STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055330	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehab Center of Tustin	2210 E. First Street Santa Ana, CA 92705

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, medical record review, and facility P&P review, the facility failed to ensure assistance in the formulation of an advance directive for four of six final sampled residents (Residents 10, 89, 93, and 118) reviewed for advance directive. * The facility failed to ensure assistance in the formulation of an advance directive was offered for Residents 10, 89, and 118. * The facility failed to follow up on advance directive status after providing educational materials to the resident's representative for Resident 93. These failures had the potential for the residents' healthcare decision and treatment preferences to be unknown, undocumented, and not honored.Findings: Review of the facility's P&P titled Advance Directive (undated) showed the resident has the right to formulate an advance directive, including right to accept or refuse medical or surgical treatment. If the resident or resident representative indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advanced directives. The resident or representative is given the option to accept or decline assistance, and care will not be contingent on either decision. The nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance. 1. Medical record review for Resident 10 was initiated on 5/5/26. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's H&P examination dated 4/3/26, showed Resident 10 was able to make medical decisions. Review of Resident 10's MDS assessment dated [DATE], showed Resident 10 was cognitively intact. Review of Resident 10's Advance Directive Acknowledgement dated 4/9/26, showed Resident 10 have not executed an advanced directive, and was provided information on right to formulate an advance directive. However, the document did not show if assistance in formulating an advance directive was offered or whether Resident 10 accepted or declined the assistance. Further review of Resident 10's medical record did not show documentation that assistance in formulating an advance directive was offered to Resident 10. 2. Medical record review for Resident 89 was initiated on 5/5/26. Resident 89 was admitted to the facility on [DATE]. Review of Resident 89's H&P examination dated 4/24/26, showed Resident 89 had the capacity to understand and make medical decisions. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 89's Advance Directive Acknowledgement dated 4/9/26, showed Resident 89 have not executed an advance directive, and was provided information on right to formulate an advance directive and resident declined the further information. However, the document did not show if assistance in formulating an advance directive was offered or whether Resident 89 accepted or declined the assistance. Further review of Resident 89's medical record did not show documentation that assistance in formulating an advance directive was offered to Resident 89. 3. Medical record review for Resident 118 was initiated on 5/5/26. Resident 118 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 118's H&P examination dated 1/4/26, showed Resident 118 had the capacity to understand and make medical decisions. Review of Resident 118's Advance Directive Acknowledgement dated 1/4/26, showed Resident 118 have not executed an advanced directive, and was provided information on right to formulate an advance directive. However, the document did not show if assistance in formulating an advance directive was offered or whether Resident 118 accepted or declined the assistance. Further review of Resident 118's medical record did not show documentation that assistance in formulating an advance directive was offered to Resident 118. On 5/6/26 at 1450 hours, an interview and concurrent medical record review for Residents 10, 89, and 118 was conducted with the Activity Assistant. The Activity Assistant verified the above findings and was unable to show documentation indicating assistance was offered in formulating an advance directive to Residents 10, 89 and 118, or whether the residents accepted or declined. On 5/8/26 at 1347 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 4. Medical record review for Resident 93 was initiated on 5/5/26. Resident 96 was admitted to the facility on [DATE]. Review of Resident 93's POLST dated 4/2/26, under Section D, showed Resident 93 had no advance directive. Review of Resident 93's Social Service assessment dated [DATE], under Advance Directives section, showed provided reading materials. However, there was no evidence of follow-up with the resident's representative regarding completion or status of the advance directive. Further review of Resident 93's medical record failed to show documented evidence of the discussions regarding the resident's wishes, and follow-up attempts by the facility staff to determine whether Resident 93 had an existing advance directive, wished to complete or decline to formulate an advance directive. On 5/7/26 at 1042 hours, an interview and concurrent medical record review for Resident 93 was conducted with the Social Services Assistant. The Social Services Assistant stated Resident 93 was confused so she discussed the advance directive with the resident's representative and provided the (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	representative with advance directive information. The Social Services Assistant was unable to provide documentation showing a follow-up regarding the status or completions of the advance directive. On 5/8/26 at 0836 hours, an interview for Resident 93 was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to meet the resident care needs for four of 20 final sampled residents (Residents 4, 83, 123, and 147). * The facility failed to routinely monitor Resident 4 for bleeding and urinary changes per the resident's care plan and clinical history. * The facility failed to rotate the insulin injection sites for Resident 83. In addition, the facility failed to follow the physician's order for hydralazine (a medication used to treat high blood pressure). * The facility failed to consistently complete the Change of Condition assessment for Resident 123 despite having multiple episodes of refusing blood sugar checks. * The facility failed to notify the physician when Resident 147 had episodes of seizures. In addition, the facility failed to follow the physician's order for amiodarone hydrochloride (medication used to treat life-threatening heart rhythm problems) and midodrine hydrochloride (used to treat symptomatic orthostatic hypotension (sudden blood pressure drop upon standing) medications for Resident 147. These failures had the potential for avoidable complications, delayed interventions, worsening health conditions, and overall compromised residents' wellˆbeing.Findings: 1. Medical record review for Resident 83 was initiated on 5/5/26. Resident 83 was admitted to the facility on [DATE], and was readmitted on [DATE]. Review of Resident 83's MDS assessment dated [DATE], showed Resident 83 had a BIMS score of 14, indicating intact cognition. a. Review of Resident 83's Order Summary Report dated 5/6/26, showed a physician's order, to administer insulin lispro (a rapid-acting, insulin designed to manage high blood sugar), inject as per sliding scale (amount of insulin to be administered based on the blood sugar results) subcutaneously before meals and at bedtime and to rotate injection sites. Review of Resident 49's Location of Administration Report for April 2026 showed the insulin lispro was administered consecutively on the same injection sites on the following dates and times: - on 4/26/26 at 1630 hours, lispro insulin was administered to the LLQ of the abdomen; - on 4/26/26 at 2100 hours, lispro insulin was administered to the LLQ of the abdomen; - on 4/27/26 at 1617 hours, lispro insulin was administered to the LLQ of the abdomen; - on 4/27/26 at 2040 hours, lispro insulin was administered to the LLQ of the abdomen; - on 4/28/26 at 1653 hours, lispro insulin was administered to the LLQ of the abdomen; - on 4/28/26 at 2055 hours, lispro insulin was administered to the LLQ of the abdomen; - on 4/30/26 at 16:01 hours, lispro insulin was administered to the LLQ of the abdomen; and - on 4/30/26 at 2043 hours, lispro insulin was administered to the LLQ of the abdomen. On 5/6/26 at 1239 hours, an interview and concurrent medical record review for Resident 83 was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	conducted with LVN 4. LVN 4 verified the above findings and stated the insulin injection site should be rotated with each insulin administration. On 5/8/26 at 1012 hours, an interview was conducted with the DON. The DON stated the expectation from the licensed nurses was to rotate the insulin injection sites. The DON was informed and acknowledged the above findings. b. Review of Resident 83's Order Summary Report dated 5/6/26, showed a physician's order to administer hydralazine hydrochloride 25 mg tablet by mouth every six hours as needed for hypertension (high blood pressure), if SBP was greater than 160 mmHg. Review of Resident 83's MAR for 4/1 to 4/30/26, showed hydralazine hydrochloride 25 mg tablet was administered to the resident when the SBP was lower than 160 mmHg on the following dates and times: - on 4/17/26 at 0000 hours, the BP reading was 130/75 mmHg; - on 4/17/26 at 0600 hours, the BP reading was 126/74 mmHg; - on 4/17/26 at 1200 hours, the BP reading was 138/84 mmHg; - on 4/17/26 at 1800 hours, the BP reading was 137/62 mmHg; and - on 4/17/26 at 1200 hours, the BP reading was 142/74 mmHg. On 5/6/26 at 1243 hours, an interview and concurrent medical record review for Resident 83 was conducted with LVN 4. LVN 4 verified the above findings and stated the hydralazine hydrochloride 25 mg tablet should not have been administered to the resident with the SBP reading below 160 mmHg as ordered by the physician. On 5/8/26 at 1010 hours, an interview was conducted with the DON. The DON stated the expectation from the licensed nurses was to administer the medication as ordered by the physician. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 147 was initiated on 5/5/26. Resident 147 was admitted to the facility on [DATE], and was readmitted on [DATE]. Review of Resident 147's H&P examination dated 3/10/26, showed Resident 147 had the capacity to understand and make decisions. Review of Resident 147's MDS assessment dated [DATE], showed Resident 147 had a BIMS score of 12, indicating moderate cognitive impairment. a. Review of Resident 147's Order Summary showed the following physician's order: - dated 3/6/26, to monitor for seizure activity every shift and notify physician if noted; and - dated 3/21/26, to administer lorazepam 1 mg tablet by mouth every six hours as needed for seizures. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 147's MAR for 3/1-3/31/26, showed Resident 147 was administered lorazepam 1 mg tablet by mouth on 3/21/26 at 1800 hours and on 3/31/26 at 1505 hours. Further review of the MAR showed Y (yes) was documented for seizure activity on 3/13/26 and 3/31/26 during the evening shift. However, further review of Resident 147's medical record failed to show the resident's physician was notified for the seizure episodes on 3/13 and 3/31/26 during the evening shift and when the resident was administered lorazepam on 3/21 at 1800 hours and on 3/31/26 at 1505 hours. On 5/7/26 at 1146 hours, an interview and concurrent medical record review for Resident 147 was conducted with LVN 3. LVN 3 verified resident MAR for 3/1-3/31/26 showed the resident was administered lorazepam on 3/21 at 1800 hours and on 3/31/26 at 1505 hours, as ordered for seizures and the monitoring for seizure activity every shift was marked Y, indicating the resident had seizures on 3/13 and 3/31/26, during the evening shift. On 5/8/26 at 0836 hours, an interview and concurrent medical record review for Resident 147 was conducted with LVN 2. LVN 2 verified the resident's medical record failed to show the resident was assessed before, during and after the seizure activity, and the physician was not notified of the seizure activities on the above dates and times. LVN 2 stated the resident should have been monitored for at least seventy-two hours for the change of condition and the physician should have been informed of the resident's condition, and duration of the seizure activity. On 5/8/26 at 1010 hours, an interview was conducted with the DON. The DON stated a seizure activity was a change of condition. The DON further stated the expectation from the licensed nurses was to inform the physician for any change of condition and monitor the resident's condition. The DON was informed and acknowledged the above findings. b. Review of Resident 147's Order Summary dated 5/8/26 showed a physician's order dated 3/6/26, to administer amiodarone hydrochloride 200 mg tablet by mouth two times a day, hold if heart rate was less than 60 beats per minute. Review of Resident 147's MAR for 3/1-3/31/26, showed Resident 147 was administered amiodarone hydrochloride 200 mg tablet on 3/8/26 at 0900 hours, when the pulse rate was 57 beats per minute. On 5/7/26 at 1146 hours, an interview and concurrent medical record review for Resident 147 was conducted with LVN 5. LVN 5 verified the above findings. LVN 5 stated the amiodarone hydrochloride 200 mg tablet should not have been administered since it would further lower the resident's pulse. c. Review of Resident 147's Order Summary dated 5/8/26 showed a physician's order dated 3/6/26, to administer midodrine hydrochloride 10 mg tablet by mouth one time a day, hold if SBP was greater than 130 mmHg. Review of Resident 147's MAR for 5/1- 5/31/26, showed Resident 147 was administered midodrine hydrochloride 10 mg on: - 5/1/26 at 0900 hours, with a BP reading of 132/70 mmHg; and - 5/5/26 at 0900 hours, with a BP ready of 131/77 mmHg. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/6/26 at 0810 hours, an interview was conducted with Resident 147 in his room. Resident 147 stated he got dizzy at times from taking his medications. Resident 147 further stated he did not know what medications he was taking. On 5/7/26 at 1142 hours, an interview and concurrent medical record review for Resident 147 was conducted with LVN 5. LVN 5 verified the above findings. LVN 5 stated the midodrine hydrochloride 10 mg tablet should not have been administered when the resident's SBP was higher than 130 mmHg as ordered by the physician. On 5/8/26 at 1017 hours, an interview was conducted with the DON. The DON stated the expectation from the licensed nurses was to read and follow the physician's order. The DON was informed and acknowledged the above findings. 3. Medical record review for Resident 4 was initiated on 5/5/26. Resident 4 was readmitted to the facility on [DATE]. Review of Resident 4's Order Summary Report showed the following physician's orders:- dated 2/28/26, to administer aspirin (used to treat mild pain, reduce fever, and lower inflammation)81 mg by mouth daily; and - dated 5/2/26, to monitor the resident every shift for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/or change in vital signs, shortness of breath, and nose bleeds for aspirin use. Notify the physician if noted. Review of Resident 4's Care Plan Report showed a care plan problem initiated on 12/4/25, addressing the resident's alteration in bowel and bladder related to use of an indwelling urinary catheter and frequent bowel incontinence. The interventions included to monitor and report signs and symptoms of a UTI (hematuria, sedimentation, dysuria, flank pain, etc.) Review of Resident 4's Care Plan Report showed a care plan problem initiated on 1/23/26, addressing the resident 's risk for bleeding, bruising and discoloration due to aspirin use. The interventions included to monitor, document, and report blood tinged or red blood in the urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy , bruising , blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. a. Review of Resident 4's Alert Note by LVN 8 dated 2/10/26 at 0940 hours, showed the resident was observed pulling on his urinary catheter with blood noted. LVN 7 was notified. LVN 8 documented upon assessment, no bleeding was noted and the urinary catheter was patent and draining. Review of Resident 4's SBAR Communication Form (General) dated 2/10/26 at 1344 hours, showed the resident's abdomen was visibly distended and firm on palpation, and the resident had no urine output in the Foley catheter since 0700 hours. The physician was notified and the resident was transferred to the acute care hospital. On 5/8/26 at 0927 hours, an interview and concurrent medical record review was conducted with the ADON and LVN 8. LVN 8 stated she wrote the Alert Note on 2/10/26, and explained an Alert Note was triggered by the CNA. LVN 8 stated on 2/10/26, she worked as the QA nurse and saw an alert from a CNA that Resident 4 was pulling on his catheter and blood was observed. LVN 8 stated then assessed the resident and added her note with the CNA's Alert Note. The ADON reviewed the resident's medical (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	record and staffing assignment for 2/9/26, and stated LVN 7 worked 2/9/26 from 1500 – 2300 hours. The ADON verified there was no documentation to show the resident was assessed by the nursing staff on 2/9/26 for either the 1500 - 2300, or the 2300 - 0700 hours shifts, before LVN 8 saw the Alert Note and assessed the resident on 2/10/26 at 0940 hours. The ADON stated LVN 7 should have assessed Resident 4 after the CNA reported bleeding, and documented his assessment to show the CNA's findings were followed-up on. b. Review of Resident 4's SBAR Communication Form (General) dated 2/17/26 at 0200 hours, showed earlier in the evening the resident was noted to have blood-tinged urine. At approximately 0200 hours, the resident was noted to have thick, dark, bright blood throughout the urinary catheter tubing. The licensed nurse left the resident's bedside and returned to change the catheter tubing with the plan to monitor the bleeding through the remainder of the shift, however, upon returning, the resident was unresponsive with abnormal vital signs. The physician was notified and 911 was called at approximately 0240 hours. Further review of Resident 4's medical record failed to show when the initial blood-tinged urine was observed by facility staff earlier in the evening. On 5/8/26 at 0927 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON verified Resident 4's SBAR Communication From (General) dated 2/17/26 at 0200 hours, showed bleeding was noted earlier in the evening. The ADON stated the resident's medical record failed to show when the bleeding was initially identified, and reported on. In addition, the ADON stated per the resident's care plan and with his history of blood in the urine, the facility staff should have monitored and documented for bleeding, including blood in the urine, and any urinary changes per the care plan, prior to the physician's order on 5/2/26. c. Review of Resident 4's medical record failed to show the nursing staff routinely monitored, documented, and reported blood-tinged or red blood in the urine per the care plan interventions dated 1/3/26, and for sign and symptoms of a UTI (blood in the urine, sedimentation, dysuria, flank pain, etc.) per the care plan interventions dated 12/2/25. On 5/8/26 at 0927 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON verified there was no documentation to show the facility staff routinely monitored and documented the resident for bleeding and urinary changes every shift prior to 5/2/26. Cross reference F580. 4. On 5/5/26 at 0935 hours, an interview was conducted with Resident 123. During the interview, Resident 123 verbalized she was not diabetic. Medical record review for Resident 123 was initiated on 5/5/26. Resident 123 was readmitted to the facility on [DATE]. Review of the facility's matrix (undated) showed Resident 123 was on insulin. Review of Resident 123's quarterly MDS assessment dated [DATE], showed Resident 123 had no cognitive impairment. Review of Resident 123's physician progress note dated 4/30/26, did not address the resident's (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	refusal of insulin administration. Review of Resident 123's MAR for May 2026 showed Resident 123 was to be administered Humulin R (insulin) 100 units/ml per sliding scale. Resident 123's physician was to be notified if Resident 123's blood sugar results were greater than 400 or less than 70 mg/dl as needed. Further review of these MAR showed Resident 123 had multiple episodes of refusing her insulin. On 5/7/26 at 1126 hours, an interview and concurrent medical record review was conducted with LVN 6. LVN 6 verified the above findings. LVN 6 verbalized Resident 123 had multiple episodes of refusing blood sugar checks. LVN 6 further stated Resident 123 refused to have her blood sugar checks, including on 5/7/26. When asked what the facility's policy was when Resident 123 refused blood sugar checks in coordination with insulin administration, LVN 6 verbalized when a resident refused their blood sugar checks for more than three days, a change in condition assessment and documentation had to be completed. LVN 6 acknowledged a current change of condition should have been completed to notify Resident 123's physician about the resident's repeated refusals of blood sugar checks.

