1/2026, and she (Resident 5) cannot remember when the dressing from her IV was last changed by the facility staff. During a concurrent observation and interview on 2/23/2026 at 10:28 a.m., with Registered Nurse (RN) 1, inside Resident 5's room, observed Resident 5 had a gauge 22 (a small-bore, blue-colored needle) peripheral IV line on the right arm covered with Kerlix (a brand of specialized medical gauze used for dressing wounds, commonly recognized by its crinkle-weave pattern that makes it fluffy, soft, and highly absorbent) without the date and initial of the licensed nurse who inserted the peripheral IV or changed the dressings. RN 1 stated the peripheral IV dressings should be changed weekly and if needed. The failure of the licensed staff to label the dressing of the peripheral IV can lead to IV site infection. During an interview on 2/25/2026 at 3:30 p.m., with the Assistant Director of Nursing (ADON), the ADON stated the licensed staff is responsible for changing the dressing of the peripheral IV line. The ADON stated it was the responsibility of RNs to ensure the site is current and labeled with the date it was inserted or last changed and the initials (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the licensed nurse who inserted or changed the dressings to ensure it is current and functioning ready for IV antibiotic infusion. The ADON stated the failure of the licensed staff to label the IV site can lead to IV insertion site infection. During a review of the facility's recent policy and procedure (P&P) titled, Catheter Insertion and Care, last reviewed on 10/23/2025, the P&P indicated peripheral IV catheters will be inserted by Nurses with demonstrated competency in IV therapy.ˆ Dressings: 3. Label on dressing should include date and time of dressing placement, initials, gauze size, and length of catheter.

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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 ensure respiratory care provided to residents was consistent with professional standards of practice for three of three sampled residents (Residents 83, 6, and 7) reviewed for respiratory care by failing to ensure: 1. Resident 83's Bilevel Positive Airway Pressure (BIPAP, a non-invasive device used to help people breathe more easily, typically while sleeping or in a hospital setting) tubing was labeled with the date it was provided or last replaced.ˆ 2. Resident 6's nebulizer (a typically, electric or battery-powered device that transforms liquid medicine into a fine, breathable mist) mask and tubing dated 2/10/2026 was discarded and replaced with a new nebulizer mask and tubing dated 2/23/2026. 3. Resident 7's oxygen via nasal cannula (NC - a simple, two-pronged device that delivers extra oxygen to the nose) was not touching the floor. The deficient practices had the potential for the residents to develop complications such as shortness of breath and desaturation (low levels of oxygen in the blood) and respiratory infections. Findings: 1. During a review of Resident 83's admission Record (AR-front page of the chart that contains a summary of basic information about the resident), the AR indicated the facility admitted the resident on 9/10/2025, with diagnoses including acute respiratory failure (a life-threatening medical emergency where the lungs suddenly fail to function properly, either by failing to get enough oxygen into the blood or by failing to remove enough carbon dioxide) with hypoxia (a condition where your body's tissues and organs are not receiving enough oxygen to function properly), chronic diastolic heart failure (a long-term condition where the heart muscle becomes too stiff or thick to properly relax and fill with blood between beats), and obstructive sleep apnea (a common disorder where breathing repeatedly stops and starts during sleep because throat muscles relax and block the airway). During a review of Resident 83's History and Physical (H&P), dated 9/12/2025, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 83's Minimum Data Set (MDS, a resident assessment tool), dated 12/11/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had an intact cognition (a person's brain is functioning normally, allowing them to think, learn, remember, and reason clearly without any significant impairment or decline). During a review of Resident 83's Order Summary Report (OSR), dated 10/2/2025, the OSR indicated an order of: - BIPAP Order #2 – BIPAP settings: Inspiratory Positive Airway Pressure (IPAP, the inhale boost or the higher, stronger pressure setting on a BiPAP machine that pushes air into your lungs when you take a breath) 20 Expiratory Positive Airway Pressure (EPAP, in simple terms, it is the lower, baseline level of air pressure a BiPAP machine delivers when you areˆbreathing outˆ(exhaling))15 Pressure Support (PS, is the extra boost of air pressure you receive only when you breatheˆin) 4.0 Use: At night (NOC) & if needed (PRN) for respiratory distress. - BIPAP Order #2 – BIPAP settings: IPAP 20 EPAP15 PS 4.0 Use: At NOC & PRN for respiratory distress at bedtime. - BIPAP Order # 4- Replace mask tubing accessories PRN, device degradation (the gradual decline in a device's performance) as needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 83's Care Plan (CP) Report regarding Resident 83 had altered respiratory status/difficulty breathing related to. obstructive sleep apnea, last revised on 10/17/2025, the CP indicated an intervention of BIPAP Order #4- Replaced Mask Tubing accessories PRN, device degradation. During a concurrent observation and interview on 2/23/2026 at 11:07 a.m., with Registered Nurse (RN) 1, inside Resident 83's room, observed a BIPAP/Continuous Positive Airway Pressure (CPAP, a small, bedside device that uses a mask and gentle air pressure to keep your airways open while you sleep) mask and tubing inside a clear plastic bag with no name of the resident and date it was provided. RN 1 stated the clear plastic bag should have been labeled with the name of the resident and the date it was provided to ensure the mask and the tubing is current and not used for more than allowable time. RN 1 stated using the BIPAP/CPAP for more than allowable time predisposes the resident to respiratory infection. RN 1 stated she is not sure how long the mask and tubing can be used but she believes it should be changed every month. During an interview on 2/25/2026 at 3:30 p.m., with the Assistant Director of Nursing (ADON), the ADON stated the BIPAP/CAPAP mask and tubing should be changed every 30 days and prn to prevent the resident from developing respiratory infection. The ADON stated that the mask and tubing develop bacteria and viruses over time that can cause infections to residents. The ADON stated the mask, and tubing should be checked for cracks and leaks to maximize its use. During a review of the facility's policy and procedure (P&P) titled, BiPAP and CPAP Therapy, last reviewed on 10/23/2025, the P&P indicated to provide clinical practice guidelines for the care and treatment of the resident who uses a positive airway pressure machine for treatment of sleep apnea. Both CPAP and BiPAP machines allow patients to breathe easily and regularly throughout the night. Equipment Cleaning and Replacement Schedule 1. CPAP/BiPAP are single use resident devices, labeled with the resident's name and date opened, stored in clean, dry containers, and should not be shared between residents. 