

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Culver West Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4035 Grandview Blvd. Los Angeles, CA 90066	
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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on interview, and record review, the facility failed to complete the Annual Minimum Data Set (MDS-a resident assessment tool) Assessment timely for one of four sampled residents (Resident 4 and Resident 12) according to the facility's policy and procedures (P&P) titled, Resident Assessment Instrument, revised 1/2/2026, This deficient practice had the potential to negatively affect the provision of necessary care and services needed for Resident 4 and Resident 12. Cross Reference F640 Findings: During a concurrent interview and record review with Minimum Data Set Coordinator (MDSN) on 7/9/2026 at 3:19 PM, Resident 4 and Resident 12's most recent annual MDS assessments were reviewed. MDSN stated Resident 4 and Resident 12's MDS was not completed at that time. MDSN stated the annual assessments were started on 6/8/2026 and should have been completed within 14 days (6/22/2026). MDSN stated the MDS delineates all the care services provided to the resident and not completing the MDS within CMS guidelines could lead to the facility not recognizing a change in the resident's condition. During an interview on 7/9/2026 at 3:25 PM, the Director of Nursing (DON) stated MDS assessments should be completed and submitted per CMS guidelines. A review of the facility's policy and procedures (P&P) titled, Resident Assessment Instrument, revised 1/2/2026, indicated the Resident Assessment Coordinator is responsible for ensuring that the Interdisciplinary Team conduct timely and appropriate resident assessments and reviews according to the following schedule: a. Within fourteen (14) days of the resident's admission to the facility; b. When there has been a significant change in the resident's condition; c. At least quarterly; and d. Once every twelve (12) months.		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS - a resident assessment tool) was transmitted timely to the Centers for Medicare and Medicaid Services (CMS) system for one out of the four sampled residents (Resident 4, Resident12) according to the facility's policy and procedures (P&P) titled, Resident Assessment Instrument, revised 1/2/2026, i . This deficient practice had the potential to result in delayed services for Resident 4 and This deficient practice had the potential to result in delayed services for Resident 12.Cross Reference F636Findings: A review of the facility's Centers for Medicare and Medicaid Services (CMS) Submission (transmission) Report dated 7/9/2026, indicated Resident 12's Annual MDS was submitted on 7/9/2026 (31 days after the assessment reference date (ARD), 6/8/2026. During a concurrent interview and record review with Minimum Data Set Coordinator (MDSN) on 7/9/2026 at 3:19 PM, Resident 4 and Resident12's most recent annual MDS assessments were reviewed. MDSN stated Resident 4 and Resident12's MDS was not completed at that time. MDSN stated the annual assessments were started on 6/8/2026 and should have been completed within 14 days (6/22/2026) and submitted within 14 days of the completion date (7/6/2026). During an interview on 7/9/2026 at 3:25 PM, the Director of Nursing (DON) stated MDS assessments should be completed and submitted per CMS guidelines. A review of the facility's policy and procedures (P&P) titled, Resident Assessment Instrument, revised 1/2/2026, indicated the Resident Assessment Coordinator is responsible for ensuring that the Interdisciplinary Team conduct timely and appropriate resident assessments and reviews according to the following schedule:a. Within fourteen (14) days of the resident's admission to the facility;b. When there has been a significant change in the resident's condition;c. At least quarterly; andd. Once every twelve (12) months.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to contact and verify with a physician if one of one sampled resident (Resident 17) can continue to take apixaban (a prescription anticoagulant (blood thinner) 2.5 (dose) milligrams (mg - unit of measure) Atrial Fibrillation (AFib-an irregular and often very rapid heart rhythm which can lead to blood clot formation in the heart increasing the risk of stroke, heart failure and other heart-related complications). This deficient practice resulted in Resident 17 not receiving apixaban after 2/2026 and substantially placing Resident 17 at increased to suffer cardiovascular event, hospitalization and death. Findings: A review of Resident 17's medical record indicated Resident 17 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses thank include, type 2 diabetes mellitus (a long term metabolic condition where the body either resists the effects of insulin (a hormone that regulates sugar)), chronic systolic congestive heart failure (medical condition where the heart cannot pump blood efficiently), primary pulmonary hypertension (high blood pressure develops within the blood vessels of your lungs), persistent atrial fibrillation (a continuous, irregular heart rhythm that lasts longer than seven days), chronic kidney disease (a condition in which the kidneys are damaged and gradually lose their ability to filter waste and excess fluid from the blood), anemia (a medical condition where your body lacks enough healthy red blood cells or hemoglobin to effectively carry oxygen to your tissues), abnormalities of gait and mobility (medical condition that changes how you walk or move) and muscle weakness. A review of Resident 17's history and physical (H&P) dated 12/23/2025 indicated, Resident 17 is alert and oriented X4 (the patient is alert and oriented to person, place, time, situation). A review of Resident 17's Minimum Data Set (MDS - a resident assessment tool) dated 4/15/2026 indicated the resident 17's cognition (The mental ability to make decision of daily living) was intact, Resident 17 was independent with eating, required set-up or clean-up assistance for oral hygiene, required supervision with personal hygiene, Resident 17 required partial moderate assistance with toileting hygiene and upper body dressing, substantial maximal assistance with shower/bathe and was totally dependent for lower body dressing and putting on/taking off footwear. During a facility tour on 7/6/2026 at 9:27am Resident 17 stated he told several facility staff on multiple occasions (dates and times unknown) to give him a medication called apixaban (a prescription anticoagulant (blood thinner) 2.5 (dose) mg (unit of measure) that he had been previously prescribed by for his primary care physician for AFIB but has been unsuccessful in convincing them (licensed staff) of his need of medication. Resident 17 stated the last time he received his AFIB medication was 2/2026. During a concurrent interview and record review on 7/7/2026 at 11:02 am, with the Minimum Data Set Nurse -lead (MDSN) nurse stated Resident 17's current electronic medical administration record, indicated he (Resident 17) was not prescribed apixaban and/or any medication for atrial fibrillation. MDSN stated she would call the Resident 17's physician to check if Resident 17 still needed apixaban for atrial fibrillation. A review of Resident 17 electronic medical administration records history indicated an order for apixaban oral tablet 2.5mg for atrial fibrillation was discontinued on 12/21/2025. A review of Resident 17 medical records on 7/7/2026 at 12:08pm indicated an order for Apixaban oral tablet 2.5mg to be given by mouth two (2) times a day resumed on 7/7/2026 at 11:27 am. During an interview on 7/9/2026 at 1:15pm, Licensed Vocational Nurse (LVN) 2 stated, if a resident a medication that he/she has previously been prescribed, LVN2 would ask the resident why the needed the medication, verify the diagnosis, check the electronic medical record and inform the resident's physician of the residents request to have the medication started or resumed. LVN 2 stated (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stopping crucial medication like apixaban indefinitely exposes a resident to risk of stroke, heart attack, pulmonary embolism which could result in sudden death. During an interview on 7/9/2026 at 1:29pm, Director of Nursing (DON) stated if a Resident requests a medication that is not on his/her current ordered medication, licensed nurses should clarify with the primary care physician (PCP) if the resident needs the medication. DON stated, discontinuing apixaban indefinitely without justification, places a Resident at risk of developing blood clots which could lead to stroke. A review of the facility's policy and procedures (P&P) titled Resident Rights dated 1/12/2026, indicated, Federal and state laws guarantee certain basic rights to all resident of this facility. These rights include the Resident's right to be informed of and participate in, his or her treatment, . have the facility to respond to his or her grievances.