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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, medical record review, and facility P&P review, the facility failed to ensure five of nine final sampled residents (Resident 8, 19, 93, 118, and 143) reviewed for accidents remained free from accident hazards. * The facility failed to provide Resident 93 with a WanderGuard (type of wander management system) and failed to monitor the functionality of the WanderGuard as per the physician's order. In addition, the facility failed to ensure Resident 93's elopement assessment was accurate and failed to provide the receptionist an updated list of the residents at risk for elopement. * The facility failed to consistently monitor Resident 8 and 19's bed and chair alarms as per the physician's order. * The facility failed to monitor the presence and safety of an unleashed pet dog within the facility while the animal's owner was hospitalized , during which the dog was being cared for by Resident 118. * The facility failed to complete post-fall Fall Risk Assessments for Resident 143 when assessments dated 4/9 and 4/20/26 were blank. These failures increased the risk of the residents ambulating or transferring without staff awareness or assistance, increased likelihood of avoidable falls, inability to identify individualized fall risk factors due to incomplete assessments. In addition, this failure to implement timely interventions to prevent accidents, and exposure to an unleashed animal could result in bites, tripping hazards, or infection control concerns for the residents, staff, and visitors.Findings: 1. Review of the facility's P&P titled Wandering and Elopements dated 2001showed the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintain the least restrictive environment for residents. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. On 5/5/26 at 0613 hours, Resident 93 was observed getting out of bed, with incontinent her brief pulled down her knees. Resident 93 then entered another resident's room before being redirected back to bed by a staff. On 5/5/26 at 0641 hours, Resident 93 was observed getting out of bed, with incontinent brief pulled down to her knees. A staff member was observed assisting Resident 93 back to bed. Medical record review for Resident 93 was initiated on 5/5/26. Resident 93 was admitted to the facility on [DATE]. a. Review of Resident 93's Elopement Risk Assessment – V2 dated 4/3/26, showed Resident 93 was independently mobile, with a diagnosis of dementia, Alzheimer's, and sundowning syndrome, with observed wandering and exit-seeking behaviors. The assessment also showed Resident 93 had no history of elopement, wandering or getting lost, and was readily accepting home placement. The assessment scored the resident as a five, below the threshold of six indicating high risk for elopement. However, review of Resident 93's plan of care showed a care plan problem dated 4/3/26, identifying Resident 93's as an elopement risk and wanderer related to history of attempting to leave the facility unattended. Review of Resident 93' Order Summary Report showed the following physician's orders: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated 4/3/26, to monitor the resident for episodes of wandering, pacing or exit seeking behavior every shift; - dated 4/3/26, to check for WanderGuard function daily during the 0700 to 1500 hours shift. Document if working – Y for yes, and N for no; - dated 4/3/26, to check for WanderGuard placement every shift; and - dated 4/23/26, may have Wander Guard serial #051325900000139J (right arm) to alert the staff of resident trying to leave the facility unassisted b. Review of Resident 93's MARs for April and May 2026 showed the following: - Resident 93 was observed with episodes of wandering, pacing or exit seeking behavior on 4/10, 4/18, 5/3, 5/4, 5/5 and 5/6/26 on the day shift, on 4/5 to 4/9, 4/12 to 4/14, 4/16, 4/19, 4/21, and 4/24/26 on the evening shift, and on 4/11, 4/17, 4/22, 4/23, 4/25 to 4/27, 4/29 to 5/1/26 on the day shift and evening shift; - The placement of Resident 93's WanderGuard was documented with checkmarks on 4/3/26 for the night shift, and on 4/4 to 5/5/26 for the day shift, evening shift and night shift, and on 5/6/26 on the day shift; and - The functionality of Resident 93's WanderGuard (which was to be checked on the day shift) was document with a N or not working on 4/23, 4/25, and 5/2/26. Further review of Resident 93's medical record did not show interventions or corrective actions taken when Resident 93's WanderGuard was not functioning while the resident had episodes of wandering, pacing or exit seeking behavior on 4/23, 4/25 and 5/2/26. On 5/6/26 at 1442 hours, an interview for Resident 93 was conducted with CNAs 2 and 6. CNA 2 stated Resident 93 had been walking and getting out of bed. CNAs 2 and 6 stated Resident 93 did not have a WanderGuard or bed alarm. On 5/6/26 at 1521 hours, an interview and concurrent medical record for Resident 93 was conducted with LVN 6. LVN 6 verified Resident 93 had a history of pacing and wandering behaviors. LVN 6 stated Resident 93 did not have a bed alarm but she has a WanderGuard. LVN 6 verified Resident 93's WanderGuard was documented to be not functioning, but there was no documentation to show it was replaced, and no documentation Resident 93 removed her WanderGuard. On 5/6/26 at 1524 hours, an observation for Resident 93 and concurrent interview was conducted with LVN 6. Resident 93 was observed without a WanderGuard. LVN 6 could not locate the device and acknowledged placement and function checks were not performed. c. On 5/6/26 at 1618 hours, an interview and concurrent medical record review was conducted with the Receptionist. The Receptionist stated she received updated elopement risk list from Social Services. The Receptionist showed a binder containing three discharged residents' face sheets and pictures. When asked if she had been given an updated list of the residents who were at risk for elopement, the Receptionist attempted to look for another binder and could not locate the binder with an updated list. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehab Center of Tustin	2210 E. First Street Santa Ana, CA 92705

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/7/26 at 1329 hours, an interview and concurrent medical record review for Resident 93 was conducted with the ADON. The ADON stated Resident 93 had a history of wandering and that was the reason she had a WanderGuard. The ADON verified Resident 93's care plan showed she had a history of attempting to leave the facility, and the interventions included providing a WanderGiard to the resident. The ADON verified Resident 93's Elopement Risk Assessment showed Resident 93 did not have a history of elopement, wandering, or getting lost. The ADON stated Resident 93 had a history of elopement and wandering per her care plan. When asked about the facility's elopement protocol, the ADON stated the alarms or WanderGuard were in place to notify the staff whenever a resident who was at risk for elopement was near the exit door. The ADON also stated Social Services, the DON or ADON would provide an updated list of residents who were at risk of elopement to the receptionists, and each of the nursing stations. 2. On 5/5/26 at 0629 hours, Resident 19 was observed asleep in bed with a bed alarm device at bedside. Medical record review for Resident 19 was initiated on 5/5/26. Resident 19 was readmitted to the facility on [DATE]. Review of Resident 19' Order Summary Report showed the following physician's orders dated on: - 3/23/25, to monitor sensor alarm for function every shift. Document (+) if working, and (-) if not working; and - 5/22/25, may have bed and wheelchair sensor alarms to alert the staff when the resident is trying to get up unassisted every shift. Review of Resident 19's plan of care showed the following care plan problems dated: - 5/22/25, to address Resident 19's bed and wheelchair sensor alarms to alert the staff when the resident is trying to get up unassisted every shift; - 4/1/26, to address Resident 19 requiring sensor alarms in bed or wheelchair; and - 4/26/26, to address Resident 19's high risk of further falls. Review of Resident 19's MARs for April and May 2026 showed the following: - Resident 19's bed and chair sensor alarms to alert the staff when the resident is trying to get up unassisted were documented with checkmarks from 4/1 to 5/5/26 on the day shift, evening shift, and night shift, and on 5/6/26 on the day shift; and - The functionality of Resident 19's sensor alarms were documented with different codes. The MAR showed a documentation of 0 on 4/6 and 4/11/26 on the day shift, on 4/3, 4/24 and 5/4/26 on the evening shift, and N on 5/5/26 on the day shift. The alarms were also not working on 5/4/26 on the evening shift. Further review of Resident 19's medical record did not show interventions or corrective actions provided when Resident 19's bed and chair sensor alarms were not working. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/6/26 at 1013 hours, an interview for Resident 19 was conducted with CNA 6. CNA 6 stated Resident 19 had bed and chair sensor alarms to alert the staff if the resident tried to get out of bed or wheelchair, and the CNAs reported to the charge nurse if the alarms did not work. On 5/6/26 at 1104 hours, an interview and concurrent medical record for Resident 19 was conducted with LVN 6. LVN 6 verified Resident 19 had a physician's orders for bed and chair sensor alarms, and the functionality was to be checked by the LVN every shift. LVN 6 verified the nurses were inconsistent with the documentation of the sensor alarms functionality, which should be (+) if working, and (-) if not. LVN 6 verified Resident 19's sensor alarms were documented to be not functioning, but there was no documentation to show it was replaced or fixed. 3. On 5/5/26 at 0625 hours, Resident 8 was observed trying to get out of bed while the bed alarm was sounding, and a CNA was at bedside. Medical record review for Resident 8 was initiated on 5/5/26. Resident 8 was readmitted to the facility on [DATE]. Review of Resident 8's plan of care showed a care plan problem dated 4/2/26, addressing Resident 8's pad alarms in bed or wheelchair. Review of Resident 8' Order Summary Report showed the following physician's orders dated 4/2/26: - to have sensor alarm in bed to alert the staff when resident was trying to get up unassisted; - to have sensor alarm in wheelchair to alert the staff when resident was trying to get up unassisted; and - to monitor sensor alarms for function every shift. Document Y if working, and N if not working. Review of Resident 8's MARs for April and May 2026 showed the following: - Resident 8's sensor alarms were documented as not working on 4/2 and 4/22/26 on the night shift, on 4/3, 4/7, 4/18, 4/19, 4/20, 4/24, 4/28, 4/29, 4/30, 5/2, and 5/3/26 on the day shift, on 4/5 and 4/21/26 on the day shift and evening shift, on 4/6 and 4/23/25 on the evening shift and night shift, on 4/17/26 on all shifts, and on 5/4 and 5/5/26 on the day shift and night shift. The MAR showed no documentation on 4/20 and 4/24/26 on the evening shift, and a documentation of W on 5/2/26 on the evening shift. Further review of Resident 8's medical record did not show what interventions or corrective actions were provided when Resident 8's bed and chair sensor alarms were not working. On 5/7/26 at 1114 hours, an interview and concurrent medical record for Resident 8 was conducted with LVN 5. LVN 5verified Resident 8 had a physician's orders for bed and chair sensor alarms, and the functionality was to be checked by the LVN every shift. LVN 8 verified the nurses were inconsistent with the documentation of the sensor alarms functionality, which should be Y if working, and N if not. LVN 5 verified Resident 8's sensor alarms were documented to be not functioning, but there was no documentation to show it was replaced or fixed. On 5/8/26 at 0836 hours, an interview for Residents 8, 19, and 93 was conducted with the DON. The (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DON was informed and acknowledged the above findings. 4. Review of the facility's P&P titled Pets, Animals, and Plants undated showed that animals permitted in the facility must be monitored and managed to prevent the spread of microorganisms and infections. The P&P stated that service animals are allowed in accordance with the Americans with Disabilities Act (ADA) and applicable laws. It also stated that service animals are not required to have documentation or certification, and staff may not request such documentation. Staff may only ask the handler what tasks the service animal performs. Further review of the P&P did not provide guidance on who is responsible for caring for a pet, what actions should be taken if the pet's owner is hospitalized , or whether residents must be assessed to determine if they can safely care for and control the pet at all times. On 5/5/26 at 0633 hours, a Beagle/[NAME] mix dog was observed walking unleashed inside Resident 118's room. On 5/5/26 at 1147 hours, an observation and concurrent interview was conducted with Resident 118. Resident 118 was observed lying in bed receiving oxygen via nasal cannula. The dog was observed walking around the room unleashed. Resident 118 stated she was not the owner of the dog and was helping take care of her roommate's service dog while the roommate was hospitalized . Resident 118 stated staff assisted her in taking the dog outside for urination and defecation and reported the dog had never urinated or defecated inside the room. On 5/5/26 at 1357 hours, an interview was conducted with CNA 8. CNA 8 stated the dog belonged to the hospitalized roommate of Resident 118. CNA 8 stated the dog was usually unleashed inside the room and taken outside with a leash for urination and defecation. CNA 8 stated she assisted Resident 118 when she was able, while the dog's owner remained hospitalized . On 5/6/26 at 0758 hours, an observation and concurrent interview were conducted with the IP. The dog was observed walking unleashed in the hallway outside of Resident 118's room. The IP verified the observation and stated the dog stayed in or just outside the room of Resident 118. On 5/6/26 at 0848 hours, the dog was observed walking unleashed outside the room of Resident 118. The residents in the hallway were observed touching dog. On 5/6/26 at 0956 hours, Resident 118 was observed sitting at the side of her bed with the dog sitting on the bed next to her. Medical record review for Resident 118 was initiated on 5/5/26. Resident 118 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 118's H&P examination dated 1/4/26, showed Resident 118 had the capacity to understand and make decisions. Review of Resident 118's MDS assessment dated [DATE], showed Resident 118 was cognitively intact. Resident 118 had impairment on one side of the upper extremity, and used a manual wheelchair. Review of Resident 118's care plan dated 2/3/26, included a problem statement acknowledging the resident shared a room with a roommate who had an approved pet dog. The interventions included (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ensuring the dog was supervised and that facility policy was followed. The care plan did not address who was responsible for caring for the dog, whether the dog should be leashed, or whether Resident 118 was able to safely manage and control the dog at all times. Further review of Resident 118's medical record did not show documentation of the resident's ability to care for or control the pet. On 5/6/26 at 1005 hours, an interview and concurrent medical record review for Resident 118 was conducted with LVN 4. LVN 4 was informed the dog had been observed multiple times leaving the room and walking into the hallway. LVN 4 stated the dog belonged to Resident 118's roommate, who was hospitalized at the time. LVN 4 verified there was no documentation indicating whether Resident 118 was able to safely care for the dog or maintain control of the animal at all times. LVN 4 further stated Resident 118 was receiving continuous oxygen and required a wheelchair and portable oxygen for ambulation and therefore would not be able to promptly get out of bed or safely manage the pet when needed. LVN 4 stated that allowing the dog to roam the hallway posed several risks, including potential for resident injury from bites or tripping hazards. LVN 4 also explained that a dog walking on the floor and getting onto the residents' beds could create infection control concerns for the residents, staff, and visitors. On 5/8/26 at 1049 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 5. Medical record review for Resident 143 was initiated on 5/5/26. Resident 143 was admitted to the facility on [DATE]. a. Review of Resident 143's SBAR Communication Form (General) dated 4/9/26, showed the resident had an unwitnessed fall and was found lying on the floor next to his bed. Review of Resident 143's Fall Risk Assessment-V2 dated 4/9/26, showed the form was used to determine the resident's fall risk (either low, moderate, or high risk) based on his current status. All nine sections of the form were blank. b. Review of Resident 143's SBAR Communication Form (General) dated 4/20/26, showed the resident had an unwitnessed fall and was found lying on the floor. Review of Resident 143's Fall Risk Assessment-V2 dated 4/20/26, showed all the sections were blank. On 5/7/26 at 1014 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated fall risk assessments were completed routinely, and after each fall, to determine the residents' risk for future falls. The DON reviewed Resident 143's Fall Risk Assessment-V2 forms dated 4/9 and 4/20/26, and verified both forms were incomplete.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, medical record review, and facility P&P review, the facility failed to ensure the respiratory care and services were provided in accordance with professional standards for two of two final sampled residents (Residents 83 and 118) reviewed for respiratory care. * The facility failed to ensure Resident 83's nasal cannula (flexible tube to deliver oxygen into the nose) was labeled and stored in a bag when not in use. In addition, the facility failed to provide oxygen as ordered by the physician. * The facility failed to ensure Resident 118's nebulizer mask, canister, and tubing were labeled and stored in a setup bag. These failures had the potential to result in inadequate respiratory care and increased infection control risks for the residents.Findings: 1. On 5/5/26 at 0633 hours, Resident 118 was observed lying in bed receiving oxygen at 2 LPM via nasal cannula. A nebulizer mask with canister and tubing was observed on top of the bedside drawer. The nebulizer equipment was not stored in a setup bag and not labeled. The plastic setup bag observed hanging on the bedside drawer was dated 4/13/26. On 5/5/26 at 0637 hours, the RN Consultant was called to the room. The RN Consultant verified the above observations and stated that the nebulizer equipment was not labeled or stored in the setup bag. The RN Consultant stated the nebulizer equipment should have been labeled and stored in a setup bag. Medical record review for Resident 118 was initiated on 5/5/26. Resident 118 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 118's Order Summary Report showed a physician's order dated 4/4/26, to administer ipratropiumˆalbuterol (used to control and prevent breathing difficulties) solution 0.5ˆ2.5 (3 mg per 3 ml) via inhalation every six hours for shortness of breath. On 5/8/26 at 1049 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated the nebulizer equipment should be changed every week and Resident 118's nebulizer equipment should have been dated and changed weekly. 