3. The face mask, tubing, and chamber with should be washed daily with warm soapy water and allowed to air dry completely. 4. All care equipment should be disinfected weekly and inspected for damage. 5. The full face/nasal mask should be replaced every 3 months or sooner if the mask is cracked, leaking, discolored, has poor seal or skin breakdown occurs.^ 7. The Tubing/Circuit should be replaced every 3 months or replaced sooner if visible moisture builds up, cracks, odor or contaminated. 2. During a review of Resident 6's AR, the AR indicated the facility admitted the resident on 8/26/2021, and readmitted the resident on 5/9/2024, with diagnoses including acute respiratory failure with hypoxia, gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 6's H&P, dated 11/2/2025, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 6's MDS dated [DATE], the MDS indicated the resident usually had the ability to make self-understood and understand others and had an intact cognition. The MDS indicated the resident was on respiratory treatment. During a review of Resident 6's OSR, dated 1/18/2026, the OSR indicated an order for ipratropium-albuterol solution (a prescription medication used to open the airways in the lungs, making it easier to breathe) 0.5-2.5 (3) milligrams (mg, a unit of weight)/three milliliters (ml, a unit of volume). Three milliliter inhales orally every four hours as needed for shortness of breath (SOB) or wheezing (a high-pitched, whistling sound that can occur during breathing when the airways in the lungs become narrowed or blocked) via nebulizer (a machine that turns liquid medicine into a fine mist that you breathe directly into your lungs through a mask or mouthpiece). During a review of Resident 6's CP Report titled, Enhanced barrier precaution (infection control measures in nursing homes requiring staff to wear gowns and gloves during high-contact care (e.g., dressing, bathing, transferring) for residents with wounds, medical devices, or resistant infections) related to indwelling medical devices (instruments placed inside the body either temporarily or permanently to assist with diagnostic, monitoring, or therapeutic functions), last revised on 1/27/2026, the CP indicated an intervention to observe proper technique during cleaning of wounds and medical devices and environmental cleaning on resident's room, equipment, and devices. During a concurrent observation and interview on 2/23/2026 at 11:14 a.m., with the Minimum Data Set Coordinator (MDSC), inside Resident 6's room, observed Resident 6's nebulizer mask and tubing placed in a clear plastic bag dated 2/10/2026. The MDSC stated that the nebulizer mask and tubing should have been discarded by the night shift nurses. The MDSC stated that the nebulizer mask and tubing should be changed every seven (7) days and labeled with the date it was provided to prevent bacteria and viruses from growing in the tubing causing respiratory infections to residents. During an interview on 2/25/2026 at 3:30 p.m., with the ADON, the ADON stated the nebulizer mask, and tubing should be changed every seven (7) days and prn to prevent the resident from developing respiratory infection. The ADON stated that the mask and tubing develop bacteria and viruses over time that can cause infections to residents. During a review of the facility's recent P&P titled, Nebulizer (Aerosol) Therapy, last reviewed on 10/23/2025, the P&P indicated nebulizer treatments shall be administered safely, aseptically, and in accordance with provider orders, scope of practice regulations, and professional standards to promote optimal respiratory function and prevent complications. Infection Control Consideration 9. Discard the administration set-up every seven (7) days. 3. During a review of Resident 7's AR, the AR indicated the facility originally admitted the resident on 1/20/2023, and readmitted in the facility on 11/4/2025, with diagnoses including acute respiratory failure (a condition that occurs when the lungs cannot release oxygen into the blood resulting to shortness of breath, confusion, drowsiness, and bluish discoloration of the lips, skin, or extremities), adult failure to thrive (a condition in older adults marked by physical and mental decline such as loss (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of appetite and weight loss), generalized muscle weakness). During a review of Resident 7's History and Physical (H&P) dated 11/6/2025, the H&P indicated Resident 7 did not have the capacity to understand and make decisions. During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was able to understand and make her needs known. The MDS further indicated Resident 7 required supervision or touching assistance with eating, partial/moderate assistance with oral hygiene, and substantial/maximal assistance to total assistance with all other activities of daily living (ADLs-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS further indicated Resident had a diagnosis of acute respiratory failure. During a review of Resident 7's Order Summary Report dated 2/26/2026, the Order Summary Report indicated the following physician's orders: - 12/14/2025: Oxygen (O2) at two (2) liters per minute (L/min – a unit of measurement) via NC continuously. Monitor and document oxygen saturation (O2 sat - a measurement of how much oxygen the blood is carrying as a percentage) every shift for may titrate to maintain O2 sat greater than 91 percent (% - a unit of measurement. During a review of Resident 7's care plan (CP) on oxygen therapy initiated on 11/12/2025, and last revised on 12/11/2025, the CP indicated to provide oxygen as ordered and to