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage practices in the facility kitchen when: Refrigerator 1's internal temperature indicated 45 degrees Fahrenheit (F- unit to measure temperature - 41 degrees F or lower). Freezer 1's internal temperature indicated 10 degrees Celsius (C- unit to measure temperature - 17 degrees C or lower). These failures had the potential to result in cross contamination (transfer of harmful bacteria from one place to another) and an increased risk of foodborne illness (any illness resulting from eating contaminated or spoiled food) to the resident who consumed food from the facility's kitchen. Findings: During a concurrent observation and interview on 7/6/2026 at 9:05 A.M. with Dietary Aid (DA) 1 in the kitchen, Refrigerator 1's internal temperature indicated 45 degrees F (recommended temperature is 41 degrees F or lower). DA 1 stated 45 degrees F is too warm for the inside of the refrigerator. DA 1 also stated that if the internal temperature of a refrigerator is too warm, then the food could potentially become contaminated, and the residents can become sick. During a concurrent observation and interview on 7/6/2026 at 9:07 A.M. with DA 1 in the kitchen, Freezer 1's internal temperature indicated 10 degrees C (recommended -17 degrees C or lower). DA 1 stated that 10 degrees C is too warm for the inside of the freezer. DA 1 also stated that if the internal temperature of a freezer is too warm, then the food could potentially become contaminated, and the residents can become sick. During an interview on 7/7/2026 at 2:10 P.M. with the Dietary Supervisor (DS), the DS stated that internal temperatures of 45 degrees F (Refrigerator 1) and 10 degrees C (Freezer 1) are too warm. The DS stated that if food storage temperatures are too warm, this can potentially cause the food to be contaminated and result in the residents becoming sick. During a review of the facility's policy and procedure (P&P) titled, Procedure for Refrigerated Storage, dated 2023, indicated: Refrigerator - 41 degrees F or lower Freezer - 0 degrees F (-17 degrees C) or lower During a review of Food Code 2022, dated 1/18/2022, the Food Code 2022 page 105, indicated, Under refrigeration that maintains the food temperature at 5 degrees C (41 degrees F) or less.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services and equipment to improve toileting and toilet transfer abilities for one of four sampled residents (Resident 5) who was continent (having voluntary control of urination and bowel movements) and able to walk and transfer (move from one surface to another) with assistance. This deficient practice resulted in Resident 5 wearing adult briefs (absorbent, disposable garments worn to manage bowel and bladder loss) and toileting in bed instead of walking to the bathroom or using a commode (portable toilet) due to lack of available toileting equipment for safe transfers, feelings of humiliation and low self-worth, and placed Resident 5 at risk for functional decline, skin breakdown (tissue damage caused by friction, shear, moisture, or pressure), and incontinence (having no or insufficient voluntary control over urination or bowel movements). Cross Reference F676 & F690 Findings: During a review of Resident 5's admission Record (AR), the AR indicated Resident 5 initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including, but not limited to end stage renal disease (ESRD, chronic kidney disease that causes gradual loss of kidney function), morbid obesity (chronic disease characterized by excessive body fat), muscle weakness, and benign prostatic hyperplasia with lower urinary tract symptoms (enlargement of the prostate gland causing urinary symptoms such as frequent urination). During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 6/1/2026, the MDS indicated Resident 5 was cognitively (mental action or process of acquiring knowledge and understanding) intact. The MDS indicated Resident 5 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene and bathing, supervision or touching assistance with upper body dressing and walking 150 feet, set-up or clean-up assistance with sit to stand, bed to chair transfers, and toilet transfers, and was independent with eating, oral hygiene, rolling to both sides, and lying to sitting on the side of the bed. The MDS indicated Resident 5 was always continent of bowel and bladder. During an observation and interview on 7/7/2026 at 9:07 am with Resident 5, Resident 5 was lying in bed wearing adult briefs. Resident 5 stated he primarily used a bed pan (shallow pan used by immobile individuals to urinate or have a bowel movement while in bed) and urinal (reusable or disposable container designed for urinating without access to a standard toilet) for toileting and wore adult briefs daily for possible accidents because the toilet in the bathroom was too low and he did not have a commode or device that elevated the toilet seat. Resident 5 stated he was over six feet tall and could not safely transfer on and off the toilet in his bathroom because the toilet seat was too low. Resident 5 stated he tried to sit on the toilet in his bathroom in the past, got stuck, and required two staff members to assist him off the toilet. Resident 5 stated he informed staff and requested equipment to elevate the toilet seat or commode that could accommodate his weight and size multiple times, but staff never gave him equipment and instructed him to use a bedpan, urinal, and adult brief instead. Resident 5 stated he was able to walk, tried to be as independent as possible, and felt humiliated and degraded because he had to wear an adult brief and toilet in bed. During an interview and record review on 7/7/2026 at 3:02 pm with Occupational Therapist 1 (OT 1), OT 1 stated OT evaluated a resident's activities of daily living (ADL, basic activities such as eating, dressing, toileting) function and provided treatment and equipment recommendations to improve ADLs, such as toileting and toilet transfers. OT 1 reviewed Resident 5's OT Discharge summary, dated [DATE], and confirmed OT 1 discharged Resident 5 from OT services because Resident 5 was no longer progressing in ADLs and no longer required skilled therapy (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(services that require specialized training and experience of a licensed therapist or therapy assistant). OT 1 confirmed OT 1 documented Resident 5 required partial/moderate assistance for toilet transfers at the time of discharge from OT services on 3/22/2026. OT 1 stated OT 1 simulated the toilet transfer only in the rehab gym with a chair and therapy mat (padded surface used for therapy treatment) and did not observe or provide treatment to address toilet transfers using a regular toilet. OT 1 stated the chair and therapy mat in the rehab gym were higher than the toilet in Resident 5's room and was not an adequate simulation since they were not the same height. OT 1 stated Resident 5 was very tall and required specialized equipment such as a raised toilet seat (bathroom accessory that attaches over an existing toilet to add height) or commode to safely transfer onto the toilet for toileting because the toilet in his room was very low to the ground. OT 1 stated Resident 5 requested to practice toilet transfers during therapy but refused to practice using a regular shower chair which could be placed over the toilet to elevate the surface as OT 1 suggested. OT 1 stated she did not know why and did not investigate Resident 5's reason for refusal but thought he likely refused because the regular shower chair she suggested was not bariatric (specialized medical and mobility equipment used to support individuals with obesity) and was likely scared to try. OT 1 stated she did not offer to practice toilet transfers with other bariatric equipment and discharged Resident 5 from therapy without further attempts to maximize Resident 5's toileting and toilet transfer abilities because she assumed he would refuse. OT 1 stated she should have investigated Resident 5's reason for refusal, offered and issued alternative equipment to ensure safe toilet transfers, and practiced toilet transfers in Resident 5's room or simulated a transfer on a surface equal to the toilet height in Resident 5's room but did not. OT 1 stated Resident 5 was able to walk and should be walking to the bathroom or using a commode instead of using an adult brief, bedpan, or urinal to promote good hygiene, dignity, and independence. During an interview on 7/7/2026 at 3:25 pm with the Director of Rehabilitation (DOR), the DOR stated residents who are continent and able to walk should be walking to the bathroom for toileting and should not be toileting in bed. The DOR stated that facility staff must notify the Rehabilitation Department (Rehab) when residents require specialized equipment, such as a bariatric raised toilet seat or commode to ensure Rehab properly assessed the resident for safe transfers and provided the necessary equipment to prevent functional decline, prevent skin breakdown, and preserve dignity. During an interview on 7/7/2026 on 4:01 pm with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated Resident 5 wore an adult brief and used a bed pan and urinal for toileting in bed. CNA 2 stated Resident 5 was able to walk and requested to use a regular toilet several times in the past but was not evaluated by Rehab and did not have the proper equipment to accommodate his height and