2. Review of the facility's P&P titled Oxygen Administration dated 2001 showed to verify physician's order for administration of oxygen. Review the physician's order. Medical record review for Resident 83 was initiated on 5/5/26. Resident 83 was admitted to the facility on [DATE], and was readmitted on [DATE]. Review of Resident 83's MDS assessment dated [DATE], showed Resident 83 had a BIMS score of 14, indicating intact cognition. a. On 5/5/26 at 0705 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 83 in the resident's room. Resident 83 was observed in the bed with oxygen set at 1.5 LPM via nasal cannula. Resident 83 stated she was supposedly receiving oxygen at 2 LPM. A wheelchair was observed with a portable oxygen tank with an unlabeled nasal cannula exposed to air and not stored in a bag. There was no bag observed on the wheelchair to store the nasal cannula. Resident 83 stated she used the oxygen when she got up on the wheelchair during the day and did not know when the nasal cannula on the wheelchair was last changed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Review of Resident 83's Order Summary Report showed a physician's order dated 4/16/26, for continuous oxygen at 2 LPM via nasal cannula. On 5/5/26 at 0715 hours, an observation and concurrent interview for Resident 83 was conducted with the DSD. The DSD verified the nasal cannula was not labeled and stored in a bag when not in use and stated it should have been. In addition, the DSD verified the resident was receiving oxygen at 1.5 LPM via nasal cannula. The DSD stated he would check the physician's order. On 5/5/26 at 1112 hours, an interview and concurrent medical record review for Resident 83 was conducted with RN 1. RN 1 verified the resident had a physician's order to administer continuous oxygen at 2 LPM via nasal cannula. On 5/8/26 at 1019 hours, an interview was conducted with the DON. The DON stated the licensed nurses are expected to change and label the nasal cannulas weekly and administer oxygen as ordered by the physician. The DON further stated the nasal cannula should be stored in a labeled bag when not in use. The DON was informed and acknowledged the above findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility P&P review, the facility failed to ensure safe medication storage in two of three medication carts (Medication Carts A and B) inspected. * The facility failed to ensure an expired glucagon emergency kit (containing one vial glucagon for injection: 1 mg glucagon and 49 mg of lactose (natural sugar), one syringe of diluent for glucagon: 12 mg/ml glycerin, water for injection, and hydrochloric acid) was not stored in Medication Cart A * The facility failed to ensure internal and external medications were stored separately. A Tear Plus (eye lubricant) eye drop medication and a bottle of Tylenol (analgesic) were stored together in Medication Cart A. * The facility failed to ensure the medication label on the bubble pack of the gabapentin (nerve pain medication) was accurate and reflected the physician's order. * The facility failed to ensure internal and external medications were not stored separately in Medication Cart B. These failures had the potential for the residents to be exposed to the expired medications and had the potential to lead to medication errors and place residents at risk of receiving the wrong type of medication.Findings: Review of the facility's P&P titled Medication Storage in the Facility revised 1/2025 showed the medications, biologicals are stored safely, securely, and properly, following manufacturer's recommendation or those of the supplier. Orally administered medications are kept separate from externally used medications, such as suppositories, liquids, and lotions. Further review of the P&P showed outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, and disposed of according to procedures for medication disposal. 1. On 5/6/26 at 1059 hours, during inspection of Medication Cart A with LVN 4, the following was observed: a. A small red box of glucagon emergency kit (an emergency medication used to treat severe, life-threatening low blood sugar (hypoglycemia) in diabetes patients who have passed out or are unable to swallow sugar) was observed opened in the top drawer with the expiration date of 2/2026. LVN 4 verified the glucagon emergency kit was expired and should not have been stored in the medication cart. LVN 4 stated the glucagon emergency kit should have been disposed of and LVN 4 was observed removing the glucagon kit from the medication cart for the disposal. b. A bottle of Tylenol (analgesic) and a Tear Plus eye drop (lubricating artificial tears) were observed stored together in the top drawer. LVN 4 verified the observation and stated the eye drops and the oral Tylenol should not have been stored together. LVN 4 was observed separating the medications. On 5/8/26 at 1049 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. Cross reference to F755 example #2. 2. On 5/6/26 at 0826 hours, a medication administration observation for Resident 99 was conducted with LVN 4. LVN 4 prepared the medications for Resident 99 including two capsules of the gabapentin 100 mg medication. The label on the bubble pack of the gabapentin medication did not include the required hold parameter. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident 99 was initiated on 5/5/26. Resident 99 was readmitted to the facility on [DATE]. Review of Resident 99's Order Summary Report showed a physician's order dated 5/5/26, to administer gabapentin 100 mg two capsules by mouth two times a day. Hold for respiratory rate less than 12 breaths per minute. On 5/6/26 at 0857 hours, an interview and concurrent medical record review for Resident 99 was conducted with LVN 4. LVN 4 verified the bubble pack label for the gabapentin medication did not match the physician's order. LVN 4 also verified there was no change of direction sticker applied on the bubble pack. 3. On 5/6/26 at 1448 hours, an inspection of Medication Cart B was conducted with LVN 6. The following medications were observed stored in the same compartment with bottles of internally used medications such as Milk of Magnesia (laxative), Pro-Stat (protein supplement) and Geri-Lanta (antacid): - two bottles of Deep Sea Premium Saline (moisturizing spray) nasal sprays; - a box of Dulera (used to treat persistent asthma by reducing airway inflammation and relaxing the lung muscles) 200 mcg/5 ml inhalation aerosol solution; - a box of oxymetazoline 0.05% nasal spray (a topical nasal decongestant); - a box of ipratropium bromide – albuterol sulfate 0.5 mg/3 mg (bronchodilator), - a box of fluticasone-salmeterol 250mcg/50 mcg (inhaled corticosteroid and long-acting beta2-agonist). LVN 6 verified the above findings. On 5/8/26 at 0836 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure complete and accurate medical records for four of 20 final sampled residents (Residents 7, 32, 92, and 143).* Resident 92's initial H&P examination was not completed.* Resident 143's shift pain monitoring did not match the resident's highest pain levels documented when PRN pain medications were administered.* Resident 7 and 143's post-fall neurological assessments had missing dates, and multiple illegible or overwritten time entries.* Resident 32's POLST was incomplete and did not show the resident had an advance directive, despite an advance directive being present in the medical record. These failures resulted in medical records that contained incomplete or inaccurate information, which could negatively affect continuity of care and clinical decisionˆmaking.Findings: 1. Medical record review for Resident 92 was initiated on 5/5/26. Resident 92 was admitted on [DATE]. Review of Resident 92's medical record failed to show a H&P examination was completed upon admission to the facility. On 5/5/26 at 1122 hours, an interview and concurrent medical record review was conducted with RN 1 and the MRD. RN 1 reviewed Resident 92's medical record and verified a H&P examination was missing. The MRD also reviewed the resident's medical record and stated the H&P could not be located but stated should have been completed. 2. Medical record review for Resident 143 was initiated on 5/5/26. Resident 143 was admitted to the facility on [DATE]. a. Review of Resident 143's MAR for April 2026 showed the acetaminophen (a pain medication) 650 mg medication was administered for mild pain (for a pain level of 1-3 out of 10; with zero being no pain and 10 being the highest pain) on the following times: - On 4/6/26 at 1518 hours, for a pain level of 3;- On 4/9/26 at 0233 hours, for a pain level of 3; and- On 4/10/26 at 1739 hours, for a pain level of 2. Review of Resident 143's MAR for April 2026 showed the hydrocodone-acetaminophen (a opioid based pain medication) 10-325 mg medication was administered for moderate to severe pain (pain level of 4-10) on the following times: - On 4/9/26 at 1825 hours, for a pain level of 8;- On 4/18/26 at 1300 hours, for a pain level of 7;- On 4/22/26 at 0900 hours, for a pain level of 6;- On 4/23/26 at 1100 hours, for a pain level of 7;- On 4/24/26 at 0845 hours, for a pain level of 7;- On 4/28/26 at 0800 hours, for a pain level of 8;- On 4/28/26 at 1300 hours, for a pain level of 7;- On 4/29/26 at 1000 hours, for a pain level of 8; and- On 4/30/26 at 1115 hours, for a pain level of 7. Further review of Resident 143's MAR for April 2026 showed to monitor the resident's level of pain every shift, with a 0-10 pain scale. The MAR showed the resident's pain level was zero for all the above shifts when acetaminophen and hydrocodone-acetaminophen were administered. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Review of Resident 143's MAR for MAY 2026 showed the hydrocodone-acetaminophen 10-325 mg medication was administered for moderate to severe pain (pain level of 4-10) on the following times: - On 5/4/26 at 0844 hours, for a pain level of 8; and- On 5/5/26 at 1721 hours, for a pain level of 7. Further review of Resident 143's MAR for May 2026 showed to monitor the resident's level of pain every shift, with a 0-10 pain scale. The MAR showed the resident's pain level was zero for all the shifts when hydrocodone-acetaminophen was administered. On 5/7/26 at 1358 hours, an interview and concurrent medical record review was conducted with LVN 9. LVN 9 reviewed Resident 143's MARs for April and May 2026 and verified the resident's pain levels were documented as zero for the shifts listed above when the PRN pain medications were administered for pain. LVN 9 stated the highest level of pain should be documented for each shift, however, when asked why the MAR showed the shift pain levels of zero when the PRN pain medications were administered for pain levels ranging from 2 to 8, LVN 9 stated the zero meant the pain medications were effective. On 5/7/26 at 1411 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated when documenting the pain level for each shift, the licensed nurse should document the resident's highest level of pain for the shift, not the pain level after pain medication was provided. c. Review of Resident 143's post fall Neurological Assessment Flow Sheet dated 4/9/26, showed two of 20 time entries were overwritten with differing numbers, making them illegible. Review of Resident 143's post fall Neurological Assessment Flow Sheet dated 4/20/26, showed six of 20 time entries were overwritten with differing numbers, making them illegible. In addition, an entry for 4/21/26 at 0340 hours, instead of the scheduled 0040 hours. On 5/7/26 at 1508 hours, an interview and concurrent medical record review was conducted with the MRD. The MRD stated corrections must be made with a single line, labeled error, with initials. The MRD verified the staff wrote over existing entries, making them illegible, and verified the time discrepancy on 4/21/26. 3. Medical record review for Resident 7 was initiated on 5/5/26. Resident 7 was readmitted to the facility on [DATE]. Review of Resident 7's post fall Neurological Assessment Flow Sheet dated 2/25 (no year) showed two time entries were overwritten with different numbers resulting in illegible/difficult to read time entries. The dates were left blank for 19 of 20 date entries, which should have covered 2/25 through 2/27/26. In addition, the last neurological assessment due on 2/27/26 at 0015 hours, was recorded at 0815 hours a blank date. On 5/7/26 at 1508 hours, an interview and concurrent medical record review was conducted with the MRD. The MRD verified the dates were missing, entries were overwritten, and the final assessment time was incorrect. 4. Medical record review for Resident 32 was initiated on 5/5/26. Resident 32 was admitted to the facility on [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 32's H&P examination dated 11/15/25, showed Resident 32 had the capacity to understand and make decisions. Review of Resident 32's Advance Health Care Directive Form dated 7/2/18, showed the advance directive was formulated on 7/2/18. However, review of Resident 32's POLST dated 11/14/25, did not show if Resident 32 had an advance directive. On 5/7/26 at 1051 hours, an interview and concurrent medical record review for Resident 32 was conducted with the ADON. The ADON verified the above findings and stated the advance directive was available in Resident 32's medical record, the POLST should have been completed to indicate the resident had an advance directive. The ADON explained an inaccurate POLST documentation could delay or negatively impact emergency care decisions. On 5/8/26 at 1049 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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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, medical record review, facility document review, and facility P&P review, the facility failed to ensure the Infection Control Prevention and Control Program was established, maintained, and implemented according to accepted standards of practice to prevent the development and transmission of communicable diseases and infections. * The facility failed to maintain an accurate infection control surveillance program for November 2025 through March 2026. The facility conducted surveillance only on the residents who exhibited signs and symptoms of infection and were prescribed antimicrobial medications. In addition, the facility failed to ensure the Infection Prevention and Control Surveillance Log, the Infection Control Monthly/Quarterly Summary Reports, and the facility's infection floor mapping for November and December 2025, and January and February 2026, contained consistent and accurate data. * The facility failed to ensure a clean personal laundry cart was covered and secured when left unattended in a resident hallway. These failures posed the risk for not identifying resident infections, preventing resident infections, and controlling the potential transmission of communicable diseases to other residents, staff, and visitors throughout the facility.Findings: Review of the facility's P&P titled Surveillance for Infection dated 2001 showed the following: Infection Control Surveillance Process will include as a minimum outcome surveillance: collection of sign and symptom data as well as laboratory data and comparing to standard written definitions (criteria) of infections, review data to detect clusters and trends review antibiotic orders and laboratory antibiograms, review newly admitted residents, tracking prevalence of infections monthly and reporting communicable disease according to the local State and Federal requirements. Loeb and Stone's or McGeers guidelines will be utilized to define infection surveillance activities. Documentation tools for the surveillance program include Infection control surveillance log, Infection control worksheet (surveillance data sheet or Infection SBAR), nurses' notes or other related documentation, total days of antibiotic treatment or other therapy, results of the surveillance program will be reported at the monthly Infection Control Committee and at the Quarterly Quality Assurance meeting. The Infection Preventionist will report at a minimum the rate of HAI (Healthcare Associated Infections), CAI (Community Associated Infection), the results of the walking rounds and compliance with infection control policies and practices, the results of data collection, patterns and trends identified. 1. a. Review of the facility's Infection Surveillance Reports for February through April 2026 showed the infection control surveillance was only conducted for the residents who were prescribed with antibiotics. There was no documented evidence of residents who exhibited signs and symptoms of infection who met the facility's criteria for a true infection (McGeer's criteria) but were not prescribed antimicrobial medications. On 5/6/26 at 1425 hours, an interview and concurrent facility document review was conducted with the IP. The IP was asked the process of how the Infection Surveillance was completed, the IP stated the residents with signs and symptoms of infection and were prescribed antibiotics were included in the Infection Surveillance list. The IP further stated the residents with signs and symptoms of infection and were not prescribed with antibiotics, were not included in the Infection Surveillance list. Further review of the facility's Infection Surveillance Report from November 2025 through April 2026 showed the facility failed to conduct comprehensive surveillance for all the residents, specifically the residents who had signs and symptoms of infection and were not prescribed antibiotic. When asked (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	how the residents with signs and symptoms of infection and were not prescribed antibiotic were monitored, the IP stated the resident monitoring would be on the progress notes. The IP was further asked, if these residents' infection symptoms recur, if she would remember if these residents had prior infection symptoms when they were not included in the Infection Surveillance Report, the IP responded she would not know. b. Review of the facility's Infection Prevention and Control Surveillance Log for: - November 2025 showed: HAI – 6 infections and CAI – 21 infections. - December 2025 showed: HAI – 10 infections and CAI – 19 infections. - January 2026 showed: HAI – 20 infections and CAI – 17 infections. - February 2026 showed: HAI – 19 infections and CAI – 8 infections. Review of the facility's Infection Control Monthly/ Quarterly Summary Report for: - November 2025 showed: HAI – 12 infections and CAI – 18 infections. - December 2025 showed: HAI – 10 infections and CAI – 19 infections. - January 2026 showed: HAI – 17 infections and CAI – 19 infections. - February 2026 showed: HAI – 19 infections and CAI – 8 infections. Review of the facility's infection floor mapping showed the following: - November 2025, total of 27 infections marked; - December 2025, total of 22 infections marked; - January 2026, total of 27 infections marked; and - February 2026, total of 22 infections marked. On 5/8/25 at 0803 hours, an interview and concurrent facility document review was conducted with the IP. The IP verified the data listed in the Infection Prevention and Control Surveillance Log; Infection Control Monthly/ Quarterly Summary Report and the infection floor mapping were inaccurate. The IP stated the previous IP who completed the above was not employed at the facility anymore. On 5/8/26 at 1030 hours, an interview was conducted with the DON. The DON stated a new IP had been hired. The DON was informed and acknowledged the above findings. 