monitor, document, report abnormal breathing patterns to the physician as a few of the interventions to maintain Resident 7's normal breathing pattern as evidenced by normal respirations, normal skin color, and regular respiratory rate or pattern. During a concurrent observation and interview on 2/23/2026 at 9:08 a.m., inside Resident 7's room with Licensed Vocational Nurse (LVN) 3, observed Resident 7 lying in bed asleep with O2 at two L/min via NC with the NC tubing touching the floor. LVN 3 state that Resident 7's O2 tubing was touching the floor. LVN 3 stated that the staff were supposed to ensure that the O2 tubing should not be touching the floor at any time. LVN 3 stated that Resident 7's O2 tubing should not be touching the floor as the floor is dirty and contaminated the tubing. LVN 3 stated that Resident 7 can potentially acquire infection due to the contaminated tubing. During an interview on 2/26/2026 at 9:50 a.m. with the Assistant Director of Nursing (ADON), the ADON stated that the staff are supposed to ensure that any resident's O2 tubing should not be touching the floor as the floor is dirty and can contaminate the tubing which can be a source of infection. The ADON stated that contamination or bacteria can travel up to the tubing from the floor and the resident can inhale the bacteria. The ADON stated that Resident 7's O2 tubing should not be touching the floor at any time as it placed Resident 7 for acquiring infection due to the contaminated O2 tubing. During a review of the facility's policy and procedure (P&P) titled, Infection and Prevention and Control, last reviewed on 10/23/2025, the P&P indicated that the facility has an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The P&P further indicated: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Healthcare associated infections (HAIs) can cause significant pain and discomfort for residents in nursing homes and can have significant adverse consequences. During a review of the facility's P&P titled, Cleaning and Disinfection of Resident Care Items and Equipment, last reviewed on 10/23/2025, the P&P indicated to provide staff with guidelines to clean and disinfect equipment to reduce the risk of transmitting infectious agents to the extent possible. The P&P further indicated that semi-critical items consist of items that come in contact with mucous membranes or non-intact skin such as respiratory therapy equipment. Such devices should be free from all microorganisms.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pain management consistent with professional standards of practice and the residents' goals and preferences for one of one sampled resident (Resident 11) by failing to ensure as needed pain medication was administered per physician's orders and according to parameters for Resident 11. These deficient practices had the potential to result in side effects from unnecessary administration of narcotics including constipation and mismanagement of resident pain resulting in limited resident participation in activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily), general activities, and mobility. Findings: During a review of Resident 95's admission Record (AR), the AR indicated that the facility originally admitted the resident on 3/6/2022 and readmitted on [DATE] with diagnoses including Parkinsonism (a progressive brain disorder that causes problems with movement, balance, and muscle control), heart failure (a condition where the heart muscle becomes too weak or stiff to pump blood efficiently), and hypertension (HTN - high blood pressure). During a review of Resident 95's History and Physical (H&P), dated 2/25/2026, the H&P indicated that the resident has the capacity to make decisions. During a review of Resident 95's physician order, the physician order indicated the following: - dated 2/24/2026, tramadol hydrochloride (also known as Ultram, a medication used to treat pain) oral tablet 50 milligrams (mg - a unit of measurement) Give one (1) tablet by mouth every six hours as needed for moderate pain. - dated 2/24/2026, Monitor level of pain (zero [0] to 10 scale): Document pain level as follows: 0 = None, one (1) to three (3) Mild Pain, four (4) to six (6) = Moderate Pain, seven (7) to 10 = Severe Pain every shift. During a review of Resident 95's Care Plan (CP) titled, Black Box Warning (BBW) for use of Ultram (tramadol), dated 2/24/2026, the CP indicated the resident will not experience side effects/interactions with the use of tramadol. The CP indicated the interventions BBW #1 addiction, abuse, and misuse and BBW #2 life-threatening respiratory depression. During a concurrent interview and record review on 2/25/2026 at 11:20 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 95's Medication Administration Record (MAR), for 2/25/2026, and Resident 95's Drug Control Receipt Record/Disposition Form for tramadol were reviewed. LVN 2 stated she did not sign the dose she gave today, 2/25/2026 on the Drug Control Receipt Record for tramadol. LVN 2 stated she gave it at 10 a.m. LVN 2 stated she forgot to sign it on the sheet after she administered the medication. LVN 2 stated she needed to sign it as soon as she administered it to make sure it was given and that she did not take the medication and there would be no miscount. During a follow-up interview on 2/25/2026 at 2:30 p.m. with LVN 2, LVN 2 stated Resident 95 reported a pain level of 6 and 7 pain and she took the higher one, pain level of 7. LVN 2 stated the tramadol was ordered for moderate pain and she should have called the physician to inform them that the resident complained of severe pain. LVN 2 stated moderate pain is 4 to 6 pain level and severe pain is 7 to 10 pain level. LVN 2 stated she thought that the pain level of 7 was moderate pain and did not call the physician at that time. During an interview on 2/26/2026 at 12:58 p.m. with the Assistant Director of Nursing (ADON), the ADON stated that the drug control receipt record sheet is for documentation and ensure correct and accurate counting of controlled medications. The ADON stated when the licensed nurses do not sign the drug control receipt record sheet the resident could overdose because the licensed nurse may give a double dose of the medication. The ADON stated the licensed nurse should have called the resident's physician because the parameters for the tramadol is to give for moderate pain which is 4 to 6 pain level and the resident reported a pain level of 7 pain level which was severe pain. The ADON stated the resident could experience a delay of treatment, can affect her mobility, ADL participation, and still be in pain when the pain medication is not provided according to the physician order. During a review of the facility's policy and procedure (P&P) titled, Controlled Substance Storage, last reviewed 10/23/2025, the P&P indicated that the Controlled substance inventory is regularly reconciled to the Medication (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administration Record and Form 12: INDIVIDUAL RESIDENT'S CONTROLLED SUBSTANCE RECORD. During a review of the facility's P&P titled, Controlled Substance Storage, last reviewed 10/23/2025, the P&P indicated the A. Elements of a controlled substance prescription:. 