weight for safe transfers in his bathroom. CNA 2 stated the toilet in his room was very low and the shower chair in the bathroom was not wide or high enough for safe transfers when placed over the toilet. During an interview on 7/8/2026 at 3:15 pm with the Director of Nursing (DON), the DON stated the facility provided Rehab evaluations, treatments, and nursing services to maintain and improve residents' abilities to perform ADLs. The DON stated that Rehab evaluates whether a resident can safely complete toilet transfers and determines the necessary equipment to ensure safe toilet transfers. The DON stated that if the facility did not provide the necessary opportunities, services, and equipment for residents who are continent and able to walk to maintain or improve ADLs by using a toilet or commode, residents may experience functional decline, skin breakdown, and embarrassment. During a review of the facility's undated Policy and Procedure (P&P) titled Activities of Daily Living (ADLs) Assistance, the P&P indicated the facility is committed to maintaining and improving each resident's abilities in ADLs to the highest practicable level. Assistance will be provided based on the resident's assessed needs, preferences, and care plan, (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ensuring: promotion of resident independence and self-care where possible, respect for resident dignity, privacy, and choices, prevention of avoidable declines in ADL function, and timely and appropriate intervention for dependent residents.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review, facility failed to provide a clear and concise policy and procedures (P&P) regarding storage of and accessibility to smoking materials (cigarettes, lighters, matches) for one out of one (1) sampled resident (Resident 17). This deficient practice had the potential to cause inconsistency and confusion for residents and staff by making it difficult to uniformly implement the policy and to ensure safety and compliance. Findings: A review of Resident 11's admission record indicated Resident 11 was originally admitted to the facility on [DATE] and re-admitted on [DATE], with diagnoses that include chronic obstructive pulmonary disease (COPD- a group of progressive, incurable lung conditions that cause long-term breathing difficulties and restricted airflow), chronic pulmonary edema (an abnormal buildup of fluid in the air sacs (alveoli) and tissues of the lungs), alcohol abuse with intoxication (improper, excessive, or non-therapeutic use of a alcohol causing temporary, reversible condition of altered consciousness, judgment, and behavior), major depressive disorder (a persistently depressed mood or a profound loss of interest in activities, lasting at least two weeks), acute respiratory failure with hypoxia (a life-threatening condition where the lungs cannot put enough oxygen into the blood), tobacco use (habitual consumption of the tobacco products-cigarettes), generalized anxiety disorder (excessive, uncontrollable, and persistent worry about everyday events and activities) and, other psychoactive substance dependence (compulsive, uncontrollable need to use a drug or alcohol despite harmful consequences). A review of Resident 11's Minimum Data Set (MDS - a resident assessment tool) dated 6/6/2026 indicated the resident 11's cognition (The mental ability to make decision of daily living) was intact, Resident 11 required set-up or clean-up assistance for eating, required supervision with oral hygiene and upper body dressing, Resident 11 required partial moderate assistance with personal hygiene, substantial maximal assistance with toileting hygiene, shower/bathe and was totally dependent for lower body dressing and putting on/taking off footwear. A review of Resident 11's Smoker's Risk Assessment, dated 5/8/2026, indicated Resident 11 was an independent smoker. During an interview on 7/8/2026 at 1:12 pm, at bedside, Resident 11 stated he kept his own cigarettes with him while in the facility. During an interview on 7/8/2026 at 2:45 pm, the Activity Director (AD) stated Residents who demonstrate independent safe smoking abilities care are allowed to smoke independently without supervision, additionally, Residents are allowed to keep their own cigarettes but not lighters. During an interview on 7/9/2026 at 1:29 pm, Director of Nursing (DON) stated Residents who have been cleared to smoke independently via assessment are not supposed to keep their cigarettes at bedside because of safety and fire hazard. A review of facility's policy and procedures (P&P) provided by medical records while onsite on 7/8/2026 titled Smoking Policy dated 1/12/2026 indicated, the Residents are not permitted to keep smoking materials, lighters, matches or any other related items in their possession. Cigarettes, matches, lighters, and other materials will be kept by the designated staff of the facility. A review of facility's P&P titled provided electronically on 7/9/2026 titled Smoking Policy-Residents dated 1/12/2026 indicated Residents who have independent smoking privileges are permitted to keep cigarettes, pipes, tobacco, and other smoking articles in their possession.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise the comprehensive care plan for one of four sampled residents (Resident 5) by failing to discontinue the Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) plan of care when Resident 5 was discharged from OT services on 3/22/2026. This deficient practice resulted in staff confusion of services provided and had the potential to negatively affect the delivery of necessary care and services. Cross Reference F550, F676, & F690 Findings During a review of Resident 5's admission Record (AR), the AR indicated Resident 5 initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including, but not limited to end stage renal disease (ESRD, chronic kidney disease that causes gradual loss of kidney function), morbid obesity (chronic disease characterized by excessive body fat), muscle weakness, and benign prostatic hyperplasia with lower urinary tract symptoms (enlargement of the prostate gland causing urinary symptoms such as frequent urination). During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 6/1/2026, the MDS indicated Resident 5 was cognitively (mental action or process of acquiring knowledge and understanding) intact. The MDS indicated Resident 5 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene and bathing, supervision or touching assistance with upper body dressing and walking 150 feet, set-up or clean-up assistance with sit to stand, bed to chair transfers, and toilet transfers, and was independent with eating, oral hygiene, rolling to both sides, and lying to sitting on the side of the bed. The MDS indicated Resident 5 was always continent of bowel and bladder. During a review of Resident 5's comprehensive care plan, initiated 2/6/2026, the care plan indicated Resident 5 required skilled OT services to address limitations in activities of daily living (ADL, basic activities such as eating, dressing, toileting) participation and generalized weakness. The care plan indicated a goal for Resident 5 to increase safety while participating in ADLs and reduce the level of assistance required for ADLs and functional transfers. The care plan indicated interventions for OT to provide treatment five times a week for four weeks for self-care training, therapeutic exercises, therapeutic activities (functional and goal-oriented tasks designed to help patients regain independence in daily living), and neuromuscular re-education (rehabilitation techniques to restore muscle function and movement). During a review of Resident 5's Occupational Therapy Discharge Summary (OT Discharge Summary), dated 3/22/2026, the OT Discharge Summary indicated OT discharged Resident 5 from OT services on 3/22/2026 due to maximal potential achieved. During an observation and interview on 7/7/2026 at 9:07 am with Resident 5, Resident 5 was lying in bed. Resident 5 stated OT discharged him from therapy several months ago and did not understand the reason for discharge since he felt he was making significant progress and improvement. Resident 5 stated Restorative Nursing Aide (nursing aide program that helps residents maintain any progress made after therapy intervention to maintain their function) services assisted with walking exercises a few times a week, but it was not enough for his recovery and needed more therapy to make him more independent. During an interview and record review on 7/8/2026 at 11:32 am with the Minimum Data Set Nurse (MDSN) and Minimum Data Set Assistant (MDSA), the MDSN stated licensed staff updated the comprehensive care plans quarterly, upon a change of condition (COC, major decline or improvement in a resident's status that will not resolve itself without intervention), and as needed. The MDSN stated the Rehabilitation Department (Rehab) was responsible for initiating, updating, and discontinuing therapy related (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services in the comprehensive care plan. The MDSN stated the MDSN and MDSA used information gathered from the OT evaluation and notes to determine the level of assistance and recommendations