2. Review of the facility's P&P titled Laundry and Linen revised 1/2014 showed the clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination, such as covering clean linen carts. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident 92 was initiated on 5/8/26. Resident 92 was admitted to the facility on [DATE]. On 5/7/26 at 1536 hours, an observation of the resident's clean personal clothing cart was conducted. The clean personal clothing cart's cover was observed to be left open, and unattended while the EVS Manager delivered clothing to a resident's room. Resident 92 was observed approaching the open clean clothing cart and proceeded to touch the clean clothing. CNA 1 was observed approaching Resident 92 as the resident was touching the clean clothing inside the cart. CNA 1 was observed walking away from Resident 92, and Resident 92 proceeded to touch more of the uncovered clean clothing inside the cart. On 5/7/26 at 1620 hours, an interview was conducted with CNA 1. CNA 1 was asked if she observed Resident 92 touching the uncovered clean clothing cart. CNA 1 verified she observed Resident 92 touching the clean clothing inside the cart and stated Resident 92 was looking for a blouse. CNA 1 verified Resident 92 should not have touched the clean clothing. On 5/7/26 at 1639 hours, an interview was conducted with the EVS Manager. The EVS Manager stated resident clean clothing was transported on a covered cart and verified the cart should remain closed when left unattended. The EVS Manager verified the above findings.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to implement their antibiotic stewardship program. * The facility failed to conduct an assessment for the McGeer's criteria to determine the true infection for two of 20 final sampled residents (Residents 8 and 148) and fourteen nonsampled residents (Residents 11, 27, 40, 44, 59, 85, 88, 90, 158, 159, 161, 163, 164, and 165). This failure had the potential for inaccurate identification of true infections and potentially inhibited the residents' physicians from discontinuing unnecessary antimicrobials.Findings: Review of the facility's P&P titled Antibiotic Stewardship dated 2001 showed the facility will implement an antibiotic stewardship program to promote appropriate use of antibiotics optimizing the treatment to infection, reducing the threat of antibiotic resistance, reducing adverse events associated with antibiotic use and improve outcomes for the residents. The IP will collect and analyze infection surveillance data, coordinate data collection, and monitor adherence to infection control policies and procedures. The facility has chosen to use guidelines developed by McGeer's/Loeb and Stone and include newer surveillance information by McGeers/Loeb and Stone Criteria for initiation of antibiotics. The nurse will inform the physician of this prescribing protocol. These guidelines may be utilized in the decision to initiate empiric antibiotic use, if the physician chooses to do so due to resident's clinical condition. The physician may decide to initiate antibiotics without meeting these criteria and the nurse will then document the clinical justification for the physician's decision. The SBAR will be utilized in conjunction with McGeer's/ Loeb and Stone guidelines to communicate with the physician when there is a change in condition. Antibiotic-time-out will be utilized when appropriate. The IP will track the antibiotic ordered, dose, route, and ordering physician. The IP will track whether the resident met Criteria when the antibiotic was ordered. The IP will track if cultures were ordered. The IP will track changes in antibiotic orders during therapy. The IP will track outcome of therapy. The IP will provide results of tracking antibiotic use, outcomes, and adverse events to the clinical staff. Review of the facility's Infection Control binder showed the monthly Infection Prevention and Control Surveillance Log for November 2025 through April 2026. The surveillance reports did not completely indicate whether the residents' infection met or did not meet the McGeer's Criteria. Furthermore, the Infection Screening Evaluation on the residents' medical record did not show all the criteria used to assess for McGeer's criteria to determine the true infection. a. Medical record review for Resident 90 was initiated on 5/6/26. Resident 90 was admitted to the facility on [DATE], and was readmitted on [DATE]. Review of Resident 90's H&P examination dated 3/2/26, showed Resident 90 had no capacity to understand and make decisions. Review of the facility's monthly Infection Prevention and Control Surveillance Log for November 2025 showed Resident 90 was prescribed with Ciprofloxacin (antibiotic) eye drops solution. The report showed the infection treated was HAI, and the McGeer's criteria was met. Further review of Resident 90's medical record failed to show the Infection SBAR was completed for infection analysis if McGeer's criteria was met or not met. On 5/7/26 at 0803 hours, an interview, medical record review for Resident 90, and concurrent facility document review was conducted with the IP. The IP verified the findings. b. Medical record review for Resident 40 was initiated on 5/6/26. Resident 40 was admitted to the facility on [DATE], and was readmitted on [DATE]. Review of Resident 40's H&P examination dated 3/28/26, showed Resident 40 had the capacity to understand and make decisions. Review of the facility's monthly Infection Prevention and Control Surveillance Log for November 2025 showed Resident 40 was prescribed with Nystatin (antifungal) powder. The report showed the infection treated was CAI, and the McGeer's criteria was met. Further review of Resident 40's medical record failed to show the Infection SBAR was completed for infection analysis if McGeer's criteria was met or not met. On 5/7/26 at 0813 hours, an interview, medical record review for Resident 40, and concurrent facility document review was conducted with the IP. The IP verified the findings. c. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident 44 was initiated on 5/6/26. Resident 44 was admitted to the facility on [DATE], and was readmitted on [DATE]. Review of Resident 44's H&P examination dated 10/15/25, showed Resident 44 was able to make needs known but had no capacity to make decisions. Review of the facility's monthly Infection Prevention and Control Surveillance Log for November 2025 showed Resident 44 was prescribed with Acyclovir (antiviral) tablet. The report showed the infection treated was HAI and met the McGeer's criteria. Review of the facility's monthly Infection Prevention and Control Surveillance Log for January 2026 showed Resident 44 was prescribed with erythromycin (antibiotic) tablet then was changed to azithromycin (antibiotic). The report did show the infection treated was HAI and met the McGeer's criteria. Further review of Resident 44's medical record failed to show the Infection SBAR was completed for infection analysis if McGeer's criteria was met or not met for both times the resident showed signs and symptoms of infection. On 5/7/26 at 0830 hours, an interview, medical record review for Resident 44, and concurrent facility document review was conducted with the IP. The IP verified the findings. d. Medical record review for Resident 59 was initiated on 5/5/26. Resident 59 was admitted to the facility on [DATE], and was readmitted on [DATE]. Review of Resident 59's Physician Progress Notes dated 6/6/25, showed the resident had no capacity to make decisions. Review of the facility's monthly Infection Prevention and Control Surveillance Log for December 2025 showed Resident 59 was prescribed with Cefepime (antibiotic) IV solution then was changed to doxycycline (antibiotic). The report showed the infection was HAI, however it did not indicate if the McGeer's criteria was met or not met. Further review of Resident 59's medical record failed to show the Infection SBAR was completed for infection analysis if McGeer's criteria was met or not met. On 5/7/26 at 0848 hours, an interview, medical record review for Resident 59, and concurrent facility document review was conducted with the IP. The IP verified the findings. e. Medical record review for Resident 27 was initiated on 5/5/26. Resident 27 was admitted to the facility on [DATE]. Review of Resident 27's Physician Progress Notes dated 12/4/25, showed resident had the capacity to understand and make decisions. Review of Resident 27's Infection SBAR dated 12/8/25, showed the infection analysis did not meet the McGeer's criteria. Review of the facility's monthly Infection Prevention and Control Surveillance Log for December 2025 showed Resident 27 was prescribed with Ceftriaxone (antibiotic) IV solution. The report showed the infection was CAI, however it did not indicate if the McGeer's criteria was met or not met. On 5/7/26 at 0856 hours, an interview, medical record review for Resident 27, and concurrent facility document review was conducted with the IP. The IP verified the findings. f. Closed record review for Resident 158 was initiated on 5/7/26. Resident 158 was admitted to the facility on [DATE], and was readmitted on [DATE]. Resident 158 was discharged on 1/26/26. Review of the facility's monthly Infection Prevention and Control Surveillance Log for December 2025 showed Resident 158 was prescribed with Ceftriaxone (antibiotic) IV solution and Ertapenem (antibiotic) IV solution then doxycycline (antibiotic) tablet. The report did not show the infection was CAI or HAI, and it did not indicate if the McGeer's criteria was met or not met. Further review of Resident 158's medical record failed to show the Infection SBAR was completed for infection analysis if McGeer's criteria was met or not met for the antibiotics prescribed in December 2025. Review of Resident 158's Admission/ readmission Initial assessment dated [DATE], showed the Infection SBAR section was incompletely filled out; and the signs and symptoms were not indicated in the form. Review of Resident 158's Physician Progress Notes dated 1/23/26, showed the resident had the capacity to make decisions. Review of the facility's monthly Infection Prevention and Control Surveillance Log for January 2026 showed Resident 158 was prescribed with cefpodoxime (antibiotic) tablet and meropenem (antibiotic) IV solution; the report showed the infection was HAI and had met the McGeer's criteria. On 5/7/26 at 0908 hours, an interview, medical record review for Resident 158, and concurrent facility document review was conducted with the IP. The IP verified the findings. g. Closed record review for Resident 159 was initiated on 5/7/26. Resident 159 was admitted to the facility on [DATE], and was readmitted on [DATE]. Resident was discharged on 1/5/26. Review of (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 159's Physician Progress Notes dated 11/27/25, showed the resident had the capacity to make decisions. Review of the facility's monthly Infection Prevention and Control Surveillance Log for December 2025 showed Resident 159 was prescribed with metronidazole (antibiotic) tablet. The report showed the infection HAI, however, it did not indicate if the McGeer's criteria was met or not met. Further review of Resident 159's medical record failed to show the Infection SBAR was completed for infection analysis if McGeer's criteria was met or not met. On 5/7/26 at 0915 hours, an interview, medical record review for Resident 159, and concurrent facility document review was conducted with the IP. The IP verified the findings. h. Medical record review for Resident 148 was initiated on 5/7/26. Resident 148 was admitted to the facility on [DATE], and was readmitted on [DATE]. Review of the facility's monthly Infection Prevention and Control Surveillance Log for December 2025 showed Resident 148 was prescribed with nitrofurantoin (antibiotic) tablets. The report showed the infection was HAI, however, it did not indicate if the McGeer's criteria was met or not met. Review of Resident 148's Physician Progress Notes dated 3/24/26, showed the resident had no capacity to understand and make decisions. Further Review of Resident 148's medical record failed to show the Infection SBAR was completed for infection analysis if McGeer's criteria was met or not met. On 5/7/26 at 0928 hours, an interview, medical record review for Resident 148, and concurrent facility document review was conducted with the IP. The IP verified the findings. i. Medical record review for Resident 85 was initiated on 5/7/26. Resident 85 was admitted to the facility on [DATE]. Review of Resident 85's Physician Progress Notes dated 12/7/25, showed resident had the capacity to make decisions. Review of the facility's monthly Infection Prevention and Control Surveillance Log for January 2026 showed Resident 85 was prescribed with doxycycline (antibiotic) tablets. The report showed the infection was HAI and had met the McGeer's criteria. Further review of Resident 85's medical record failed to show the Infection SBAR was completed for infection analysis if McGeer's criteria was met or not met. On 5/7/26 at 0955 hours, an interview, medical record review for Resident 85, and concurrent facility document review was conducted with the IP. The IP verified the findings. j. Closed record review for Resident 161 was initiated on 5/7/26. Resident 161 was admitted to the facility on [DATE], and was discharged on 1/15/26. Review of Resident 161's H&P examination dated 12/11/25, showed the resident did not have the capacity to understand and make decisions. Review of the facility's monthly Infection Prevention and Control Surveillance Log for January 2026 showed Resident 161 was prescribed with Zosyn (antibiotic) IV solution. The report showed the infection was HAI and had met the McGeer's criteria. Further review of Resident 161's medical record failed to show the Infection SBAR was completed for infection analysis if McGeer's criteria was met or not met. On 5/7/26 at 1050 hours, an interview, medical record review for Resident 161, and concurrent facility document review was conducted with the IP. The IP verified the findings. k. Closed record review for Resident 11 was initiated on 5/7/26. Resident 11 was admitted to the facility on [DATE], and was readmitted on [DATE]. Resident was discharged on 4/2/26. Review of Resident 11's Physician Progress Notes dated 2/23/26, showed the resident had the capacity to understand and make decisions. Review of the facility's monthly Infection Prevention and Control Surveillance Log for January 2026 showed Resident 11 was prescribed with azithromycin (antibiotic) tablet. The report showed the infection was HAI and had not met the McGeer's criteria. Further review of Resident 11's medical record failed to show the Infection SBAR was completed for infection analysis if McGeer's criteria was met or not met. On 5/7/26 at 1025 hours, an interview, medical record review for Resident 11, and concurrent facility document review was conducted with the IP. The IP verified the findings. 1. Closed record review for Resident 163 was initiated on 5/7/26. Resident 163 was admitted to the facility on [DATE], and was discharged on 1/24/26. Review of Resident 163's Physician Progress Notes dated 11/26/25, showed the resident had the capacity to make decisions. Review of the facility's monthly Infection Prevention and Control Surveillance Log for January 2026 showed Resident 163 was prescribed with azithromycin (antibiotic) tablet. The report showed the infection was HAI and had not met the McGeer's criteria. (continued on next page)

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Advanced Rehab Center of Tustin	2210 E. First Street Santa Ana, CA 92705

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident 163's medical record failed to show the Infection SBAR was completed for infection analysis if McGeer's criteria was met or not met. On 5/7/26 at 1058 hours, an interview, medical record review for Resident 163, and concurrent facility document review was conducted with the IP. The IP verified the findings. m. Closed record review for Resident 164 was initiated on 5/7/26. Resident 164 was admitted to the facility on [DATE], and was readmitted on [DATE]. Resident was discharged on 1/27/26. Review of Resident 164's Physician Progress Notes dated 11/27/25, showed resident had the capacity to understand and make decisions. Review of the facility's monthly Infection Prevention and Control Surveillance Log for January 2026 showed Resident 164 was prescribed with cephalexin (antibiotic) capsule. The report showed the infection was HAI and had met the McGeer's criteria. Further review of Resident 164's medical record failed to show the Infection SBAR was completed for infection analysis if McGeer's criteria was met or not met. On 5/7/26 at 1105 hours, an interview, medical record review for Resident 164, and concurrent facility document review was conducted with the IP. The IP verified the findings. n. Closed record review for Resident 165 was initiated on 5/7/26. Resident 165 was admitted to the facility on [DATE] and was readmitted on [DATE]. Resident was discharged on 2/6/26. Review of Resident 165's Physician Progress Notes dated 11/12/25, showed the resident had no capacity to understand and make decisions. Review of the facility's monthly Infection Prevention and Control Surveillance Log for January 2026 showed Resident 165 was prescribed with ciprofloxacin (antibiotic) eye drops. The report showed the infection was HAI and had met the McGeer's criteria. Further review of Resident 165's medical record failed to show the Infection SBAR was completed for infection analysis if McGeer's criteria was met or not met. On 5/7/26 at 1128 hours, an interview, medical record review for Resident 165, and concurrent facility document review was conducted with the IP. The IP verified the findings. o. Closed record review for Resident 88 was initiated on 5/7/26. Resident 88 was admitted to the facility on [DATE], and was readmitted on [DATE]. Resident was discharged on 4/26/26. Review of the facility's monthly Infection Prevention and Control Surveillance Log for January 2026 showed Resident 88 was prescribed with nitrofurantoin (antibiotic) capsules. The report showed the infection was HAI and had met the McGeer's criteria. Review of Resident 88's H&P examination dated 3/18/26, showed the resident had no capacity to make decisions. Further review of Resident 88's medical record failed to show the Infection SBAR was completed for infection analysis if McGeer's criteria was met or not met. On 5/7/26 at 1140 hours, an interview, medical record review for Resident 88, and concurrent facility document review was conducted with the IP. The IP verified the findings. p. Medical record review for Resident 8 was initiated on 5/7/26. Resident 8 was admitted to the facility on [DATE], and was readmitted on [DATE]. Review of the facility's monthly Infection Prevention and Control Surveillance Log for February 2026 showed Resident 8 was prescribed with Levaquin (antibiotic) tablet. The report showed the infection was HAI and had not met the McGeer's criteria. Review of Resident 8's H&P examination dated 3/16/26, showed the resident had the capacity to understand and make decisions. Further review of Resident 8's medical record failed to show the Infection SBAR was completed for infection analysis if McGeer's criteria was met or not met. On 5/7/26 at 1156 hours, an interview, medical record review for Resident 8, and concurrent facility document review was conducted with the IP. The IP verified the findings. On 5/8/26 at 1030 hours, an interview was conducted with the DON. The DON stated the previous IP left the facility, and the facility had recently employed a new IP.