13) PRN (as needed) orders clearly delineate the condition for which they are being administered, for example, as needed for severe pain (pain scale 7 - 10),. Documentation of the Controlled Substance Prescription: Each controlled substance prescription is documented in the resident's medical record with the date, time, and signature of the person receiving the prescription. The prescription is recorded on (the physician order sheet.), and recorded on the MAR. During a review of the facility's P&P titled, Administering Medications, last reviewed 10/23/2025, the P&P indicated 3. Medications must be administered in accordance with the orders. 9. Following verification of the resident and scheduled medication, the licensed nurse follows the ?pour, pass, chart' standard of practice. During a review of the facility's P&P titled, Pain Assessment and Management, last reviewed 10/23/2025, the P&P indicated that The facility provides pain management to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Residents are at risk for having pain that may affect function, impair mobility, impair mood, or disturb sleep, and diminish quality of life. The facility recognizes the importance of evaluating resident's reports of pain, or nonverbal signs suggesting pain. Use of Opioids for Pain Management. 3. The facility, with guidance from the physician, uses the lowest possible effective dosage for the shortest amount of time possible with consideration to all medical needs and the resident including their choices, preferences and goals for care.

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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. Based on interview and record review, the facility failed to ensure residents who received hemodialysis (HD, process of removing waste products and excess fluid from the body) received treatment consistent with professional standards of practice for one of one sampled residents (Resident 86) reviewed under the Dialysis care area by failing to provide communication with the HD Center (a specialized outpatient facility that provides HD) and ensure that licensed nurses (LN) performed and documented assessments before and after Resident 86's hemodialysis sessions. These deficient practices placed the resident at risk for a delay in care and services and a delay in detecting complications resulting from HD. Findings: During a review of Resident 86's admission Record (AR), the AR indicated the facility admitted the resident on 2/15/2024, with diagnosis that included End Stage Renal Disease (ESRD -irreversible kidney failure), dependence on renal (kidney) dialysis, hypertension (HTN, high blood pressure), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial paralysis or weakness on one side of the body) following cerebral infarction (CVA-stroke, loss of blood flow to a part of the brain). During a review of Resident 86's Minimum Data Set (MDS - resident assessment tool) dated 1/25/2026, the MDS indicated the resident was usually able to understand others and usually able to make himself understood. The MDS further indicated that the resident required partial / moderate assistance from staff for bathing, dressing, and walking. During a review of Resident 86's Care Plan (CP) titled, (Resident 86) has potential for complications of ESRD/HD clinical manifestations., initiated 2/15/2024 and last reviewed 2/4/2026, the CP indicated interventions that included the following: - Access site/location of left arm arteriovenous (AV) shunt (a surgically created connection between an artery and a vein used for HD). - Call the physician for any changes in the resident's condition. - Communicate with the HD center staff regarding plan of care, lab values, and any other changes of condition via the HD communication form. - Apply direct pressure over AV shunt if bleeding is present. If bleeding is severe, call emergency services or physician immediately. During a review of Resident 86's Physician Order Summary, the Physician Order Summary indicated the following orders: - HD, vital signs (measurements of the body's most basic, life-sustaining functions, including body temperature, heartbeat, breathing rate, and blood pressure) pre (before) and post (after) HD, two times a day Tuesday, Thursday, and Saturday, dated 10/24/2025. During an interview on 2/25/2026 at 12:35 a.m., with Registered Nurse (RN) 1, RN 1 stated the facility process for HD residents is a resident assessment is completed by the LN prior to sending the resident to HD to ensure the resident is stable. RN 1 stated the HD Communication Record form is used to communicate with the HD center the resident's vital signs, the type of access site, any complications at the access site, any changes in resident condition, and the signature of the LN and date. RN 1 stated when residents return from HD, the LN immediately completes and documents a post HD assessment to make sure the resident is stable. During a follow-up concurrent interview and record review on 2/25/2026 at 3:07 p.m., with the Registered Nurse (RN) 1, RN 1 reviewed Resident 86's physician's orders, HD Communication Record forms dated 1/13/2026 and 2/19/2026, Dialysis Communication Record V-2 form dated 1/2026 to 2/2026 in the electronic health record (EHR), and progress notes for 1/2026 and 2/2026 and noted the following: - On 1/13/2026, there was no documented evidence that Resident 86 was assessed upon returning to the facility after HD. RN 1 stated there was no documentation by the assigned LN to indicate what time the resident returned from HD. RN 1 stated it was important to assess and document when the resident returns to make sure they are stable because the resident is at risk for bleeding or a change in the blood pressure. RN 1 stated it is important to catch any change of condition quickly to treat and minimize the effects of