for interventions a resident required for all ADLs. The MDSN reviewed Resident 5's care plan and confirmed Resident 5 had a care plan for OT services, five times a week for ADLs and weakness. The MDSN stated she was unaware Resident 5 was discharged from OT services and thought OT was providing Resident 5 with OT services because the care plan indicated Resident 5 had OT services, five times a week. The MDSN stated it was important that staff updated the care plan because inaccurate care plans could result in staff confusion and lack of necessary services. During an interview and record review on 7/8/2026 at 12:06 pm with the Director of Rehabilitation (DOR), the DOR stated Rehab was responsible for initiating, updating, and discontinuing therapy related services in the comprehensive care plan upon admission, quarterly, and as needed. The DOR reviewed Resident 5's care plan and confirmed Resident 5 had an active care plan for OT services, five times a week to address ADLs and strengthening. The DOR reviewed Resident 5's OT Discharge summary, dated [DATE], and confirmed OT discharged Resident 5 from OT services on 3/22/2026 and was no longer receiving therapy services. The DOR stated OT should have discontinued the OT care plan when OT discharged Resident 5 from therapy services on 3/22/2026 but did not. The DOR stated that staff must update the care plan to accurately indicate the services being provided. The DOR stated that if staff did not update the care plan, it could result in staff confusion and lack of or delay of necessary care which could lead to functional and ADL decline. During an interview on 7/8/2026 at 3:15 pm with the Director of Nursing (DON), the DON stated staff developed comprehensive and individualized care plans for every resident to identify the type of care to provide the residents in the facility. The DON stated Rehab was responsible for initiating, updating, and discontinuing therapy and Restorative Nursing Aide (RNA, nursing aide program that helps residents maintain any progress made after therapy intervention to maintain their function) care plans upon admission, quarterly, upon a COC, and as needed. The DON stated Rehab should discontinue the therapy care plan and create a new RNA care plan for functional maintenance once a resident was discharged from therapy services to ensure the residents received the proper care and staff were aware of the types of services the resident was or was not receiving. The DON stated staff must review and update care plans to accurately reflect services provided to ensure the facility provided the appropriate care the residents need to prevent decline. During a review of the facility's Policy and Procedures (P&P) titled Care Plans, Comprehensive Person-Centered, revised 1/12/2026, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P indicated assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. The P&P indicated the Interdisciplinary Team must review and update the care plan when: there has been a significant change in a resident's condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay, and at least quarterly, in conjunction with the required quarterly MDS assessment.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services and equipment to improve toileting and toilet transfer abilities for one of four sampled residents (Resident 5) who was continent (having voluntary control of urination and bowel movements) and able to walk and transfer (move from one surface to another) with assistance. This deficient practice resulted in Resident 5 wearing adult briefs (absorbent, disposable garments worn to manage bowel and bladder loss) and toileting in bed instead of walking to the bathroom or using a commode (portable toilet) due to lack of available toileting equipment for safe transfers, feelings of humiliation and low self-worth, and placed Resident 5 at risk for functional decline, skin breakdown (tissue damage caused by friction, shear, moisture, or pressure), and incontinence (having no or insufficient voluntary control over urination or bowel movements). Cross Reference F550, F657, & F690 Findings: During a review of Resident 5's admission Record (AR), the AR indicated Resident 5 initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including, but not limited to end stage renal disease (ESRD, chronic kidney disease that causes gradual loss of kidney function), morbid obesity (chronic disease characterized by excessive body fat), muscle weakness, and benign prostatic hyperplasia with lower urinary tract symptoms (enlargement of the prostate gland causing urinary symptoms such as frequent urination). During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 6/1/2026, the MDS indicated Resident 5 was cognitively (mental action or process of acquiring knowledge and understanding) intact. The MDS indicated Resident 5 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene and bathing, supervision or touching assistance with upper body dressing and walking 150 feet, set-up or clean-up assistance with sit to stand, bed to chair transfers, and toilet transfers, and was independent with eating, oral hygiene, rolling to both sides, and lying to sitting on the side of the bed. The MDS indicated Resident 5 was always continent of bowel and bladder. During a review of Resident 5's Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Discharge Summary (OT Discharge Summary), dated 3/22/2026, the OT Discharge Summary indicated Resident 5 required partial/moderate assistance with toilet/commode transfers. The OT Discharge Summary indicated OT discharged Resident 5 from OT services due to maximal potential achieved. During an observation and interview on 7/7/2026 at 9:07 am with Resident 5, Resident 5 was lying in bed wearing adult briefs. Resident 5 stated he primarily used a bed pan (shallow pan used by immobile individuals to urinate or have a bowel movement while in bed) and urinal (reusable or disposable container designed for urinating without access to a standard toilet) for toileting and wore adult briefs daily for possible accidents because the toilet in the bathroom was too low and he did not have a commode or device that elevated the toilet seat. Resident 5 stated he was over six feet tall and could not safely transfer on and off the toilet in his bathroom because the toilet seat was too low. Resident 5 stated he tried to sit on the toilet in his bathroom in the past, got stuck, and required two staff members to assist him off the toilet. Resident 5 stated he informed staff and requested equipment to elevate the toilet seat or commode that could accommodate his weight and size multiple times, but staff never gave him equipment and instructed him to use a bedpan, urinal, and adult brief instead. Resident 5 stated he was able to walk, tried to be as independent as possible, and felt humiliated and degraded because he had to wear an adult brief and toilet in bed. During an interview and record review on 7/7/2026 at 3:02 (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pm with Occupational Therapist 1 (OT 1), OT 1 stated OT evaluated a resident's activities of daily living (ADL, basic activities such as eating, dressing, toileting) function and provided treatment and equipment recommendations to improve ADLs, such as toileting and toilet transfers. OT 1 reviewed Resident 5's OT Discharge summary, dated [DATE], and confirmed OT 1 discharged Resident 5 from OT services because Resident 5 was no longer progressing in ADLs and no longer required skilled therapy (services that require specialized training and experience of a licensed therapist or therapy assistant). OT 1 confirmed OT 1 documented Resident 5 required partial/moderate assistance for toilet transfers at the time of discharge from OT services on 3/22/2026. OT 1 stated OT 1 simulated the toilet transfer only in the rehab gym with a chair and therapy mat (padded surface used for therapy treatment) and did not observe or provide treatment to address toilet transfers using a regular toilet. OT 1 stated the chair and therapy mat in the rehab gym were higher than the toilet in Resident 5's room and was not an adequate simulation since they were not the same height. OT 1 stated Resident 5 was very tall and required specialized equipment such as a raised toilet seat (bathroom accessory that attaches over an existing toilet to add height) or commode to safely transfer onto the toilet for toileting because the toilet in his room was very low to the ground. OT 1 stated Resident 5 requested to practice toilet transfers during therapy but refused to practice using a regular shower chair which could be placed over the toilet to elevate the surface as OT 1 suggested. OT 1 stated she did not know why and did not investigate Resident 5's reason for refusal but thought he likely refused because the regular shower chair she suggested was not bariatric (specialized medical and mobility equipment used to support individuals with obesity) and was likely scared to try. OT 1 stated she did not offer to practice toilet transfers with other bariatric equipment and discharged Resident 5 from therapy without further attempts to maximize Resident 5's toileting and toilet transfer abilities because she assumed he would