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview, facility document review, and facility P&P review, the facility failed to ensure three of three staff (LVNs 1 and 4, and CNA 7) reviewed for COVID-19 vaccinations were educated and offered the COVID-19 vaccination. * The facility failed to offer the educational materials of the risks and benefits for the COVID-19 vaccines and offer the COVID-19 vaccine to LVNs 1 and 4, and CNA 7. These failures put the residents at risk for increased risk of infection and transmission of COVID-19.Findings: Review of the facility's P&P titled Employee Infection and Vaccination Status dated 2001 showed prior to or upon an employee's duty assignment, the facility will assess the status of an employee's vaccination against infectious conditions, screening for tuberculosis, and recent history of communicable diseases. Employees will be current with mandated vaccinations prior to performing direct resident care. Employees are offered or provided with vaccinations per state or local agency policies/regulations. Employees are provided with educational materials to make informed decisions for non-mandated vaccinations. If declined, a declination form is completed and placed in the employee's health record. Documentation of vaccinations include the signature of a licensed healthcare provider and employee when being administered. Vaccinations that are declined by the employee are documented on the applicable declination form and placed in the employee's health record. Review of the facility's employee screening, education, and offering for the COVID-19 vaccine failed to show documented evidence the facility offered educational materials of the risk and benefits of the vaccine, and offer the vaccine to LVNs 1 and 4, and CNA 7. On 5/6/26 at 1450 hours, an interview and concurrent facility document review was conducted with the IP. The IP verified LVNs 1 and 4,and CNA 7 did not have any documentation to show the facility provided employee screening, education and offering the COVID-19 vaccine to LVNs 1 and 4, and CNA 7. On 5/6/26 at 1111 hours, an interview was conducted with CNA 7. CNA 7 stated she did not remember if she received an employee screening, education or was offered the COVID-19 vaccine. On 5/8/26 at 0945 hours, an interview was conducted with the DSD. The DSD stated he did not provide the employee screening, education or offered the COVID-19 vaccine to the employees. The DSD further stated the IP should provide to the employees. On 5/8/26 at 1030 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure resident care was provided in a manner that maintained and enhanced dignity for one of 20 final sample residents (Resident 19). * The facility failed to ensure CNA 2 sat next to Resident 19 while assisting the resident to eat. This failure had the potential to negatively impact Resident 19's sense of dignity, self-worth, and well-being.Findings: Review of the facility's P&P titled Assisting the Impaired Resident with In-Room Meals dated 2001 showed if the staff is going to be seated during the feeding, to position a chair where it will be convenient for you and the resident. On 5/5/26 at 0800 and 0805 hours, Resident 19 was observed being assisted with eating by CNA 2. CNA 2 was observed standing over Resident 19, who was seated upright in bed. On 5/5/26 at 0810 hours, an observation for Resident 19 and concurrent interview was conducted with CNA 2. CNA 2 verified she had been standing over Resident 19 while assisting the resident with eating. When asked about the facility's expectation for assisting the residents with meals, CNA 2 stated she was supposed to be seated when assisting a resident with eating. Medical record review for Resident 19 was initiated on 5/5/26. Resident 19 was readmitted to the facility on [DATE]. Review of Resident 19's H&P examination dated 8/7/25, showed Resident 19 had no mental capacity to make decisions. Review of Resident 19's plan of care showed a care plan problem dated 7/6/23, addressing the resident's alteration in physical functioning. The interventions included to assist with meals. On 5/7/26 at 1350 hours, an interview was conducted with the DSD. When asked about the facility's policy for assisting the residents with eating, the DSD stated the staff should be seated beside the residents when assisting with eating to promote residents' dignity. On 5/8/26 at 0836 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure two of five sampled residents for unnecessary medications (Residents 19 and 148) and two of 20 final sampled residents (Residents 8 and 93) reviewed for informed consents were provided the right to self-determination regarding the use of the psychotropic medications and treatments. * The facility failed to ensure the informed consents for buspirone (antianxiety) and Seroquel (antipsychotic) medications were accurate for Resident 93. * The facility failed to ensure the informed consent for buspirone medication included the indication of use and manifested behavior, and the informed consent for fluoxetine (antidepressant) medication was verified by two licensed nurses for Resident 148. * The facility failed to ensure the informed consent for risperidone (antianxiety) and Depakote (antimanic) medications included administration method and whether the medications had caution and warning summary, FDA-approved use, and black warning label for Resident 19. In addition, the facility failed to ensure the informed consent for risperidone medication included the name of the resident's representative who gave the consent via telephone for Resident 19. * The facility failed to ensure the informed consent for Seroquel medication included the name of resident's representative who gave the consent via telephone for Resident 8. These failures posed the risk of the residents and their representatives to not have informed decision-making regarding treatment risks and benefits related to the use of psychotropic medications.Findings: Review of the AFL 25-27 titled AB 48 - Nursing Facility Resident Informed Consent Protection Act of 2023 dated 10/7/25, showed the prescriber must share the material information a reasonable person in the resident's condition and circumstances would consider necessary for the resident or representative to make a decision about the treatment. Material information that the provider shall provide includes but is not limited to how the facility and prescriber will monitor and respond to any adverse side effects and inform the resident of side effects. The AFL also showed the facility must check the medical record for proper informed consent prior to an initial administration. Review of the AFL 25-38.1, titled Notice of Release of Psychotherapeutic Drug Informed Consent Form dated 2/3/26, showed effective 1/1/26, the Psychotherapeutic Drug Informed Consent Form or equivalent in-house form must be used for new residents, residents being prescribed a new psychotherapeutic drug, or residents having a psychotherapeutic drug dosage change. The Psychotherapeutic Drug Informed Consent Form Instruction Sheet showed the form will be completed by. entering the drug category and providing the possible side effects and significant risks associated with the use of the psychotherapeutic drug. Review of the facility's P&P titled Informed Consent for Psychotherapeutic Medications dated 9/10/25, showed the following:- Verification of informed consent shall be obtained by a licensed nurse in person/ verbally/ via telephone. This will be recorded in the resident's medical records, a licensed nurse can sign the form and document the name of the person who gave the consent (verbal/ telephone) and the date;- If the resident or resident's representative cannot sign the informed consent form during the informed consent verification, the licensed nurse can sign the form and document the name of the person who gave the consent and the date- The facility will disclose the material information for proper informed consent for a prescription for psychotherapeutic drugs which includes the following information: the reason for the treatment includes their probably frequency and duration, and the nature, degree, duration and probability of the side effects and significant risks commonly known by the health professions. 1. Medical record review for Resident 93 was initiated on 5/5/26. Resident 93 was admitted to the facility on [DATE]. Review of Resident 93's Order Summary Report showed the following physician's orders:- dated 4/2/26, to administer buspirone 5 mg one tablet by mouth two times a day for anxiety manifested by inability to relax;- dated 4/3/26, to administer Seroquel 25 mg one tablet by mouth in the evening for psychosis as evidenced by angry outburst; and- dated 4/3/26, to administer Seroquel 50 mg one tablet by mouth one time a day for (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychosis as evidenced by angry outburst. Review of Resident 93's Psychotropic Medication Administration Informed Consent (Anti-depressant) dated 4/2/26, showed an informed consent for antidepressant medication used for buspirone 5 mg medication. The informed consent included side effects associated with antidepressant medications and did not contain accurate side effects and risks associated with antianxiety medications such as buspirone. Review of Resident 93's Psychotropic Medication Administration Informed Consent (Anticonvulsant/Antimanic) dated 4/2/26, showed an informed consent for anticonvulsant/antimanic medication was used for Seroquel 25 mg medication. The informed consent included side effects associated with anticonvulsant/antimanic medications and did not contain accurate side effects and risks associated with antipsychotic medications such as Seroquel. Review of Resident 93's Psychotropic Medication Administration Informed Consent (Antianxiety) dated 4/2/26, showed an informed consent for antianxiety medication was used for Seroquel 50 mg medication. The informed consent included side effects associated with antianxiety medications and did not contain accurate side effects and risks associated with antipsychotic medications such as Seroquel. Review of Resident 93's MAR for April and May 2026 showed the following:- Resident 93 was administered buspirone 5 mg medication on 4/3 to 5/4/26 at 0900 and 1700 hours, on 5/5/26 at 1700 hours, and on 5/6/26 at 0900 hours;- Resident 93 was administered Seroquel 25 mg medication on 4/3 to 5/5/26 at 1700 hours; and- Resident 93 was administered Seroquel 50 mg medication on 4/3 to 5/4/26, and 5/6/26 at 0900 hours. On 5/6/26 at 1147 hours, an interview and concurrent medical record review for Resident 93 was conducted with RN 2. RN 2 verified the informed consent forms used were inaccurate related to the use of buspirone and Seroquel medications for Resident 93. 2. Medical record review for Resident 148 was initiated on 5/5/26. Resident 148 was readmitted to the facility on [DATE]. Review of Resident 93's Order Summary Report showed the following physician's orders:- dated 3/23/26, to administer dluoxetine 40 mg one capsule by mouth one time a day for depression manifested by persistent feeling of hopelessness; and-4/28/26, to administer buspirone 5 mg one tablet by mouth every 12 hours a day for anxiety manifested by verbalization of feeling anxious. Review of Resident 148's Psychotropic Medication Administration Informed Consent (Antidepressant) dated 3/24/26, showed only one licensed nurse verified the informed consent via phone related to the use of fluoxetine medication. Review of Resident 148's Psychotropic Medication Administration Informed Consent (Antianxiety) dated 4/16/26, did not show the reason for use or behavior manifestation related to the use of buspirone were included in the consent form. Review of Resident 148's MARs for April and May 2026 showed the following:- Resident 148 was administered the fluoxetine medication from 4/1 to 4/26/26, and 4/29 to 5/5/26 at 0900 hours; and- Resident 148 was administered buspirone medication from 4/29 to 5/5/26 at 0900 and 2100 hours On 5/7/26 at 0907 hours, an interview and concurrent medical record review for Resident 148 was conducted with RN 2. RN 2 stated two licensed nurses had to sign the informed consent to verify the resident or resident's representative had given consent for the use of the psychotherapeutic medication. RN 2 verified the informed consent form for fluoxetine showed only one licensed nurse verified the informed consent via telephone. RN 2 further verified the informed consent form for buspirone medication did not include the indication for use or the behavior manifestation related to the use of the buspirone medication for Resident 148. 3. Medical record review for Resident 19 was initiated on 5/5/26. Resident 19 was readmitted to the facility on [DATE]. Review of Resident 19's Order Summary Report showed the following physician's orders:- dated 9/18/25, to administer Depakote 125 mg three capsules by mouth three times a day for affective mood disorder manifest by anger outburst/ poor impulse control; and- dated 3/21/26, to administer risperidone 0.25 mg one tablet by mouth two times a day for bipolar disorder manifested by persistent yelling and screaming despite ADLs met. Review of Resident 19's Psychotropic Medication Administration Informed Consent (Anticonvulsant/Antimanic Agents) for Depakote medication dated 2/13/26, did not show the administration method, and whether the Depakote medication had caution and warning summary, FDA-approved use, and black box warning label. Review of Resident 19's (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Psychotropic Medication Administration Informed Consent (Antipsychotic) for risperidone dated 2/13/26, did not show administration method, and whether the risperidone medication had caution and warning summary, FDA-approved use, and black box warning label. Furthermore, the informed consent did not show the name of the resident's representative who gave the consent via telephone. Review of Resident 19's MAR for April and May 2026 showed the following:- Resident 19 was administered the Depakote medication from 4/1 to 5/5/26 at 0900, 1300, and 1700 hours, and on 5/6/25 at 0900 and 1300 hours; and- Resident 19 was administered the risperidone medication from 4/1 to 5/5/26 at 0900 and 1700 hours, and on 5/6/26 at 0900 hours. On 5/6/26 at 1126 hours, an interview and concurrent medical record review for Resident 19 was conducted with RN 2. RN 2 verified the informed consent form for risperidone medication did not show the name of the resident's representative who gave the consent via telephone. RN 2 further verified the informed consent forms for risperidone and Depakote medications did not include the administration method, and whether the medications had caution and warning summary, FDA-approved use, and black box warning label related to the use of the risperidone and Depakote medications for Resident 19. 4. Medical record review for Resident 8 was initiated on 5/5/26. Resident 8 was readmitted to the facility on [DATE]. Review of Resident 8's Order Summary Report showed a physician's order dated 4/16/26, to administer quetiapine (Seroquel) 25 mg half tablet by mouth every evening for psychosis as evidenced by standing abruptly without asking for staff assistance. Review of Resident 8's Psychotropic Medication Administration Informed Consent (Antipsychotic) for Seroquel medication dated 4/17/26, did not show the name of the resident's representative who gave the consent via telephone. Review of Resident 8's MAR for April and May 2026 showed Resident 8 was administered the Seroquel 25 mg half tablet medication from 4/18 to 4/23, 4/25, 4/28 to 5/6/26 at 1300 hours. On 5/6/26 at 1112 hours, an interview and concurrent medical record review for Resident 8 was conducted with RN 2. RN 2 verified the informed consent form for Seroquel medication did not show the name of the resident's representative who gave the consent via telephone. On 5/8/26 at 0836 hours, an interview for Residents 8, 19, 93, and 148 was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medications were safely administered for one of 91 residents (Resident 59). * Resident 59 had Vitamin A and D (skin protectant) ointment at bedside. However, Resident 59 did not have a physician's order to keep the medication at the bedside. This failure had the potential for the resident to administer the medication inaccurately, develop adverse reactions, and negatively affect the resident's well-being.Findings: Review of the facility's P&P titled Resident Self-Administration of Medications dated 2001 showed as part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is re-assessed periodically based on changes in the resident's medical and/or decision-making status. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer are stored on a central medication cart or in the medication room. A licensed nurse transfers the unopened medication to the resident when the resident requests them. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer are stored on a central medication cart or in the medication room. A licensed nurse transfers the unopened medication to the resident when the resident requests them. Review of the facility's P&P titled Medication Storage in the Facility revised January 2025 showed medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized. Medical record review for Resident 59 was initiated on 5/5/26. Resident 59 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 59's Physician Progress Note dated 6/6/25, showed the resident had no capacity to make decisions. Review of Resident 59's MDS assessment dated [DATE], showed the resident's BIMS was 14, indicating the resident had intact cognition. On 5/5/26 at 0631 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 59 in the resident's room. An unlabeled ointment in a medication cup was observed on top of the resident's bedside table. Resident 59 stated it was Vitamin A&D ointment and the licensed nurses usually gave him the Vitamin A&D ointment for him to apply on his lips. However, review of Resident 59's Order Summary Report dated 5/5/26, failed to show a physician's order for self-administration of the Vitamin A&D ointment. On 5/5/26 at 0640 hours, an observation and concurrent interview for Resident 59 was conducted with LVN 3. LVN 3 verified Resident 59 had the Vitamin A&D ointment on top of his bedside table. On 5/5/26 at 1339 hours, a follow up interview and concurrent medical record review was conducted with LVN 3 for Resident 59. LVN 3 verified Resident 59 had no physician's order for the Vitamin A&D ointment and/or for the resident to administer the medication by himself. On 5/5/26 at 1000 hours, an interview was conducted with the DON. The DON stated the licensed nurse should not have left the Vitamin A&D ointment on the resident's bedside table. The DON was informed and acknowledged the above findings.