high blood pressure or bleeding. - On 2/19/2026, The HD Communication Record form was blank and not completed for the pre-HD facility assessment. RN 1 stated the LN should have completed the form to communicate the resident's vital signs and access site information, but it was not completed. RN 1 stated it was important to complete the form, (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	so the HD center has a comparison of vital signs, the LN's name, the date the information was collected, and any access site information. During a concurrent interview and record review on 2/25/2026 with Licensed Vocational Nurse (LVN) 2, LVN 2 reviewed Resident 86's HD Communication Record form dated 2/19/2026. LVN 2 stated she did not complete Resident 86's HD Communication Record form on 2/19/2026. LVN 2 stated it was important to complete the form including an assessment because the form is used to communicate with the HD center about the resident's condition before going to HD and the LN name as the point of contact. During an interview and record review on 2/26/2026 at 11:39 a.m. with the Assistant Director of Nursing (ADON), the ADON reviewed the facility policy and procedure (P&P) regarding HD. The ADON stated the facility process is to complete the HD Communication Record form with the LN's assessment. The ADON stated the form is a communication tool between the facility and the HD center and if the form is not completed the resident may be dialyzed with a recent history of low blood pressure potentially resulting in even lower blood pressure during HD and a change of condition causing issues for the resident. The ADON further stated the process after HD is that the LN assesses the resident when they return because they may have high blood pressure or bleeding. The ADON stated if the resident is not assessed the LN may not catch high blood pressure or bleeding resulting in a delay of treatment and leading to hospitalization of the resident. The ADON stated the facility P&P was not followed for Resident 86. During a review of the facility P&P titled, Dialysis Management, last reviewed 10/23/2025, the P&P indicated, PURPOSE . to provide residents who require dialysis care, services consistent with professional standards of practice, a comprehensive person-centered care plan which meets the residents' goals and preferences. INTENT. To ensure the facility assures that each resident receives care and services for the provision of hemodialysis . consistent with professional standards of practice including the: . Ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility. Ongoing assessment and oversight of the resident before, during and after dialysis treatments, including monitoring the resident's condition during treatments, monitoring for complications, implementing appropriate interventions, and using appropriate infection control practices; and . Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately account for one dose of tramadol (a controlled medication used to treat pain) affecting Resident 95 in one of two inspected medication carts (Medication Cart 1). This deficient practice increased the risk of diversion (any use other than that intended by the prescriber) of controlled medications (medications with a high risk for diversion) and that Resident 95 could have received too much or too little medication due to lack of documentation resulting in serious health complications such as drug overdose (occurs when a substance is taken in quantities that pose severe health risks or death). Findings: During a review of Resident 95's admission Record (AR), the AR indicated that the facility originally admitted the resident on 3/6/2022, and readmitted on [DATE], with diagnoses including Parkinsonism (a progressive brain disorder that causes problems with movement, balance, and muscle control), heart failure (a condition where the heart muscle becomes too weak or stiff to pump blood efficiently), and hypertension (HTN - high blood pressure). During a review of Resident 95's History and Physical (H&P), dated 2/25/2026, the H&P indicated that the resident had the capacity to make decisions. During a review of Resident 95's physician order, dated 2/24/2026, the physician order indicated tramadol hydrochloride oral tablet 50 milligrams (mg - a unit of measurement) Give one (1) tablet by mouth every six hours as needed for moderate pain. During a concurrent interview and record review on 2/25/2026 at 11:20 a.m. with Licensed Vocational Nurse (LVN) 2, reviewed Resident 95's Medication Administration Record (MAR) for 2/25/2026 and Resident 95's Drug Control Receipt Record/Disposition Form for tramadol. LVN 2 stated she (LVN 2) did not sign the dose she (LVN 2) administered today 2/25/2026, on the Drug Control Receipt Record for tramadol. LVN 2 stated she (LVN 2) administered the medication at 10 a.m. LVN 2 stated she (LVN 2) forgot to sign it on the sheet after she (LVN 2) administered the medication. LVN 2 stated she (LVN 2) needed to sign it as soon as she (LVN 2) administered it to make sure it was given and that she did not take the medication and there would be no miscount. During an interview on 2/26/2026 at 12:58 p.m. with the Assistant Director of Nursing (ADON), the ADON stated that the drug control receipt record sheet is for documentation and ensure correct and accurate counting of controlled medications. The ADON stated when the licensed nurses do not sign the drug control receipt record sheet the resident could overdose because the licensed nurse may give a double dose of the medication. During a review of the facility's policy and procedure (P&P) titled, Controlled Substance Storage, last reviewed 10/23/2025, the P&P indicated that the Controlled substance inventory is regularly reconciled to the Medication Administration Record and Form 12: INDIVIDUAL RESIDENT'S CONTROLLED SUBSTANCE RECORD. During a review of the facility's P&P titled, Controlled Substance Storage, last reviewed 10/23/2025, the P&P indicated the A. Elements of a controlled substance prescription:. 13) PRN (as needed) orders clearly delineate the condition for which they are being administered, for example, as needed for severe pain (pain scale 7 - 10),. Documentation of the Controlled Substance Prescription: Each controlled substance prescription is documented in the resident's medical record with the date, time, and signature of the person receiving the prescription. The prescription is recorded on (the physician order sheet.), and recorded on the MAR. During a review of the facility's P&P titled, Administering Medications, last reviewed 10/23/2025, the P&P indicated 3. Medications must be administered in accordance with the orders. 