refuse. OT 1 stated she should have investigated Resident 5's reason for refusal, offered and issued alternative equipment to ensure safe toilet transfers, and practiced toilet transfers in Resident 5's room or simulated a transfer on a surface equal to the toilet height in Resident 5's room but did not. OT 1 stated Resident 5 was able to walk and should be walking to the bathroom or using a commode instead of using an adult brief, bedpan, or urinal to promote good hygiene, dignity, and independence. During an interview on 7/7/2026 at 3:25 pm with the Director of Rehabilitation (DOR), the DOR stated residents who are continent and able to walk should be walking to the bathroom for toileting and should not be toileting in bed. The DOR stated that facility staff must notify the Rehabilitation Department (Rehab) when residents require specialized equipment, such as a bariatric raised toilet seat or commode to ensure Rehab properly assessed the resident for safe transfers and provided the necessary equipment to prevent functional decline, prevent skin breakdown, and preserve dignity. During an interview on 7/7/2026 on 4:01 pm with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated Resident 5 wore an adult brief and used a bed pan and urinal for toileting in bed. CNA 2 stated Resident 5 was able to walk and requested to use a regular toilet several times in the past but was not evaluated by Rehab and did not have the proper equipment to accommodate his height and weight for safe transfers in his bathroom. CNA 2 stated the toilet in his room was very low and the shower chair in the bathroom was not wide or high enough for safe transfers when placed over the toilet. During an interview on 7/8/2026 at 3:15 pm with the Director of Nursing (DON), the DON stated the facility provided Rehab evaluations, treatments, and nursing services to maintain and improve residents' abilities to perform ADLs. The DON stated that Rehab evaluates whether a resident can safely complete toilet transfers and determines the necessary equipment to ensure safe toilet transfers. The DON stated that if the facility did not provide the necessary opportunities, services, and equipment for residents who are continent and able to walk to (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	maintain or improve ADLs by using a toilet or commode, residents may experience functional decline, skin breakdown, and embarrassment. During a review of the facility's undated Policy and Procedure (P&P) titled Activities of Daily Living (ADLs) Assistance, the P&P indicated the facility .is committed to maintaining and improving each resident's abilities in ADLs to the highest practicable level. Assistance will be provided based on the resident's assessed needs, preferences, and care plan, ensuring: promotion of resident independence and self-care where possible, respect for resident dignity, privacy, and choices, prevention of avoidable declines in ADL function, and timely and appropriate intervention for dependent residents.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, and record review, the facility failed to provide one of one (1) sampled resident (Resident 17) with the opportunity to make choices about aspects of his (Resident 17's) care planning that is significant to the resident overall health and well-being according to the facility's policy and procedures (P&P) titled Resident Rights dated 1/12/2026. This deficient practice denied Resident 17 the right to be informed of and participate in his treatment plan with the potential to affect Resident 17's ability to attain or maintain his highest practicable physical, mental, and psychosocial well-being. Findings: A review of Resident 17's medical record indicated Resident 17 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that include, type 2 diabetes mellitus (a long term metabolic condition where the body either resists the effects of insulin (a hormone that regulates sugar)), chronic systolic congestive heart failure (medical condition where the heart cannot pump blood efficiently), primary pulmonary hypertension (high blood pressure develops within the blood vessels of your lungs), persistent atrial fibrillation (a continuous, irregular heart rhythm that lasts longer than seven days), chronic kidney disease (a condition in which the kidneys are damaged and gradually lose their ability to filter waste and excess fluid from the blood), anemia (a medical condition where your body lacks enough healthy red blood cells or hemoglobin to effectively carry oxygen to your tissues), abnormalities of gait and mobility (medical condition that changes how you walk or move) and muscle weakness. A review of Resident 17's history and physical (H&P) dated 12/23/2025 indicated, Resident 17 is alert and oriented X4 (the patient is alert and oriented to person, place, time, situation). A review of Resident 17's Minimum Data Set (MDS - a resident assessment tool) dated 4/15/2026 indicated the resident 17's cognition (The mental ability to make decision of daily living) was intact, Resident 17 was independent with eating, required set-up or clean-up assistance for oral hygiene, required supervision with personal hygiene, Resident 17 required partial moderate assistance with toileting hygiene and upper body dressing, substantial maximal assistance with shower/bathe and was totally dependent for lower body dressing and putting on/taking off footwear. During a facility tour on 7/6/2026 at 9:27am Resident 17 stated he told several facility staff on multiple occasions (dates and times unknown) to give him a medication called apixaban (a prescription anticoagulant (blood thinner) 2.5 (dose) mg (unit of measure) that he had been previously prescribed by for his primary care physician for AFIB but has been unsuccessful in convincing them (licensed staff) of his need of medication. Resident 17 stated the last time he received his AFIB medication was 2/2026. During a concurrent interview and record review on 7/7/2026 at 11:02 am, with the Minimum Data Set Nurse -lead (MDSN) nurse stated Resident 17's current electronic medical administration record, indicated he (Resident 17) was not prescribed apixaban and/or any medication for atrial fibrillation. MDSN stated she would call the Resident 17's physician to check if Resident 17 still needed apixaban for atrial fibrillation. A review of Resident 17 electronic medical administration records history indicated an order for apixaban oral tablet 2.5mg for atrial fibrillation was discontinued on 12/21/2025. A review of Resident 17 medical records on 7/7/2026 at 12:08pm indicated an order for Apixaban oral tablet 2.5mg to be given by mouth two (2) times a day resumed on 7/7/2026 at 11:27 am. During an interview on 7/9/2026 at 1:15pm, Licensed Vocational Nurse (LVN) 2 stated, if a resident a medication that he/she has previously been prescribed, LVN2 would ask the resident why the needed the medication, verify the diagnosis, check the electronic medical record and inform the resident's physician of the residents request to have the medication started or resumed. LVN 2 stated stopping crucial medication like (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	apixaban indefinitely exposes a resident to risk of stroke, heart attack, pulmonary embolism which could result in sudden death. During an interview on 7/9/2026 at 1:29pm, Director of Nursing (DON) stated if a Resident requests a medication that is not on his/her current ordered medication, licensed nurses should clarify with the primary care physician (PCP) if the resident needs the medication. DON stated, discontinuing apixaban indefinitely without justification, places a Resident at risk of developing blood clots which could lead to stroke. A review of the facility's policy and procedures (P&P) titled Resident Rights dated 1/12/2026, indicated, Federal and state laws guarantee certain basic rights to all resident of this facility. These rights include the Resident's right to be informed of and participate in, his or her treatment, . have the facility to respond to his or her grievances.