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Advanced Rehab Center of Tustin	2210 E. First Street Santa Ana, CA 92705

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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, medical record review, and facility P&P review, the facility failed to provide a reasonable accommodation to meet the needs of one of 90 residents (Resident 136) observed for call light accessibility. * The facility failed to ensure Resident 136's call light was within the resident's reach. This failure had the potential to negatively impact the resident's psychosocial well-being and may cause delays in receiving necessary care.Findings: Review of the facility's P&P titled Answering the Call Light revised 3/2021 showed the purpose of the procedure to ensure timely responses to the resident's request and needs. Under the section General Guidelines, showed when the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. Review of the facility P&P titled Accommodation of Needs dated 3/2021 showed in order to accommodate individual needs and preferences, adaptation may be made to the physical environment, including resident's bedroom bathroom, as well as common areas in the facility which included installing longer cords or providing remote controlled overhead or task lighting so that they are easily assessable. On 5/5/26 at 0734 hours, Resident 136 was observed lying in bed and yelling for help. When asked if she could call the facility staff, Resident 136 stated yes and began searching for the call light button. The callˆlight button was observed clipped at the head of the bed. Resident 136 continued searching for the call light but was unable to reach it. On 5/5/26 at 0736 hours, LVN 4 was called into Resident 136's room. During the observation and concurrent interview, LVN 4 verified the call light was not within Resident 136's reach. LVN 4 was observed moving the call light button closer to Resident 136 and repositioning the resident in bed. LVN 4 stated Resident 136 was forgetful but able to use the call light to request staff assistance. LVN 4 stated the call light should have been within the resident's reach. On 5/5/26 at 0742 hours, Resident 136 was observed using the call light and asking staff for a drink. Medical record review for Resident 136 was initiated on 5/5/26. Resident 136 was admitted to the facility on [DATE]. Review of Resident 136's H&P examination dated 4/16/26, showed Resident 136 had no capacity to understand and make decisions. Review of Resident 136's Care Plan dated 4/16/26, showed a care plan problem addressing Resident 136's ADL self -care and mobility performance deficit related to impaired mobility and required staff assistance with the ADLs. The intervention included to place a call light within easy reach, and to encourage the resident to use the call light /bell to call for assistance. On 5/8/26 at 0921 hours, an interview was conducted with RN 2. RN 2 stated Resident 136 had dementia and was forgetful. RN 2 further stated Resident 136 was able to use the call light sometimes if she remembered, and the call light button should always be within the resident's reach. On 5/8/26 at 1049 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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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 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 observation, interview, medical record review, and facility P&P review, the facility failed to timely notify the resident's physician for changes in condition for one of one final sampled resident (Resident 4) reviewed for change of condition. * The facility failed to timely follow-up on and notify Resident 4's physician regarding the resident's urinary changes. This failure resulted in a delay in obtaining and implementing physician interventions.Findings: Review of the facility's P&P titled Change in a Resident's Condition or Status dated 2001 showed the facility will promptly notify the physician of changes in the resident's medical condition or with specific instructions to do so. Medical record review for Resident 4 was initiated on 5/5/26. Resident 4 was readmitted to the facility on [DATE]. Review of Resident 4's Care Plan Report showed a care plan problem initiated on 12/4/25, addressing the resident's alteration in bowel and bladder related to use of an indwelling urinary catheter and frequent bowel incontinence. The interventions included to monitor and report signs and symptoms of a UTI (hematuria, sedimentation, dysuria, flank pain, etc.) Review of Resident 4's Care Plan Report showed a care plan problem initiated on 1/23/26, addressing the resident's risk for bleeding, bruising and discoloration due to aspirin use. The interventions included to monitor, document, and report blood tinged or red blood in the urine. a. Review of Resident 4's Alert Note by LVN 8 dated 2/10/26 at 0940 hours, showed the resident was observed pulling on his urinary catheter with blood noted. LVN 7 was notified. LVN 8 documented upon assessment, no bleeding was noted and the urinary catheter was patent and draining. Review of Resident 4's SBAR Communication Form (General) dated 2/10/26 at 1344 hours, showed the resident's abdomen was visibly distended and firm on palpation, and the resident had no urine output in the Foley catheter since 0700 hours. The physician was notified and the resident was transferred to the acute care hospital. On 5/8/26 at 0927 hours, an interview and concurrent medical record review was conducted with the ADON and LVN 8. LVN 8 stated she wrote the Alert Note on 2/10/26, and explained an alert note was triggered by the CNA. LVN 8 stated on 2/10/26, she worked as the QA nurse, and saw an alert from a CNA that Resident 4 was pulling on his catheter and blood was observed. LVN 8 stated she assessed the resident and flushed the resident's urinary catheter with approximately 30 ml of irrigation fluid, and observed approximately 30 ml of irrigation fluid return from the tubing. LVN 8 stated she did not observe blood during flushing and did not check the urinary drainage bag for blood or urinary output. LVN 8 stated since she did not observe any abnormal findings, she did not notify the physician. The ADON reviewed the resident's medical record and facility staffing assignment for 2/9/26, and stated LVN 7 (the LVN in the Alert Note showed as being notified of the bleeding) worked on 2/9/26 from 1500 - 2300 hours. The ADON stated when a CNA reported the resident pulling on their urinary catheter with blood was observed, the LVN should have assessed the resident and documented their findings to show whether the LVN verified or did not verify the CNA's observations. The ADON verified there was no documentation to show the resident was assessed by the nursing staff on 2/9/26 during the 1500 - 2300, or 2300 - 0700 shifts. The ADON further stated if blood was observed in the urine by the licensed nurse, the physician should be notified immediately. The ADON verified the only documentation to show the physician was notified was on 2/10/26 at 1344 hours, when his abdominal distension and lack of urinary output was observed and reported, prompting the resident's transfer to the acute care hospital. b. Review of Resident 4's SBAR Communication Form (General) dated 2/17/26 at 0200 hours, showed earlier in the evening the resident was noted to have blood-tinged urine. At approximately 0200 hours, the resident was noted to have thick, dark, bright blood throughout the urinary catheter tubing. The licensed nurse left the resident's bedside and returned to change the catheter tubing with the plan to monitor the bleeding through the remainder of the shift, however, upon returning, the resident was unresponsive with abnormal vital signs. The physician was notified and 911 was called at approximately 0240 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hours. Further review of Resident 4's medical record failed to show when the initial blood-tinged urine was observed by facility staff earlier in the evening. On 5/8/26 at 0927 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON verified Resident 4's SBAR Communication Form (General) dated 2/17/26 at 0200 hours, showed bleeding was noted earlier in the evening but was not documented at the time when the bleeding was initially identified. The ADON stated the physician should have been notified immediately when bleeding was first observed. Cross reference F684, example # 3.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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, medical record review, and facility P&P review, the facility failed to ensure one of five final sampled residents (Resident 148) reviewed for unnecessary medication was free from unnecessary psychotropic medications. * The facility failed to ensure Resident 148 was monitored for the side effects related to the use of lorazepam (antianxiety), buspirone (antianxiety), fluoxetine (antidepressant) and mirtazapine (antidepressant). In addition, the monthly behavior summary for mirtazapine medication did not match the documentation of the episodes when Resident 148 ate less than 50%. These failures had the potential to result in unrecognized adverse medication effects, delayed or inadequate clinical intervention, and inaccurate clinical decision-making regarding the continued use of the psychotropic medications for Resident 148.Findings: Review of the facility's P&P titled Psychotropic Medication Use dated 2001 showed psychotropic medication management includes adequate monitoring for efficacy and adverse consequences. According to Dailymed.nlm.nih.gov:- The most adverse reactions with lorazepam use include central nervous effects and respiratory depression;- The more commonly observed untoward events associated with the use of buspirone hydrochloride tablets not seen at an equivalent incidence among placebo-treated patients include dizziness, nausea, headache, nervousness, lightheadedness, and excitement;- Residents with major depressive disorder, may experience worsening of their depression and/or the emergence of suicidal ideation and behavior (suicidality) or unusual changes in behavior, whether or not they are taking antidepressant medications, and this risk may persist until significant remission occurs, related to the use of fluoxetine; and- To monitor all antidepressant-treated patients for any indication of clinical worsening and emergence of suicidal thoughts and behaviors, especially during the initial few months of drug therapy, and at times of dosage changes related to the use of mirtazapine. Medical record review for Resident 148 was initiated on 5/5/26. Resident 148 was readmitted to the facility on [DATE]. Review of Resident 148's Order Summary Report showed the following physician's orders:- dated 3/23/26, to administer fluoxetine 40 mg one capsule by mouth one time a day for depression manifested by persistent feeling of hopelessness;- dated 4/16/26, to administer mirtazapine 15 mg one tablet by mouth one time a day for depression manifested by poor oral intake less than 50% each meal;- dated 4/28/26, to administer buspirone 5 mg one tablet by mouth every 12 hours a day for anxiety manifested by verbalization of feeling anxious;- dated 4/29/26, to administer lorazepam 0.5 mg one tablet by mouth every six hours as needed for anxiety manifested by inability to relax for 14 days; and-dated 5/3/26, to monitor side effects of antidepressant medications every shift. a. Review of Resident 148's MARs for April and May 2026 showed the following:- Resident 148 was administered the fluoxetine medication from 4/1 to 4/26/26, and 4/29 to 5/5/26 at 0900 hours;- Resident 148 was administered the mirtazapine medication from 4/8 to 4/16/26 at 2100 hours, and on 4/17 to 4/26, 4/29 to 5/5/26 at 0900 hours;- Resident 148 was administered the buspirone medication from 4/29 to 5/5/26 at 0900 and 2100 hours;- Resident 148 was monitored for side effects of antianxiety medication on 5/3/26 on evening and night shifts;- Resident 148 was monitored for side effects of antidepressant medication on 5/3/26 on evening and night shifts, and 5/4 to 5/5/26 on day, evening, night shifts;- Resident 148 was not monitored for side effects related to the use of fluoxetine, mirtazapine, buspirone and lorazepam medications; and- Resident 148's meal intake each meal was not documented in the MAR. Further review of Resident 148's medical record did not show documented evidence the resident was monitored medication side effects related to the use of fluoxetine, mirtazapine, buspirone and lorazepam medications. b. Review of Resident 148's Documentation Survey Report v2 for April and May 2026 under Amount Eaten section, showed the following:- Resident 148 consumed 26 to 50% on 4/8 at dinner, 4/9 at lunch and dinner, and 4/10/26 at dinner (a total of four episodes); and- Resident 148 consumed 0 to 25% on 4/14, 4/23 and 4/24/26 at (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	breakfast and lunch, and on 4/20, 4/21, 4/25 and 4/29/26 at lunch (a total of 10 episodes). Review of Resident 148's Monthly Psychotropic Summary Sheet for the Remeron medication from 4/8 to 4/30/26, showed there were a total of four episodes of poor oral intake less than 50% each meal related to the use of the Remeron (mirtazapine) medication. The monthly psychotropic summary was inconsistent with the documentation of Resident 148's meal intake. On 5/7/26 at 0907 hours, an interview and concurrent medical record review for Resident 148 was conducted with RN 2. RN 2 verified there was no side effect monitoring for the use of lorazepam, buspirone, fluoxetine, and mirtazapine medications. RN 2 further verified the monthly behavior summary for the mirtazapine medication did not match the RNA documentation of episodes when Resident 148 ate less than 50%. On 5/8/26 at 0836 hours, an interview for Resident 148 was conducted with the DON. The DON was informed and acknowledged the above findings.

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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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure accurate and timely PASARR Level I screenings for two of two final sampled residents (Residents 10 and 32) reviewed for PASARR. * The facility failed to ensure PASARR level I screening was completed when Resident 10 entered the facility as an exception (an exempted acute care hospital discharge) and stayed more than 30 days. * The facility failed to ensure the accuracy of the PASARR Level 1 screening for Resident 32. These failures posed the risk for Residents 10 and 32 of not properly screened for serious mental illness, intellectual disability, or related conditions, potentially resulting in inadequate levels of service, incomplete assessments, and lack of appropriate interventions and evaluations.Findings: Review of the facility's P&P titled admission Criteria revised 3/2019 showed all new admission and readmissions are screened for mental disorder (MD), intellectual disabilities (ID) or related disorder (RD) per the Medicaid PASARR. The facility conducts a level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD. If the level I screen indicates that the individual may meet the criteria for a MD, ID or RD, he or she is referred to the state PASARR representative for the level II (evaluation and determination) screening process. 1. Medical record review for Resident 10 was initiated on 5/5/26. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's admission Record dated 5/6/26, showed Resident 10 had diagnoses of bipolar disorder and anxiety disorder. Review of Resident 10's Order Summary Report showed a physician's order dated 3/31/26, to administer duloxetine HCL 30 mg one capsule by mouth one time day for depression as manifested by verbalization of feeling hopelessness. Review of Resident 10's Preadmission Screening and Resident Review (PASARR) level I screening dated 3/31/26, showed Resident 10 had a diagnosed serious mental illness, was receiving psychotropic medication and met the criteria for an exempted acute care hospital discharge. Review of Resident 10's Notice of Exempted Hospital Discharge letter from DHCS dated 3/31/26, showed the PASARR Level I screening determined a Level II Mental Health Evaluation was not required. The letter included a summary of the Level I screening results, which was negative, with the reason noted as exempted hospital discharge. Further review of the letter showed if the resident remained in the nursing facility for more than 30 days, the facility was required to submit a new Level I screening as a resident review on the 31st day. Further review of Resident 10's medical record failed to show a new PASARR Level I screening was completed when Resident 10 remained in the facility beyond 30 days. 2. Medical record review for Resident 32 was initiated on 5/5/26. Resident 32 was admitted to the facility on [DATE]. Review of Resident 32's admission Record dated 5/7/26, showed Resident 32 had diagnoses of anxiety disorder and unspecified psychosis. Review of Resident 32's Physician Order Summary Report showed the following physician's orders:- dated 11/14/25, to administer buspirone HCL (antianxiety medication) 7.5 mg one tablet by mouth every 12 hours for anxiety as manifested by restlessness.- dated 4/1/26, to administer Seroquel (antipsychotic medication) 25 mg two tablets by mouth at bed time for psychosis as manifested by delusional ideation. Review of Resident 32's PASARR Level I screening completed by the acute care hospital on [DATE], showed Resident 32 had no diagnosed serious mental illness and was not receiving any psychotropic medications. Further review of Resident 32's medical record did not show the facility initiated the new PASARR Level I screening to correct the inaccurate acute care hospital-completed PASARR. On 5/7/26 at 0859 hours, an interview and concurrent medical record review for Residents 10 and 32 was conducted with the ADON. The ADON verified Resident 10 was admitted to the facility under an exempted acute care hospital discharge. The ADON explained if a resident was admitted under this status remained in the facility for more than 30 days, the facility was required to initiate a new PASARR Level I screening. The ADON verified she was unable to provide documentation showing the facility initiated a new Level I PASRR for (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 10 after the resident stayed longer than 30 days. The ADON also stated the facility was responsible for reviewing PASARR Level I screenings completed by the acute care hospitals to ensure accuracy and if the screening was inaccurate, the facility must initiate a new PASARR. The ADON verified the PASARR completed by the acute care hospital for Resident 32 was not accurate. The ADON also confirmed she could not find documentation indicating that the facility initiated a new PASRR screening for Resident 32. The ADON stated that new PASRR screenings should have been initiated for both Residents 10 and 32. On 5/8/26 at 1049 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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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, medical record review, and facility P&P review, the facility failed to develop a comprehensive, person-centered plan of care to reflect the individual care needs for two of 20 final sampled residents (Residents 143 and 148). * The facility failed to address Resident 143's use of the hydroxyzine HCl medication for anxiety in the care plan. * The facility failed to develop a care plan problem and interventions to address the use of the buspirone medication (antianxiety) for Resident 148. These failures had the potential to result in inconsistent, incomplete, and nonˆindividualized care for the residents.Findings: Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered revised 3/2022 showed the following: - Comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; and - Assessments of residents are ongoing and care plans are revised as information about the resident and the residents' condition changes. 1. Medical record review for Resident 148 was initiated on 5/5/26. Resident 148 was readmitted to the facility on [DATE]. Review of Resident 148's Order Summary Report showed a physician's order dated 4/28/26, to administer buspirone 5 mg one tablet by mouth every 12 hours a day for anxiety manifested by verbalization of feeling anxious. However, review of Resident 148's plan of care did not show a care plan problem, goal or interventions addressing the use of the buspirone medication. On 5/7/26 at 0907 hours, an interview and concurrent medical record review for Resident 148 was conducted with RN 2. RN 2 verified Resident 148 was receiving the buspirone medication as ordered and confirmed no care plan had been developed to address the use of the medication. On 5/8/26 at 0836 hours, an interview for Resident 148 was conducted with the DON. The DON was informed and acknowledged the above findings 2. Medical record review for Resident 143 was initiated on 5/5/26. Resident 143 was admitted on [DATE]. Review of Resident 143's MAR for April 2026 showed a physician's order dated 4/24/26 (discontinued 5/3/26), to administer hydroxyzine HCl (an antihistamine that can be used to treat anxiety) 25 mg by mouth every eight hours PRN for anxiety, with documented administration on:- 4/25/26 at 2054 hours;- 4/26/26 at 0912 hours;- 4/28/26 at 1539 hours; and - 4/30/26 at 1533 hours. Review of Resident 143's Order Summary report showed a physician's order dated 5/3/26, to administer hydroxyzine HCl 25 mg by mouth every eight hours PRN for anxiety. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	However, review of Resident 143's Care Plan Report did not show any problem, goal, or interventions addressing the resident's use of the hydroxyzine HCl medication or the resident's anxiety symptoms. On 5/7/26 at 1358 hours, an interview and concurrent medical record review was conducted with LVN 9. LVN 9 verified the resident received hydroxyzine HCl for anxiety and had a current physician's order for the medication. LVN 9 verified the resident's care plan did not address the use of the hydroxyzine HCl medication or any medication management for anxiety, and stated it should have been included.