9. Following verification of the resident and scheduled medication, the licensed nurse follows the ?pour, pass, chart' standard of practice.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to prepare the menu to meet a resident`s nutritional needs for one of four residents (Resident 25) on puree diet (a texture modified diet that consists of smooth, pudding-like consistencies that are easy to swallow) by failing to have the puree broccoli recipe available and followed which indicated to perform International Dysphagia Diet Standardization Initiative (IDDSI, a standardized framework used to classify food textures and liquid thickness for people with dysphagia) testing (methods to confirm the flow or textural characteristics of a particular food or liquid) to ensure appropriate texture standards for residents with dysphagia (difficulty swallowing). This deficient practice resulted in Resident 25's lunch plate on 2/23/2026, containing broccoli that wept (release of moisture, forming liquid on the surface) potentially resulting in the resident choking (when food gets stuck in your airway, blocking the flow of the air to your lungs) on the food.^^^ Findings:^ During a review of Resident 25's admission Record (AR, front page of the chart that contains a summary of basic information about the resident), the AR indicated the facility admitted the resident on 11/6/2025, with diagnoses including dysphagia, chronic respiratory failure (serious condition that slowly develops when the lungs cannot get enough oxygen into the blood) with hypoxia (low oxygen in the tissues), and chronic obstructive pulmonary disease (COPD, is a chronic inflammatory lung disease that causes obstructed airflow from the lungs). During a review of Resident 25's Minimum Data Set (MDS, a resident assessment tool), dated 2/4/2026, the MDS indicated Resident 25 had the ability to understand others and had the ability to make herself understood. The MDS further indicated Resident 25 required supervision or touching assistance with eating and oral hygiene, and substantial/maximal assistance to total assistance dressing and personal hygiene and was dependent on staff for toileting and bathing. The MDS further indicated Resident 25 was on mechanically altered (requires change in texture of food or) and therapeutic diet. During a review of Resident 25's Order Summary Report dated 2/26/2026, the Order Summary Report indicated a physician's order dated 2/23/2026 for consistent carbohydrate (CCHO - a nutritional approach that involves eating a similar, measured amount of carbohydrates at each meal to maintain stable blood sugar levels) no added salt (NAS - eliminating the use of salt during cooking and at the table) diet pureed texture, mildly thick consistency, fortify diet (practice of adding vitamins and minerals to commonly consumed foods during processing to increase the nutritional value). During a review of the facility's Diet Spreadsheet - Spring/Summer 2025, the Diet Spreadsheet indicated the following menu for lunch on 2/23/2026 for Pureed (PU4) / (texture): - Pureed Penne with mushroom sauce one and one half (1/2 - a unit of measurement) cups - Pureed seasoned fresh broccoli florets, number twelve (12) scoop - Pureed garlic bread (PU4) - number 12 scoop - Pureed key lime pie - number 12 scoop - Choice of beverage During a kitchen tray line (specialized, assembly-line food service system) observation on 2/23/2026 at 12:02 p.m. observed [NAME] 1 plating the resident lunch meals. Observed Resident 25's tray prepared with the plate covered, and sitting on the tray line. Just prior to being placed in the meal cart, the surveyor asked to see the plate. Resident 25's plate cover was removed and observed puree broccoli, puree pasta, and puree bread. Observed a green tinted, water like liquid surrounding the broccoli. [NAME] 1 stated the broccoli was separating and should not have water, but it did. [NAME] 1 stated he (Cook 1) needed to stir the broccoli more. Observed cook 1 stirred the broccoli and replated Resident 25's meal. Observed [NAME] 1 did not perform IDDSI standardized testing on the prepared puree foods during tray line. [NAME] 1 stated the process for making pureed broccoli was to measure the cooked broccoli and puree in the blender, then add water or a commercial thickener (food additive designed to increase the thickness of liquids and food items) to make sure it was not lumpy and was an applesauce like texture. [NAME] 1 stated [NAME] 3 prepared the puree broccoli. [NAME] 3 then stated she (Cook 3) prepared the broccoli by placing an unmeasured amount of cooked broccoli from the regular recipe in the blender with an (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unmeasured amount of cooking water. The Dietary Supervisor (DS) stated there is a recipe for puree broccoli. The Surveyor asked to see the recipe and observed the DS walk to the recipe binder. The DS stated the puree broccoli recipe was not with the printed recipes and the DS would now print recipe. The DS, [NAME] 1, [NAME] 2, and [NAME] 3 stated they were not familiar with the term IDDSI spoon tilt test (method used to determine the stickiness of puree foods and the ability of the food to hold its shape and easily fall off a spoon when tilted). During a follow-up interview and record review on 2/23/2026 at 1:42 p.m. with [NAME] 1, [NAME] 3, and the DS, reviewed the recipe titled, Pureed Seasoned Fresh Broccoli Florets, dated 2026. [NAME] 1 stated the recipe indicated to place the broccoli from the regular recipe into a blender and blend until smooth and if the consistency needed thinning, then gradually add water or if it needs thickening then add commercial thickener. [NAME] 1 stated the recipe indicated to perform appropriate IDDSI testing to ensure texture standards are met. [NAME] 1 stated he (Cook 1) did not know the term IDDSI testing, but puree should be smooth and not separate with liquid. The DS and [NAME] 2 stated they did not know the term IDDSI testing. During an interview on 2/24/2026 at 1:42 p.m. with [NAME] 1 and [NAME] 2, [NAME] 2 stated he (Cook 2) had worked at the facility for a year and a half and there had never been printed puree menus available to follow in the facility kitchen. [NAME] 2 stated he (Cook 2) did not follow a recipe to determine how much water or thickener to add to puree foods. [NAME] 2 stated he (Cook 2) looks at the food and