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 6), who was assessed as at risk to develop pressure ulcer (a localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear) and was admitted without pressure ulcers, received the necessary care and services to prevent pressure ulcer from developing, by failing to: Prevent Resident 6 from developing a right heel pressure injury while residing in the facility Revise the resident right heel skin impairment care plan interventions These deficient practices had the potential for Resident 6 not to receive the necessary care and services to prevent the development of pressure ulcer. Findings: A review of Resident 6's admission Record indicated the facility admitted the resident on 2/10/2026 and with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), muscle weakness and right hip fracture. A review of Resident 6's Admit/Readmit Assessment, dated 2/10/2026, indicated the resident required extensive assistance with bed mobility and the resident did not have any pressure injuries. A review of Resident 6's Braden Scale (pressure sore risk predictor tool) dated 2/10/2026, indicated Resident 6 had a Braden score of 16 which indicated the resident in the at risk category to develop a pressure injury. A review of Resident 6's History and Physical (H&P), dated 2/11/2026, indicated Resident 6 on had a history of multiple falls and was admitted to the facility on [DATE] after a hospital stay after the resident fell and sustained a right hip fracture. A review of Resident 6's admission Minimum Data Set (MDS- a resident assessment tool) dated 2/13/2026, indicated the resident's cognition (ability to think, understand, and reason) was moderately impaired. The MDS indicated Resident 6 required substantial assistance with bed mobility. The MDS also indicated Resident 6 was dependent upon staff for oral hygiene, showering, dressing and toileting hygiene. The MDS also indicated Resident 6 was always incontinent, was at risk for developing pressure ulcers, and did not have any unhealed pressure ulcers. A review of Resident 6's Quarterly MDS, dated [DATE], indicated Resident 6 had one unstageable pressure injury. A review of Resident 6's Wound Physician Progress Note, dated 2/13/2026, indicated the resident had one wound described as a surgical wound to the right hip. The Wound Progress Note did not indicate the resident had any other wounds. A review of Resident 6's Wound Physician Progress Note, dated 2/20/2026, indicated the wound physician was asked to evaluate and treat the resident's wounds. The progress note indicated the resident had two wounds, a right hip surgical wound and a stage 3 sacral coccyx pressure ulcer (Full-thickness loss of skin. Dead and black tissue may be visible). A review of Resident 6's Wound Physician Progress Note, dated 2/27/2026, indicated the resident had developed a third wound, a right heel (DTI - purple or maroon colored area of discolored intact skin developed due to damage of underlying soft tissue from pressure). A review of Resident 6's physician orders regarding the treatment of the resident's right heel were as follows:-On 2/23/2026 the facility was to cleanse Resident 6's right heel wound cleansed with normal saline, pat dry, paint with betadine, cover with dry dressing then wrap with kerlix (a stretchy fluffy gauze) every day and as needed for 21 days- On 2/27/2026 Resident 6's right heel was to be cleansed with normal saline, pat dry, apply betadine, cover with abdominal pad (ABD - a thick, high absorbent medical bandage), wrap with rolled gauze, secure with tape every day and as needed for 21 days- On 4/21/2026, the resident's right heel pressure ulcer was to be cleansed with normal saline, pat dry, apply hydrogel (a jelly like wound dressing that adds moisture to the wound and doesn't stick to the wound), cover with xeroform (a non-adherent mesh gauze dressing (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impregnated with Vaseline and a deodorizing and antimicrobial agent apply donut or abdominal pad (ABD) with a hole cut 2 layers, secure with rolled gauze every other day and as needed for 30 days-on 4/28/2026 Resident 6's right heel pressure injury was to be cleansed with normal saline, pat dry, apply Santyl ointment (a prescription ointment used to remove dead tissue from pressure injuries) , cover with ABD pad, secure will rolled gauze every day and as needed for 30 days-on 6/29/2026 the treatment indicated staff were to cleanse with normal saline, pat dry, apply Santyl ointment, calcium alginate, cover with ABD pad and rolled gauze every day; and-On 7/3/2026, the physician ordered Resident 6's right heel to be cleansed with NS, pat dry, apply Santyl ointment, collagen sheet (a soft biodegradable pad that promotes new tissue growth), cover with ABD pad and rolled gauze every day During a record review on 7/7/2026 at 9:57 AM, Resident 6's care plans were reviewed. Resident 6's Actual Impairment to Skin Integrity of the Right Hell care plan indicated the impairment was a deep tissue pressure injury. The goal was for the resident to have no complications from the pressure injury (PI). The care plan interventions included to provide the resident with heel protectors at all times when in bed. The care plan interventions also indicated the treatment for the wound was to cleanse with normal saline (NS - a saltwater solution), pat dry, paint with betadine, cover with dry dressing then wrap with kerlix. The care plan did not address Resident 6 not wearing both heel protectors or the Pressure Relief Ankle Foot Orthosis (Prafo- boot isa highly adjustable brace designed to treat foot drop [is the inability to lift the front part of the foot, causing the foot to drag or slap the ground when walking], manage contractures [are structural changes to your soft and connective tissues that cause them to stiffen, tighten and contract], and offload heel pressure). The care plan also did not include the current physician wound treatment order of cleansing the site with normal saline, applied Santyl ointment, collagen sheet cover with an abdominal pad and wrap with rolled gauze. During a concurrent interview and observation on 7/6/2026 at 10:20 AM, Resident 6 was observed laying in bed. The resident was laying on a low air loss mattress (LALM-mattress designed to treat and prevent pressure ulcers). The resident's feet were bare and there was a kerlix wrapped around the resident's right heel and ankle. Resident 6 stated Licensed Vocational Nurse (LVN) 3 changed the dressing today. During a concurrent interview and observation on 7/8/2026 at 10:16 AM, Resident 6's wound care was observed. Resident 6 was observed wearing a Pressure Relief Ankle Foot Orthosis (PRAFO - a specialized medical device) boot to the right foot. Resident 6's left foot did not have a heel pad or PRAFO boot. LVN 3 removed the dressing that was in place and stated the wound was 50 percent slough (yellow or white tissue that adheres to the ulcer bed in strings or thick clumps) and 50 percent granulation (new tissue). LVN 3 proceeded to administer the current wound treatment of cleansing the site with normal saline, applied Santyl ointment, collagen sheet cover with an abdominal pad and wrap with rolled gauze. LVN 3 also stated the wound physician determined Resident 6 only needed to wear the PRAFO boot on his right foot. During an interview on 7/8/2026 at 12:14 PM, Certified Nursing Assistant (CNA) 3 stated Resident 6 only wears one PRAFO boot on the right foot. CNA 3 stated it was their understanding that the resident only needed to wear the boot on the right foot. During a concurrent observation at Resident 6 was observed wearing a PRAFO boot on the right foot and the left PRAFO boot was observed in the resident's room closet. During a concurrent interview and record review on 7/09/2026 at 10:17 AM, Resident 6's electronic medical record was reviewed. LVN 3 stated the facility admitted Resident 6 on 2/10/2026. LVN 3 stated Resident 6 developed the right heel pressure injury in the facility on 2/23/2026. During a review of Resident 6's care plans, LVN 3 stated Resident 6's right heel skin impairment care plan was not updated when the physician determined Resident 6 could only wear the PRAFO boot on the right heel and was not updated with the current wound treatment orders until today (7/9/2026) for Resident 6. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 3 stated the care plan addresses how a resident's care is to be administered and the goal. LVN 3 stated not updating the care plan could lead to the resident not receiving the care they require. During an interview on 7/9/2026 at 1:24 PM, the Director of Nursing (DON) stated the care plan is part of the nursing process and guides the assessment, planning and decision on the appropriate interventions to provide the resident. The DON also stated a resident's wound care plan should be updated as needed and should include the current treatment order, medications to facilitate wound healing. The DON further stated not updating the care plan may result in the resident receiving the wrong interventions and the wound could worsen. A review of the facility's policy and procedures (P&P) titled, Prevention of Pressure Ulcers/Injuries, revised 1/12/2026, indicated, staff were to review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable and staff were to review the interventions and strategies for effectiveness on an ongoing basis. A review of the facility's (P&P), Care Plans, Comprehensive Person- Centered, revised 1/12/2026, indicated, Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services to improve or maintain range of motion (ROM, full movement potential of a joint) for two of four sampled residents (Residents 9 and 10) with ROM and mobility (ability to move) concerns by failing to: Ensure Restorative Nursing Aide (RNA, nursing aide program that helps residents maintain any progress made after therapy intervention to maintain their function) provided passive ROM (PROM, movement at a given joint with full assistance from another person) exercises to Resident 9's left elbow and left knee in accordance with physician's orders, dated 2/19/2027. Objectively (unbiased, based on facts) measure Resident 10's ROM impairments of both shoulders during the Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday activities) evaluation, dated 4/2/2026. These deficient practices had the