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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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to provide necessary treatment and follow-up care to maintain the vision needs for one of one final sampled resident (Resident 123) reviewed for vision and hearing. * The facility failed to ensure Resident 123's follow-up eye specialize appointment was scheduled. This failure posed a risk of the resident not receiving appropriate care for the resident's vision needs.Findings: On 5/5/26 at 935 hours, an interview was conducted with Resident 123. Resident 123 stated she had not been able to see her eye specialist and had not received any information regarding a follow-up appointment. Medical record review for Resident 123 was initiated on 5/5/26. Resident 123 was readmitted to the facility on [DATE]. Review of Resident 123's H&P examination dated 3/10/26, showed Resident 126 had the capacity to understand and make decisions. Resident 123's diagnoses included bilateral eye blindness. Further review of Resident 123's medical record showed an eye specialist progress note dated 1/21/26, documenting diagnoses of diabetes and bilateral eye cataracts. The progress note showed Resident 123 was referred for follow-up with another eye specialist. On 5/6/26 at 0946 hours, an interview and concurrent medical record review was conducted with the Social Services Assistant. When asked about scheduling the follow-up eye specialist appointment noted on 1/21/26, the Social Services Assistant stated she had not received any information about the referral. The Social Services Assistant stated the nursing staff were responsible for informing the Social Services of any follow-up appointments recommended by outside providers. The Social Services Assistant verified the progress note dated 1/21/26, showed a referral to another eye specialist. The Social Services Assistant stated she would begin follow-up. On 5/6/26 at 1001 hours, an interview and concurrent medical record review was conducted with LVN 6. When asked about Resident 123's progress note dated 1/21/26, which showed the referral for Resident 123, LVN 6 stated she informed the SSD and nursing management via a group chat about any appointments for Resident 123.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to properly maintain and assess the IV access for one of one final sampled resident (Resident 148) reviewed for IV catheter care. * The facility failed to ensure Resident 148's PICC line was monitored accurately, and the physician was notified when there was a change in the external catheter length measurement as per the physician's order. In addition, the facility failed to measure and document Resident 148's arm circumference after the initial assessment on 4/2/26. These failures had the potential to delay the identification of PICCˆrelated complications and place the resident at increased risk for harm.Findings: Review of the facility's P&P titled PICC Dressing Change dated 3/2023 showed the following:- Dressing changes using transparent dressings are performed upon admission (if not dated or site is not visible for assessment), at least weekly, and if the integrity of the dressing has been compromised (wet, loose, or soiled); and- The length of the external catheter is obtained upon admission, during dressing changes, or if signs or symptoms of complications are present. On 5/5/26 at 0617 hours, during the initial tour of the facility, Resident 148 was observed in bed, and a single-lumen PICC line catheter was observed on her right upper arm with a dressing dated 5/4/26. Medical record review for Resident 148 was initiated on 5/5/26. Resident 148 was readmitted to the facility on [DATE]. Review of Resident 148's Order Summary Report showed the following physician's orders dated:- 4/2/26, for PICC/Midlines, to document arm circumference in cm one time only.- 4/2/26, to measure external catheter length of the PICC and midlines with each dressing change and as needed every night shift every Sunday (Notify physician if the external length has changed since the last measurement). Document the external catheter length in cm.- 4/2/26, to measure external catheter length of the PICC and midlines with each dressing change and as needed (Notify physician if the external length has changed since the last measurement). Document the external catheter length in cm.- 4/28/26, to measure external catheter length of the PICC and midlines with each dressing change and as needed in the morning every seven days. (Notify physician if the external length has changed since the last measurement). Document the external catheter length in cm.- 4/28/26, to measure external catheter length of PICC and midlines with each dressing change and as needed. (Notify physician if the external length has changed since the last measurement). Document external catheter length in cm. Review of Resident 148's IV MARs for April and May 2026 showed the following: - Resident 148's arm circumference was measured once as 24 cm on 4/3/26, with no further measurements documented.- Resident 148's PICC line dressing changes occurred on 4/28, 4/29, 4/30, 5/2, 5/4, and 5/6/26.- Resident 148's PICC line external catheter was documented as 12 cm on 4/8, 4/12, 4/21, and 5/5/26, but as 0.5 cm on 4/29 and 5/6/26. On 5/7/26 at 0907 hours, an interview and concurrent medical record review for Resident 148 was conducted with RN 2. RN 2 stated the RNs were responsible for administering the IV medications, and PICC line maintenance, such as changing the dressing every Sunday and as needed, and measuring the arm circumference and the external catheter of the PICC line with each dressing changes and as needed. RN 2 verified Resident 148's arm circumference was only measured one time on 4/2/26, and not with every dressing change. RN 2 also verified Resident 148's PICC line external catheter measurement changed from 12 to 0.5 cm. When asked if the physician had been notified when there was change in the measurement of the external catheter, RN 2 could not provide any documentation to show the physician was notified. On 5/7/26 at 1323 hours, an interview and concurrent medical record review for Resident 148 was conducted with the ADON. When asked about the PICC lines, the ADON stated We do not normally check the external catheter and arm circumference. The ADON verified there were physician's orders for Resident 148 to check the arm circumference and external catheter of the resident's PICC line. The ADON verified Resident 148's PICC line external catheter measurement changed from 12 to 0.5 cm, but there was no documented (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evidence to show the physician was notified when the external length had changed since the last measurement. On 5/8/26 at 0836 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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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, medical record review, and facility P&P review, the facility failed to ensure appropriate pain management for two of five final sampled residents (Residents 83 and 148) reviewed for pain management. * The facility failed to provide nonpharmacological interventions for pain management to Resident 83 prior to administering the pain medication. * The facility failed to provide nonpharmacological interventions for pain management to Resident 148 prior to administering the pain medication. In addition, the Norco (narcotic pain medication) medication was administered to Resident 148 when the documented pain level was 0/10 (on the pain scale of 0 to 10 with 0 = no pain and 10 = worst). These failures had the potential to result in ineffective pain management and/or expose the residents to unnecessary medication use and associated adverse effects.Findings: Review of the facility's P&P titled Pain Assessment and Management dated 2001 showed the pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. Assess the resident at admission and during ongoing assessments to help identify the resident who is experiencing pain or for whom pain may be anticipated during specific procedures, care, or treatment. Nonpharmacological interventions may be appropriate alone or in conjunction with medications. Some non-pharmacological interventions includes a. environmental - adjusting the room temperature, smoothing the linens, providing a pressure reducing mattress, repositioning, etc.; b. physical - ice packs, cool or warm compresses, baths, transcutaneous electrical nerve stimulation (TENS), massage, acupuncture, etc.; c. exercise - range of motion exercises to prevent muscle stiffness and contractures; and d. cognitive or behavioral - relaxation, music, diversions, activities, etc. Pharmacological interventions (i.e., analgesics) may be prescribed to manage pain; however, they do not usually address the cause of pain and can have adverse effects on the resident (e.g., drowsiness, increased risk of falling; loss of appetite). When opioids are used for pain management, the resident is monitored for medication effectiveness, adverse effects, and potential overdose. The medication regimen is implemented as ordered. Results of the interventions are documented and communicated directly to the provider when appropriate. Ongoing communication between the prescriber and the staff is necessary for the optimal and judicious use of pain medications. 1. Medical record review for Resident 83 was initiated on 5/5/26. Resident 83 was admitted to the facility on [DATE], and was readmitted on [DATE]. Review of Resident 83's MDS assessment dated [DATE], showed Resident 83 had a BIMS score of 14, indicating intact cognition. Review of Resident 83's Order Summary Report dated 5/6/26, showed a physician's order dated 4/28/26, to administer hydrocodone-acetaminophen (Norco-narcotic pain medication) 10-325 mg tablet by mouth every eight hours as needed for moderate to severe pain (4-10). Document nonpharmacologic interventions as follows: 1-Relaxation, 2-Adjust room temp/lighting, 3- Reposition, 4-Toileting, 5-Music/TV, 6-Snacks, 7-Warm/Cold compress, 8-Others. Review of Resident 83's MAR for 4/1 through 4/30/26 showed the resident was administered hydrocodone-acetaminophen 10-325 mg tablet on: - 4/29/26 at 1246 hours, for pain level of 6 (on the pain scale of 0 to 10 with 0 = no pain and 10 = (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	worst); - 4/30/26 at 0303 hours, for pain level of 8; and - 4/30/26 at 1215 hours, for pain level at 6, Review of Resident 83's MAR for 5/1 through 5/31/26 showed the resident was administered hydrocodone-acetaminophen 10-325 mg tablet on: - 5/1/26 at 0309 hours, for pain level of 8; - 5/1/26 at 1826 hours, for pain level of 8; - 5/2/26 at 1957 hours, for pain level of 7; - 5/3/26 at 1407 hours, for pain level of 6; - 5/4/26 at 0507 hours, for pain level of 9; - 5/4/26 at 1936 hours, for pain level of 8; - 5/5/26 at 1255 hours, for pain level of 6; and - 5/5/26 at 2153 hours, for pain level of 8. On 5/6/26 at 1105 hours, an interview was conducted with Resident 83. Resident 83 verified receiving the hydrocodone-acetaminophen medication for her pain management but was not offered nonpharmacological interventions prior to receiving the pain medication. On 5/6/26 at 1222 hours, an interview and concurrent record review for Resident 83 was conducted with LVN 4. LVN 4 stated nonpharmacologic interventions should be offered when the resident reports pain and documented in the MAR. LVN 4 verified the resident's MAR failed to show nonpharmacologic interventions were provided to the resident prior to administering the pain medication. On 5/8/26 at 1005 hours, an interview was conducted with the DON. The DON stated the licensed nurses are expected to provide nonpharmacologic interventions for the residents. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 148 was initiated on 5/5/26. Resident 83 was admitted to the facility on [DATE]. Review of Resident 148's Order Summary Report showed a physician's order dated 4/14/26, to administer Norco 5/325 mg tablet by mouth every six hours as needed for moderate to severe pain (4-10 pain level). Hold for respirations less than 12 breaths per minute. Document nonpharmacological interventions as follows: 1-Relaxation, 2-Adjust room temp/lighting, 3- Reposition, 4-Toileting, 5-Music/TV, 6-Snacks, 7-Warm/Cold compress, 8-Others. Review of Resident 148's MAR for April and May 2026 showed Resident 148 was administered the (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Norco 5/325 mg medication on: - 4/16/26 at 2048 hours, for pain level of 8; - 4/18/26 at 2359 hours, for pain level of 8; - 4/19/26 at 2058 hours, for pain level of 8; - 4/21/26 at 0454 hours, for pain level of 5; - 4/24/26 at 0830 hours, for pain level of 8; - 4/25/26 at 0020 hours, for pain level of 7, at 1014 hours, for pain level of 8, and 2015 hours, for pain level of 5; - 4/26/26 at 0832 hours, for pain level of 0; - 4/28/26 at 2226 hours, for pain level of 6; - 4/30/26 at 2335 hours, for pain level of 6; - 5/2/26 at 0037 hours, for pain level of 8, at 1238 hours, for pain level of 9, and at 2332 hours, for pain level of 7. However, further review of Resident 148' s medical record did not show documented evidence the resident was provided with nonpharmacological interventions prior to administration of Norco. On 5/7/26 at 0907hours, an interview and concurrent medical record review for Resident 148 was conducted with RN 2. RN 2 verified nonpharmacologic interventions were not provided to Resident 148 when the resident complained of pain, and prior to providing Norco medication. RN 2 also verified the Norco medication was administered when Resident 148's pain level was 0/10. On 5/8/26 at 0836 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure necessary pharmaceutical services were provided to maintain safe and appropriate medication administration for one nonsampled resident (Resident 99) and one of three medication carts (Medication Cart A) inspected. * The facility failed to ensure LVN 4 checked Resident 99's respiratory rate prior to administering the gabapentin (nerve pain medication), as prescribed by the physician. This failure placed the resident at risk for potential side effects or complications. * The facility failed to document when the glucagon emergency kit (used to treat sever, life threatening low blood sugar) was opened and failed to replace it within 72 hours as required by the facility's P&P. This failure had the potential to delay timely emergency treatment for residents experiencing severe hypoglycemia.Findings: 1. On 5/6/26 at 0826 hours, a medication administration observation for Resident 99 was conducted with LVN 4. LVN 4 prepared the medications for Resident 99 including two capsules of the gabapentin 100 mg medication. During the medication administration observation, LVN 4 administered the gabapentin medication to Resident 99 without checking the resident's respiratory rate. Medical record review for Resident 99 was initiated on 5/5/26. Resident 99 was readmitted to the facility on [DATE]. Review of Resident 99's Order Summary Report showed a physician's order dated 5/5/26, to administer gabapentin 100 mg two capsules by mouth two times a day. Hold for respiratory rate less than 12 breaths per minute. On 5/6/26 at 0857 hours, an interview and concurrent medical record review for Resident 99 was conducted with LVN 4. LVN 4 stated the charge nurses were responsible for checking the residents' vital signs and verified she did not check Resident 99's respiratory rate prior to administering the gabapentin medication. On 5/8/26 at 0836 hours, an interview for Resident 99 was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Review of the facility's P&P titled Emergency Pharmacy Service and Emergency Kits revised 1/2025 showed when an emergency medication is needed, the nurse unlocks the container and removes the required medication. After removing the medication, complete the emergency e-kit slip and reseal the emergency supply. An entry is made in the emergency logbook containing all required information. Use of emergency medication is noted on the resident's MAR.used sealed kits are replaced with new sealed kits within 72 hours of opening. On 5/6/26 at 1059 hours, during inspection of Medication Cart A with LVN 4, a small red box of glucagon emergency kit (expiration date of 2/2026) was observed opened and unsealed in the top drawer of Medication Cart A. There was no documentation indicating when it had been opened or for which resident the medication was administered to. LVN 4 verified the findings and stated she could not locate any log documenting when the kit was opened or used. LVN 4 stated the glucagon emergency kit should have been immediately replaced after it was opened and once an emergency kit was opened, the nursing staff had must notify the pharmacy for immediate replacement to prevent (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	delays in emergency medication availability. On 5/8/26 at 1049 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. Cross reference to F761, example #1.a.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility document review, the facility failed to ensure the irregularities in a resident's drug regimen were identified and reported for one of one final sampled resident (Resident 123) reviewed for insulin (hormone produced by the body to regulate blood sugar) use. * The facility's pharmacy review binder did not contain pharmacy recommendations addressing Resident 123's repeated refusal of insulin injections and related blood sugar checks. This failure posed the risk of Resident 123 not receiving appropriate care and monitoring for diabetes management.Findings: Review of the facility's Matrix (undated) showed Resident 123 was receiving insulin therapy. Medical record review for Resident 123 was initiated on 5/5/26. Resident 123 was readmitted to the facility on [DATE]. Review of Resident 123's Face Sheet dated 5/6/26, showed under the Diagnosis Information the resident had Type 2 Diabetes Mellitus. Review of Resident 123's MARs for April and May 2026 showed Resident 123 had a physician's order dated 4/13/26, to administer Humulin R (insulin) injections, per sliding scale. Further review of MARs showed Resident 123 had multiple episodes in which the resident refused her insulin injections and blood sugar checks. Review of the facility's Pharmacy Recommendations Binder for 2026 showed no documented pharmacy recommendations addressing Resident 123's ongoing refusals of insulin injections and blood sugar monitoring. On 5/13/26 at 1622 hours, a telephone interview was conducted with Pharmacy Consultant 1. Pharmacy Consultant 1 was informed and verified the above findings.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure one of five sampled residents (Resident 148) reviewed for unnecessary medications was free from unnecessary medications. * The facility failed to ensure Resident 148's heart rate was checked prior to administering the amiodarone (antiarrhythmic medication), as prescribed by the physician. This failure increased the risk of medicationˆrelated adverse effects and had the potential to negatively impact the resident's health and wellˆbeing.Findings: Medical record review for Resident 148 was initiated on 5/5/26. Resident 148 was readmitted to the facility on [DATE]. Review of Resident 148's Order Summary Report showed a physician's order dated 3/23/26, to administer amiodarone 200 mg one tablet by mouth two times a day for arrythmia. Hold for heart rate less than 60 beats per minute. Review of Resident 148's MAR for April and May 2026 showed Resident 148 was administered the amiodarone medication from 4/1 to 4/26/26 at 0900 and 1700 hours, and on 4/29 to 5/5/26 at 0900 and 1700 hours. However, there was no documented evidence to show the licensed nurses monitored Resident 148's heart rate prior to the administration of the amiodarone medication from 4/1 to 4/22/26 at 0900 and 1700 hours, and on 4/23/26 at 0900 hours. On 5/7/26 at 0907 hours, an interview and concurrent medical record review for Resident 148 was conducted with RN 2. RN 2 verified the above findings. On 5/8/26 at 0836 hours, an interview for Resident 148 was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the laboratory testing was completed as ordered by the physician for one of five sampled residents (Resident 83) reviewed for unnecessary medication. * The facility failed to ensure Resident 83's baseline laboratory tests, including a CBC (a blood test to determine health status, including anemia and infection), lipid panel (a blood test measuring cholesterol and triglycerides to assess cardiovascular risk), CMP (a blood panel test that measures sugar (glucose) levels, electrolyte/fluid balance, kidney function, and liver function), glycohemoglobin A1C (measures the average amount of glucose (sugar) attached to hemoglobin in red blood cells over the past two to three months), magnesium (a blood test to measure magnesium levels in the serum to diagnose deficiencies or excesses which are crucial for heart, nerve, and muscle function) and phosphorus (measures the amount of phosphate in the blood, which is essential for bone health, energy production, and nerve function. It is primarily used to check for kidney disease) were completed as ordered by the physician. This failure posed a risk for undetected laboratory abnormalities, which could significantly impact the resident's health and wellˆbeing.Findings: Review of the facility's P&P titled Lab and Diagnostic Test Results - Clinical Protocol dated 2001 showed the physician will identify and order diagnostic and lab testing based on diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests. Medical record review for Resident 83 was initiated on 5/5/26. Resident 83 was admitted to the facility on [DATE], and was readmitted on [DATE]. Review of Resident 83's MDS assessment dated [DATE], showed Resident 83 had a BIMS score of 14, indicating intact cognition. Review of Resident 83's Order Summary Report dated 5/6/26, showed a physician's order dated 4/25/26, for baseline laboratory testing (CBC, lipid panel, complete metabolic panel, glycohemoglobin A1C, magnesium and phosphorus). The order specified the test was to be completed on Monday then weekly thereafter. However, review of Resident 83's medical record failed to show the laboratory test results for the above laboratory testing that were due on 4/27 and 5/4/26. On 5/6/26 at 1248 hours, an interview and concurrent medical record review for Resident 83 was conducted with LVN 4. LVN 4 verified the laboratory orders were active and required weekly testing beginning 4/27/26, and the resident's medical record did not contain the required laboratory results for the ordered tests. On 5/8/26 at 1008 hours, an interview was conducted with the DON. The DON stated the licensed nurses were responsible for entering laboratory orders into the laboratory portal to ensure completion. The DON was informed and acknowledged the above findings.