used a plastic spoon to taste the food to determine the correct texture of puree. [NAME] 1 stated the typical kitchen set-up did not include puree recipes and [NAME] 1 used the regular recipe and removed the number of servings needed and pureed the food. [NAME] 1 stated recipes should always be followed and nothing should ever be made up in the kitchen. [NAME] 1 stated it was important to follow recipes exactly, but there were no puree recipes in the kitchen during lunch service on 2/23/2026. During an interview on 2/24/2026 at 2:09 p.m. with the DS, the DS stated the puree recipes should be printed, in the kitchen, and followed when preparing meals. The DS stated on 2/23/2026 during the lunch service the cooks did not have the puree recipes, but they should have. The DS stated when the cooks did not have the puree recipes to follow, they should have notified the DS to print the recipes, but they did not. During an interview and record review on 2/24/2026 at 3:58 p.m. with the Speech-Language Pathologist (SLP), the SLP stated IDDSI is a diet level system for modified diets for residents that are at risk of choking and possible aspiration (accidentally inhaling food or liquid into the lower airway) from food or liquids that are too thin or too thick. The SLP stated puree is level 4 and like a pudding texture. The SLP stated the IDDSI testing for puree is to visually make sure there are no lumps, to use the spoon tilt test, or to use the fork drip test (puree food should not drip or continuously flow through the tines of the fork). During an interview and record review on 2/24/2026 at 4:32 p.m. with the DS, the DS reviewed the MS 1 Diet Manual (MS1DM), last revised 9/26/2025, and stated the MS1DM is a kitchen resource for any questions regarding the MS 1 diets, menu, and recipes. The DS stated the MS1DM indicates level 4 puree foods must pass the IDDSI Appearance Test (no lumps), Fork Drip Test, and Spoon Tilt Test. The DS stated on 2/23/2026 during the lunch service the kitchen staff did not perform IDDSI testing on the puree broccoli and it resulted in broccoli being watery that could potentially cause liquid going to the lungs, coughing, and aspiration when served to residents. During an interview on 2/25/2026 at 2:11 p.m., with the RD, the RD stated that the proper consistency for a pureed diet is that it slides off the spoon, maintains its shape and form, not sticky, and not watery. The RD further stated the cook should follow the recipe and the recipe has instructions on what to do. The RD stated the cook should test the consistency of the pureed diet during tray line and adjust as needed using water or thickener depending on the consistency. The RD stated the pureed diet served should have been the correct consistency for the residents to be able to swallow the food without any choking which may lead to aspiration pneumonia (a lung infection caused by inhaling something other than air into the lungs such as food, liquid, saliva or stomach contents). During a concurrent interview and record review on 2/26/2026 at 9:58 a.m. with the Assistant Director of Nursing (ADON), the ADON reviewed the photograph of Resident 25's lunch (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tray contents dated 2/23/2026. The ADON stated that the liquid was separating from the puree broccoli. The ADON stated liquid should not separate from the broccoli because it was the wrong consistency to serve to residents. The ADON stated on 2/23/2026 during the lunch service when the DS, [NAME] 1, [NAME] 2, and [NAME] 3 did not follow puree recipes, did not perform IDDSI testing, and prepared broccoli that wept they did not demonstrate competence with IDDSI standards used in the MS 1 system potentially resulting in Resident 25 choking and aspirating when the puree broccoli wept. During a review of the MS1DM document titled, Common Ground between National Dysphagia Diet (NDD) and IDDSI, dated 2025, the MS1DM document indicated, The National Dysphagia Diet (NDD) of 2002 was replaced with the International Dysphagia Diet Standardization Initiative (IDDSI) Framework. This document explores the development of the IDDSI framework and the identification of diet levels. IDDSI is the only professionally recognized and supported diet framework as of October 2021. IDDSI framework consists of 8 more clearly defined levels (0-7) of drinks through foods. Drinks and foods are tested using IDDSI Testing Methods. Testing Methods such as the Spoon Tilt Test to ensure safety of a pureed food product. During a review of the MS1DM document titled, IDDSI Texture-Modified Diets, dated 2025, the MS1DM document indicated, texture-modified diets are prepared and served by the physician or community speech language pathologist when a resident has difficulty chewing and/or swallowing. The residents' acceptance and tolerance of the diet determine the extent of texture modification and meals need to be modified to suit individual resident preferences. Use the IDDSI testing methods to evaluate the final consistency.Testing Info. Level 4 - Pureed PU 4. sits in a mound or pile above the fork, does not dollop or drip continuously through a fork. Holds its shape on a spoon, falls off easily if the spoon is tilted or lightly flicked, must not be firm or sticky, should be smooth with no lumps, no chewing ability needed, and can be eaten with a spoon. During a review of the MS1DM document titled, Pureed (PU4), dated 2025, the MS1DM document indicated, This modification is designed for people who have severe chewing and/or swallowing problems. Properly pureed foods eliminate the chewing phase. Pureed diet menus follow the foods on the regular menu as closely as possible and differ primarily in consistency. Puree all foods to a smooth, lump-free, Extremely Thick (EX4) consistency (not firm or sticky). Use an appropriate recipe. Always refer to the recipe and spreadsheet for directions . Foods on this level must pass the IDDSI Appearance Test, Fork Drip Test and Spoon Tilt Test. Food is smooth, with no lumps. Food sits in a mound on a fork, does not drip continuously through the tines of a fork, holds its shape on a spoon, slides off spoon easily (not sticky). Pureed food must pass both tests! During a review of the facility's P&P titled, Standardized Recipes, last reviewed on 10/23/2025, the P&P indicated, Purpose. To provide the dietary department with guidelines for the use of standardized recipes. Food products prepared and served by the dietary department will utilize standardized recipes. Standardized recipes will have adjustments or separate recipes for therapeutic and consistency modifications. Recipes will have diet modifications noted. The Dietary Manager or designee will monitor and routinely verify the recipes used by the cooks. During a review of the facility provided Job Description for Cook, dated 10/2016, the Job Description indicated, Job Title: Cook. Reports to. Dietary Manager. Prepares and cooks for the regular and modified diets for the resident population. Reviews menus prior to preparation of food. Prepares meals in accordance with planned menus, standardized recipes and production sheets. Prepares food for therapeutic diets in accordance with planned menus. Prepares meals in accordance with planned menus, standardized recipes and production sheets. Prepares food for therapeutic diets in accordance with planned menus. To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed are representative of the knowledge, skill, and/or ability required.