potential to cause ROM decline leading to contractures (loss of motion of a joint associated with stiffness and joint deformity) and an overall decline in physical functioning and activities of daily living (ADL, basic activities such as eating, dressing, toileting). Findings: 1. During a review of Resident 9's admission Record (AR), the AR indicated Resident 9 initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including, but not limited to left-sided hemiplegia (weakness to one side of the body), contracture of an unspecified joint (where two bones meet), and muscle wasting and atrophy (thinning or loss of muscle tissue). During a review of Resident 9's Order Summary Report (OSR), the OSR indicated a physician's order, dated 2/19/2026, for RNA to provide PROM exercises to Resident 9's both arms and both legs, seven times a week. During a review of Resident 9's Minimum Data Set (MDS, a resident assessment tool), dated 5/13/2026, the MDS indicated Resident 9 had severe cognitive (mental action or process of acquiring knowledge and understanding) impairment for daily decision making. The MDS indicated Resident 9 required substantial/maximal assistance (helper does more than half the effort) for rolling to both sides and sit to lying and required dependent assistance (helper does all the effort or required the assistance of two or more helpers for the resident to complete the activity) for hygiene, bathing, dressing, and bed to chair transfers. The MDS indicated Resident 9 had functional ROM limitations (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one arm and one leg. During an observation of Resident 9's RNA session on 7/8/2026 at 10:40 am, in Resident 9's room, Resident 9 was lying in bed. Resident 9 was wearing a left-hand splint (a firm device used to stabilize and immobilize an injured bone or joint) and the left elbow was fully straight. Resident 9's both hips and knees were straight with both feet pointing downwards towards the foot of the bed. Restorative Nursing Aide (RNA) 2) stood on Resident 9's right side and provided PROM to Resident 9's right shoulder, elbow, wrist, hand, hip, knee, and ankle. RNA 1 stood on Resident 9's left side and assisted with PROM to Resident 9's left shoulder, wrist, hip, and ankle. RNA 1 did not provide PROM to Resident 9's left elbow, fingers, or knee. During an interview on 7/8/2026 at 10:51 am with RNA 1, RNA 1 confirmed RNA had orders to provide PROM to Resident 9's both arms and both legs which meant assisting Resident 9 with ROM exercises to the entire leg, including the hips, knees, and ankles and to the entire arm, including the shoulder, elbow, wrist, and hand. RNA 1 stated she provided PROM to Resident 9's left wrist and left hand in the morning before applying the left-hand splint and confirmed she did not assist with ROM exercises to Resident 9's left elbow and left knee during the RNA session. RNA 1 stated that staff must perform PROM exercises for Resident 9's arms and legs (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because Resident 9 could not follow directions and has extremely stiff and contracted joints, especially in the left elbow and left knee. RNA 1 stated she should have assisted Resident 9 with left elbow and left knee ROM exercises as ordered but did not. RNA 1 stated if RNA did not provide exercises as ordered, it could result in ROM decline. During an interview on 7/8/2026 at 12:06 pm with the Director of Rehabilitation (DOR), the DOR stated the purpose of the RNA program was to maintain and improve a resident's functional level and ROM after discharge from therapy. The DOR stated Rehab determined the types of exercises RNAs were to perform when creating an RNA program. The DOR stated if an RNA order was written for ROM exercises to both legs, it was expected the RNA provide ROM exercises to the entire leg, which included the hips, knees, and ankles. The DOR stated if an RNA order was written for ROM to both arms, it was expected the RNA provide ROM exercises to the entire arm, which included the shoulder, elbow, wrist, and hand. The DOR stated if RNA did not provide RNA services as ordered, it could potentially result in a decline in ROM and ADLs and contracture development. During an interview on 7/8/2026 at 3:15 pm with the Director of Nursing (DON), the DON stated it was important for RNA to provide exercises as ordered to ensure the residents in the facility maintained their level of function and to prevent potential declines in mobility, ADLs, and contracture development. During a review of the facility's Policy and Procedures (P&P) titled, Resident Mobility and ROM, revised 1/12/2026, the P&P indicated residents will not experience an avoidable reduction in ROM and residents with limited ROM will receive treatment and services to increase and/or prevent a further decrease in ROM. The P&P indicated the care plan will include specific interventions, exercises, and therapies to maintain, prevent avoidable decline in, and/or improve mobility and ROM. During a review of facility's P&P titled, Restorative Nursing Services, revised 1/12/2026, the P&P indicated residents will receive restorative nursing care as needed to help promote optimal safety and independence. 2. During a review of Resident 10's admission Record (AR), the AR indicated Resident 10 initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including, but not limited to chronic obstructive pulmonary disease (COPD, lung disease that causes obstruction of airflow and can limit normal breathing), Parkinson's disease (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement), and weakness. During a review of Resident 10's OT Evaluation and Plan of Treatment (OT Evaluation), dated 4/2/2026, the OT Evaluation indicated Resident 10's ROM of both shoulders were impaired. The OT Evaluation did not indicate objective measurements and degree of ROM movement for Resident 10's both shoulders. During a review of Resident 10's MDS, dated [DATE], the MDS indicated Resident 10 had moderate cognitive impairment. The MDS indicated Resident 10 required supervision or touching assistance for eating and rolling to both sides, partial/moderate assistance (helper does less than half the effort) for oral hygiene, upper body dressing, personal hygiene, and bed to chair transfers, and substantial/maximal assistance (helper does more than half the effort) for toileting hygiene, bathing, lower body dressing, and tub/shower transfers. During an observation on 7/7/2026 at 12:48 pm, in Resident 10's room, Resident 10 was sitting in a wheelchair with both elbows bent and resting on the wheelchair armrests. Resident 10 opened and closed both hands and bent and straightened both elbows. Resident 10 did not attempt to move both shoulders or raise both arms overhead when asked. During a concurrent interview and record review on 7/7/2026 at 3:45 pm with the DOR, the DOR stated therapists (in general) measured ROM during OT evaluations to establish a baseline to track changes to the joint since ROM impacts a resident's ability to safely and independently perform ADLs. The DOR stated therapists objectively measured ROM using goniometers (instrument used for the precise measurement of angles) to determine a resident's baseline ROM and detect changes in joint ROM. The DOR stated OT should objectively measure any (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	joint ROM limitations observed during the OT evaluation using a goniometer because it was an objective way of establishing a resident's ROM baseline and monitoring for changes in ROM. The DOR reviewed Resident 10's OT Evaluation, 4/2/2026, and confirmed OT assessed Resident 10's both arms and determined Resident 10's ROM of both shoulders were impaired. The DOR confirmed the OT Evaluation did not indicate specific ROM measurements of Resident 10's shoulder ROM impairments and was not objective. The DOR stated that if the OT evaluation did not indicate objective ROM measurements of a resident's ROM impairments, facility staff cannot effectively monitor and detect ROM changes, which could lead to a decline in ROM, mobility, and ADLs. During an interview on 7/8/2026 at 3:15 pm with the DON, the DON stated the facility monitored for changes in ROM by therapy evaluations, observations, and staff report. The DON stated it was important staff documented objectively during ROM evaluations to establish an accurate baseline assessment of a resident's joints because it enabled facility staff to effectively monitor changes and provide the appropriate services to address any declines. During a review of the facility's P&P titled, Resident Mobility and ROM, revised 1/12/2026, the P&P indicated residents will not experience an avoidable reduction in ROM and residents with limited ROM will receive treatment and services to increase and/or prevent a further decrease in ROM. The P&P indicated the care plan will include specific interventions, exercises, and therapies to maintain, prevent avoidable decline in, and/or improve mobility and ROM. The P&P indicated the care plan will include the type, frequency, and duration of interventions as well as measurable goals and objectives. During a review of the facility's P&P titled, Charting and Documentation, revised 1/12/2026, the