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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 facility document review, the facility failed to ensure the menus were followed for 25 of 91 residents receiving mechanically altered diets. * The facility failed to follow the menu for the residents receiving mechanically altered diets when the residents did not receive the correct meal portion sizes as specified in the menu and spreadsheet. These failures posed the risk that residents' nutritional needs would not be met, potentially leading to unintentional weight loss and further medical complications.Findings: Review of the facility's document titled Diet Tally dated 5/6/26, showed three residents had a physician's order for an IDDSI Level 4 (Puree) diet, four residents had a physician's order for an IDDSI Level 5 (Minced and Moist) diet, and 18 residents had a physician's order for an IDDSI Level 6 (Soft & Bite Sized) diet. Review of the facility's document titled Cooks Spreadsheet dated 5/6/26, showed for the following for the lunch meal:- The IDDSI Level 4 diet should have received 3/4 cup (scoop #10 x 2) pureed sweet and sour chicken, and 1/2 cup (scoop #8) pureed sesame noodles.- The IDDSI Level 5 diet should have received 3/4 cup (scoop #10 x 2) minced/moist sweet and sour chicken and 1/2 cup (scoop #8) minced/moist sesame noodles.- The IDDSI Level 6 diet should have received 3/4 cup (scoop #10 x 2) soft/bite sized sweet and sour chicken and 1/2 cup (scoop #8) soft/bite sized sesame noodles. On 5/6/26 at 1152 hours, during the observation of the lunch meal tray line, the following portion sizes was observed:- The IDDSI Level 4 diet was served 1/3 cup pureed sweet and sour chicken (a difference of six tablespoons and two teaspoons less than the specified quantity per the menu spreadsheet) and 1/3 cup pureed stir fry vegetables (a difference of two and half tablespoons less than the specified quantity per the menu spreadsheet).- The IDDSI Level 5 was served 1/3 cup minced/moist sweet and sour chicken (a difference of six tablespoons and two teaspoons less than the specified quantity per the menu spreadsheet) and 1/3 cup minced/moist sesame noodles (a difference of two and half tablespoons less than the specified quantity per the menu spreadsheet).- The IDDSI Level 6 was served 1/3 cup soft/bite sized sweet and sour chicken (a difference of six tablespoons and two teaspoons less than the specified quantity per the menu spreadsheet) and 1/3 cup soft bite sized sesame noodles (a difference of two and half tablespoons less than the specified quantity per the menu spreadsheet). Photographic evidence was taken of the lunch meal tray line portion sizes. On 5/7/26 at 0930 hours, an interview was conducted with the Dietary Supervisor and RD. The photographs of the lunch meal tray line portion sizes on 5/6/26, were shared with the Dietary Supervisor and RD. The Dietary Supervisor verified the scoop sizes for the IDDSI Level 4 sweet and sour chicken and stir fry vegetables, scoop sizes for the IDDSI Level 5 sweet and sour chicken and sesame noodles and the scoop sizes for the IDDSI Level 6 sweet and sour chicken and sesame noodles were incorrect. The Dietary Supervisor verified the portions served did not meet the amounts listed on the Cook's Spreadsheet and stated the correct menu portions must be followed to ensure residents receive adequate nutrition.

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	055330	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehab Center of Tustin	2210 E. First Street Santa Ana, CA 92705

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and facility document review, the facility failed to ensure food for the residents on textured-modified diet was prepared in accordance with accepted standards for four of 91 residents received IDDSI Level 5 diets. * The facility failed to follow the guidelines for the IDDSI Level 5 Minced and Moist diet when the minced and moist foods were not served in the correct consistency. This failure had the potential to increase the risk of choking, aspiration, and inadequate nutrition for residents requiring a modified texture diet.Findings: According to the IDDSI Framework 2.0 dated July 2019 Level 5 Minced and Moist should be soft and moist with no separate thin liquid. Meat should be finely minced and served in mildly, moderately or extremely thick smooth, sauce or gravy, draining any excess liquid. Review of the facility's document titled Diet Tally dated 5/6/26, showed four residents received a Level 5 Minced and Moist diet. Review of the facility's document titled Cooks Spreadsheet dated 5/6/26, showed Level 5 Minced and Moist diets should receive 3/4 cup minced and moist chicken for the lunch meal. The spreadsheet did not list a sauce or gravy for the Level 5 Minced and Moist chicken. On 5/6/26 at 1230 hours, during an observation of the lunch meal tray line, the Level 5 Minced and Moist chicken was served with a thin sauce poured over the meat. The minced/moist chicken was in a separate steam table pan from the sauce. Photographic evidence was obtained of all foods on the tray line. On 5/7/26 at 0930 hours, an interview was conducted with the RD. The RD was shown and reviewed the photograph of the Level 5 Minced and Moist chicken as served. The RD verified the Level 5 Minced and Moist meat should have thickened liquid mixed into the meat rather than thin liquid served on top of the meat.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure one of 20 final sampled residents (Resident 107) food preferences were honored. * The facility failed to ensure Resident 107's eggs were prepared to her stated preference, resulting in her receiving and eating eggs that were too runny and not consistent with her preference. This failure had the potential to negatively affect the resident's dining experience and overall satisfaction with care.Findings: On 5/5/26, at 815 hours, an observation and concurrent interview was conducted with Resident 107. Resident 107 was observed with her breakfast tray on her overbed table. The breakfast tray included sunny side-up eggs that appeared runnier than typically served. Resident 107 was observed gesturing to the Dietary Supervisor to indicate she disliked the runny eggs served. The Dietary Supervisor was then observed telling Resident 107 the facility had run out of eggs. Medical record review for Resident 107 was initiated on 5/5/26. Resident 107 was admitted to the facility on [DATE]. Review of Resident 107's H&P examination dated 3/21/26, showed Resident 107 had the capacity to make decisions. The H&P also showed the resident's diagnoses included post-stroke status. On 5/7/26 at 0828 hours, an interview was conducted with Resident 107. When asked about her breakfast served on 5/5/26, including the runny eggs served, Resident 107 gestured she ate the eggs served on 5/5/26, but did not like extra runny eggs served. On 5/8/26, at 0945 hours, an interview and concurrent medical record review was conducted with the RD. The RD was informed of the above findings. The RD verified the facility ran out of eggs on 5/5/26. When asked when the new delivery of eggs arrived, the RD stated the egg shipment arrived around noon on 5/5/26. The RD acknowledged Resident 107 could have been offered an alternative entree rather than being served eggs that were not consistent with the resident's food preference.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure the food safety and sanitation guidelines were followed. * The facility failed to ensure a floor drain in the kitchen was clean. This failure had the potential to compromise kitchen sanitation and cause foodborne illnesses to the medically vulnerable residents population who consumed food prepared in the kitchen.Findings: According to the USDA Food Code Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces and Utensils (C) showed, the nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. On 5/5/26 at 0829 hours, during the initial tour of the kitchen, an observation and concurrent interview was conducted with the Dietary Supervisor. A floor drain located under a food preparation sink was observed with excessive black residue and food remnants. The Dietary Supervisor verified the floor drain was not clean.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and facility document review, the facility failed to ensure the Facility Assessment was complete and accurate. * The facility failed to ensure the Facility Assessment included input from residents and resident representatives. In addition, the Facility Assessment inaccurately indicated the facility employed a Social Services Director and only one treatment nurse. These failures posed the risk that the facility may not have identified or planned for the necessary resources to meet residents' needs.Findings: Review of the Facility assessment dated [DATE], failed to show input from the residents and resident representatives was obtained to complete the facility assessment. The assessment further showed the facility had one Social Services Director employed and one LVN treatment nurse. On 5/6/26 at 0946 hours, an interview was conducted with the Social Services Assistant. The Social Services Assistant stated the facility had not had a Social Services Director since March or April 2026. Review of the facility's May 2026 monthly staff assignment showed two treatment nurses were employed by the facility. On 5/7/26 at 1400 hours, an interview was conducted with the Administrator. The Administrator was informed and verified the above findings.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to ensure for a safe and comfortable environment for two of 43 resident rooms (Rooms A and B). * The facility failed to ensure the room temperature was maintained in comfortable level for Rooms A and B, when the residents residing in the rooms complained of the room temperature being too cold. The temperature was 71 degree Fahrenheit. This failure posed the risk of the residents not being able to sleep comfortably.Findings: On 5/5/26 at 0815 hours, during the initial tour, there were two residents observed inside Room A with blankets covering their bodies. Both residents stated the temperature inside Room A was cold after 1730 hours. The temperature inside Room A felt cold. On 5/6/26 at 0750 hours, during an observation, a cold breeze was felt inside Room A. On 5/6/26 at 0750 hours, a subsequent observation was conducted inside Room B. There was a cool strong breeze coming out of Room B's vent and moving a privacy curtain near the vent. On 5/6/26 at 0843 hours, an interview was conducted with the Maintenance Assistant. The Maintenance Assistant verified a cool breeze was coming out of the vent inside Rooms A and B. When asked how the staff could adjust the temperature for the residents during the times when the maintenance department was not in the facility, the Maintenance Assistant verbalized staff could retrieve the key from the key cabinet or ask the supervising nurse for the key to open the covered, locked thermostat and adjust the temperature. The Maintenance Director was observed going to the facility's key cabinet and was observed not finding the key for the locked thermostat. The Maintenance Director then asked RN 2 for the key. RN 2 stated she did not have the key to the thermostats and then checked a drawer full of keys. The Maintenance Director acknowledged the key to open the covered locked thermostat was not available to the staff during the hours the maintenance staff was not in the facility. The Maintenance Director verified the above findings.

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F 0583 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interview, and facility document review, the facility failed to protect the residents' identifiable information. * The facility's Survey Inspection Results binder for public viewing included two Confidential Resident Rosters (a list which identified the names of the residents by their identifiers given for surveys to protect the residents' identities). This failure resulted in confidential residents' information being accessible to the public.Findings: On 5/7/26 at 1100 hours, the Survey Inspection Results binder was observed in a wall pocket in the hallway between the front lobby and Nurse's Station A, accessible for public review. Review of the Survey Inspection Results binder showed two Confidential Resident Rosters for the following surveys:- an Abbreviated Survey dated 2/19 - 2/24/26, with five resident identifiers and their names; and - an Abbreviated Survey dated 4/15/26, with four resident identifiers and their names. The rosters were identified as being confidential and had Confidential printed diagonally across the page in a large grey font. On 5/7/26 at 1128 hours, an interview and concurrent facility document review was conducted with the Administrator. The Administrator verified the confidential resident rosters should not have been placed in the public survey binder for public view.

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F 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to timely complete the admission MDS assessments for two of 20 final sampled residents (Residents 92 and 143). - Resident 92's admission MDS assessment was late and incomplete.- Resident 143's admission MDS assessment was completed late.These failures had the potential to delay the establishment of a standardized, holistic baseline assessment of the residents' functional capabilities and health needs upon admission, as well as delay required submission of an assessment data to CMS.Findings: 1. Medical record review for Resident 92 was initiated on 5/5/26. Resident 92 was admitted on [DATE]. Review of Resident 92's EHR showed an admission MDS assessment dated [DATE]. The assessment was incomplete with only one of 18 sections completed. The resident's 14th day in the facility was 4/30/26. On 5/5/26 at 1410 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. The MDS Coordinator reviewed Resident 92's medical record and verified the admission MDS assessment was still incomplete, and not completed within the required 14-day timeframe. 2. Medical record review for Resident 143 was initiated on 5/5/26. Resident 143 was admitted on [DATE]. Review of Resident 143's admission MDS assessment dated [DATE], showed it was electronically signed as completed on 4/3/36. The resident's 14th day at the facility was 4/1/26. On 5/7/26 at 1031 hours, an interview and concurrent medical record review was conducted with the MDS Assistant. The MDS Assistant reviewed Resident 143's medical record and verified the admission Assessment was not completed within the required 14-day timeframe.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and facility document review, the facility failed to ensure three of four CNA employee personnel files contained annual performance evaluations. * CNA 3, 4, and 5's employee personnel files failed to contain the staff's annual performance evaluations. These failures posed a risk that the CNAs may not receive appropriate inˆservice education or performanceˆbased feedback necessary to ensure quality resident care.Findings: On 5/6/26 at 1000 hours, an interview and concurrent review of CNA 3, 4, and 5's employee personnel files was conducted with the DSD. The following was observed: - CNA 3's employee personnel file showed a date of hire of 6/19/12. - CNA 4's employee personnel file showed a date of hire of 8/13/24. - CNA 5's employee file showed a date of hire of 11/29/23. When asked to provide the most recent performance evaluations, the DSD stated he was unable to locate CNA 3, 4, and 5's prior performance evaluations.