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, the facility failed to ensure residents receive food that accommodates their intolerances, preferences, and appealing options of similar nutritive value for one of six sampled residents (Resident 44) when during dining observation facility task on 2/25/2026, the resident was served two well done eggs out of three eggs instead of over easy per resident's preferences and two burnt toasts for breakfast.ˆ The deficient practice failed to accommodate the resident preference, which resulted in the resident becoming upset and delayed the resident's breakfast because the food had to be re-prepared correctly. Findings: During a review of Resident 44's admission Record (AR), the AR indicated the facility admitted the resident on 1/19/2026, with diagnoses including type two (2) diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), sepsis (a life-threatening blood infection), and muscle weakness. During a review of Resident 44's History and Physical (H&P), dated 1/20/2026, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 44's Minimum Data Set (MDS, a resident assessment tool), dated 1/27/2026, the MDS indicated the resident had the capacity to make self-understood and understand others and had moderate cognitive impairment (a significant, noticeable decline in thinking and memory skills that goes beyond normal aging, often making daily tasks (like managing finances or medication) challenging, yet not severe enough to be classified as dementia). The MDS indicated the resident was on mechanically altered and therapeutic diet. During a review of Resident 44's Order Summary Report (OSR), dated 1/30/2026, the OSR indicated an order of Consistent Carbohydrate Diet (CCHO, it is a diabetes-friendly eating plan where youˆeat roughly the same amount of carbohydrates at the same meals every dayˆto keep your blood sugar levels stable, rather than letting them spike and crash) regular texture, thin liquids consistency, double protein with meals, no potatoes, peas, and corn. During a review of Resident 44's Care Plan (CP) Report titled, Nutrition Risk: The resident is at nutrition risk secondary to increased nutrient needs related to wound healing as evidenced by unstageable pressure injury (PI) (a deep, severe wound where the full depth of damage cannot be determined because it is completely covered by dead skinˆ(yellow, tan, gray, green, or brown slough/eschar)) at coccyx (commonly known as theˆtailbone, isˆthe small, triangular bone located at the very bottom of the spine)., last revised on 1/23/2026, the CP indicated an intervention to provide and honor food preferences. During an interview on 2/23/2026 at 9:50 a.m., with Resident 44, Resident 44 stated the Kitchen does not know how to cook the eggs. Resident 44 stated they drown the food with gravy, and the oatmeal was stone cold during breakfast. During a concurrent observation and interview on 2/25/2026 at 8 a.m., with Resident 44, Resident 44 stated he (Resident 44) was upset because he (Resident 44) asked the Kitchen for over easy eggs and a toast for breakfast. Observed two eggs cooked over hard and two burnt toasts on the resident's breakfast tray. Took a picture of the tray and also compared contents against the meal tray ticket. During a review of Resident 44's Meal Tray Ticket (MTT) for Breakfast, dated 2/25/2026, the MTT indicated over easy egg- three each; Bacon- three each, and milk- eight fluid ounces (Fl oz., a US customary unit used to measure theˆvolumeˆ(space) a liquid takes up, not its weight) During a concurrent interview and record review on 2/25/2026 at 1:34 p.m., with the Dietary Supervisor (DS), reviewed the photo of meal tray contents of Resident 44 on 2/24/2026, breakfast time. The DS stated the toasts were burnt and two eggs were not cooked over easy. The DS stated he (DS) was made aware of the resident's complaint and he (DS) has spoken to the resident regarding the issue. The DS stated the failure of the kitchen to cater to the resident's preferences had made the resident upset and possibly the resident not eating that could lead to weight loss on residents. During a concurrent interview and record review on 2/25/2026, at 3:30 p.m., with the Assistant Director of Nursing (ADON), reviewed the photo of meal tray contents of Resident 6 on 2/24/2026, breakfast time. The ADON stated 2 eggs were not cooked over easy and 2 pieces of (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	burnt toast was placed on the resident's meal tray. The ADON stated the facility should honor the resident's preference on the way he wants his eggs cooked which is over easy and the toast should not be burnt as it is not appealing to eat them and probably the taste will not be great as well. The ADON stated the facility`s failure to honor the resident's food preference could lead to the resident not eating the meal, which can lead to weight loss. During a review of the facility's recent policy and procedure (P&P) titled, Menus, last reviewed on, the P&P indicated the facility assures menus are developed and prepared to meet resident choices including their nutritional, religious, cultural, and ethnic needs while using established national guidelines. Guidance 1. The facility makes reasonable efforts to provide food that is appetizing to and culturally appropriate for residents. 5. Residents receive food in the amount, type, consistency, and frequency to maintain normal body weight and acceptable nutritional values. 6. Resident preferences and needs are incorporated into the development of the individual food plan.