P&P indicated documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: A. Ensure the facility staff are provided with one clear policy and procedures regarding whether or not, residents who independently smoked cigarettes, could keep smoking materials, lighters, matches or any other smoking related items as evidenced by the following two conflicting and confusing facility policies and procedures titled: 1. Smoking Policy dated 1/12/2026 indicated, Residents are not permitted to keep smoking materials, lighters, matches or any other related items in their possession. Cigarettes, matches, lighters, and other materials will be kept by the designated staff of the facility .2. Smoking Policy-Residents dated 1/12/2026 indicated, Residents who have independent smoking privileges are permitted to keep cigarettes, pipes, tobacco, and other smoking articles in their possession. This deficient practice had the potential to cause confusion among staff and residents placing the residents, staff and guests at increased risk for fire related injuries, hospitalization and death. B. Ensure Certified Nursing Assistant (CNA) 1 did not make private arrangements with a private transportation company (PTC) to pick up one of one sampled residents (Resident 99) from the facility and transported Resident 99 to and from a bank in Pasadena 20 miles away from the facility unaccompanied and without supervision, without a physician's order, without facility staff awareness and consent from Resident 99 family members and awareness. This deficient practice placed Resident 99 at increased risk for psychological harm (the mental and emotional harm caused by a highly distressing, threatening, or overwhelming even), accidents and falls with injury, hospitalization, and death. Findings: A. A review of Resident 11's admission record indicated Resident 11 was originally admitted to the facility on [DATE] and re-admitted on [DATE], with diagnoses that include chronic obstructive pulmonary disease (COPD- a group of progressive, incurable lung conditions that cause long-term breathing difficulties and restricted airflow.), chronic pulmonary edema (an abnormal buildup of fluid in the air sacs (alveoli) and tissues of the lungs), alcohol abuse with intoxication (improper, excessive, or non-therapeutic use of a alcohol causing temporary, reversible condition of altered consciousness, judgment, and behavior), major depressive disorder (a persistently depressed mood or a profound loss of interest in activities, lasting at least two weeks), acute respiratory failure with hypoxia (a life-threatening condition where the lungs cannot put enough oxygen into the blood), tobacco use (habitual consumption of the tobacco products-cigarettes), generalized anxiety disorder (excessive, uncontrollable, and persistent worry about everyday events and activities) and, other psychoactive substance dependence (compulsive, uncontrollable need to use a drug or alcohol despite harmful consequences). A review of Resident 11's Minimum Data Set (MDS - a assessment tool) dated 6/6/2026 indicated the resident 11's cognition (The mental ability to make decision of daily living) was intact, Resident 11 required set-up or clean-up assistance for eating, required supervision with oral hygiene and upper body dressing, Resident 11 required partial moderate assistance with personal hygiene, substantial maximal assistance with toileting hygiene, shower/bathe and was totally dependent for lower body (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dressing and putting on/taking off footwear. A review of Resident 11's Smoker's Risk Assessment, dated 5/8/2026, indicated Resident 11 was an independent smoker. During an interview on 7/8/2026 at 1:12 pm, at bedside, Resident 11 stated he kept his own cigarettes with him while in the facility. During an interview on 7/8/2026 at 2:45 pm, the Activity Director (AD) stated that residents who demonstrate independent safe smoking abilities care are allowed to smoke independently without supervision, additionally, Residents are allowed to keep their own cigarettes but not lighters. During an interview on 7/9/2026 at 1:29 pm, Director of Nursing (DON) stated Residents who have been cleared to smoke independently via assessment are not supposed to keep their cigarettes at bedside because of safety and fire hazard. A review of the facility's policy and procedures (P&P) provided by medical records while onsite on 7/8/2026 titled Smoking Policy dated 1/12/2026 indicated, Residents are not permitted to keep smoking materials, lighters, matches or any other related items in their possession. Cigarettes, matches, lighters, and other materials will be kept by the designated staff of the facility . A review of the facility's P&P titled provided electronically on 7/9/2026 titled Smoking Policy-Residents dated 1/12/2026 indicated, Residents who have independent smoking privileges are permitted to keep cigarettes, pipes, tobacco, and other smoking articles in their possession. B. Cross Reference F808 and F835 During a review of Resident 99's admission record, dated 6/14/2025, indicated Resident 99 was admitted to the facility on 6/14/2025 with diagnoses but not limited to transient ischemic attack (TIA- a temporary blockage of blood flow to the brain causing stroke symptoms), end stage renal disease (kidneys have permanently stopped working), anarthria (inability to speak clearly), dysphagia (difficulty swallowing), and hemiplegia (severe or complete loss of voluntary movement on one entire side of the body) affecting the right side. During a review of Resident 99's physician order, dated 2/5/2026, indicated, (Resident 99) may go out on Therapeutic pass on Monday, Wednesday, and Friday with an outside agency. They will be riding with resident to and from the Fitness gym (gymnasium- is a dedicated indoor or outdoor facility equipped for physical exercise, sports, and athletic training). During a review of Resident 99's Minimum Data Set (MDS- a resident assessment tool), dated 3/16/2026, indicated Resident 99 used a wheelchair (an assistive device) and required total physical assistance transferring from a bed to a chair (wheelchair). The MDS also stated Resident 99's cognitive patterns were moderately impaired (a person's memory or thinking have started to weaken). (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 99's history and physical (H&P- a detailed story written by a physician about your medical care), dated 8/12/2025, indicated, This Resident (Resident 99) due to complex medical problems and history of illness is: High Risk for falls. During a review of Resident 99's notarized (a document is one that has been officially verified, witnessed, and authenticated by a neutral public official known as a notary public) Financial Power of Attorney (POA) Packet, the Acknowledgement form, dated 4/26/2026, indicated Resident 99's name. The date of the signed Signature and Acceptance form was illegible. During a review of the facility's Release of Responsibility for Leave of Absence sign in/out form, undated, indicated no documented evidence that Resident 99 signed in or signed out for OOP for the month of April 2026. ^ During a telephone interview on 7/7/2026 at 3:11 P.M. with Family Member (FM) 1, FM 1 stated that between 4/26/2026 to 4/30/2026, CNA 1 organized and paid a PTC to transport Resident 99 to a bank 20 miles away from the facility and to also meet Resident 99's FM 3. FM 1 stated that Resident 99 (FM 1's father) had changed the resident's financial POA (Power of Attorney) from FM 1 and FM 4 to FM 2. During a telephone interview on 7/8/2026 at 9:15 A.M. with FM 2, FM 2 stated, Resident 99 changed Resident 99's financial Power of Attorney (POA- is a legal document that allows one person (the principal) to designate a trusted person or entity (the agent or attorney-in-fact) to make legal, financial, or medical decisions on their behalf) from FM1 and FM 4 to FM 2 in 4/2026 per Resident 99 and FM 3's requests. FM 2 stated Resident 99 wanted to control over Resident 99's finances. FM 2 stated FM 2 was aware that Resident 99 had traveled to the resident's bank to change over the resident's financial POA but did not know how Resident 99 arrived at the bank or if FM 3 was able to meet Resident 99 at the bank. ^ During an interview on 7/8/2026 at 11:28 A.M. with CNA 1, CNA 1 confirmed and stated CNA 1 was at CNA 1's residence when CNA 1 used an application (app- a software designed to run on handheld devices like smartphones and tablets) on CNA 1's cellular phone to make transportation arrangements with a PTC and also paid the PTC to transport Resident 99 to the bank in Pasadena on 4/2026. CNA 1 did not provide the date and refused to share proof of the PTC records. CNA 1 stated that CNA 1 did not inform the facility Admin, Director of Nursing (DON) or any facility staff. CNA 1 stated that Resident 99 traveled alone to a bank in Pasadena via PTC without adequate supervision which placed Resident 99 at increased risk for physical harm such as a vehicle accident. CNA 1 stated Resident 99 said was to meet FM 3 at the bank in Pasadena, however, CNA 1 does not know if Resident 99 met with FM 3 at the bank. CNA 1 refused to provide/share the month and or the date when CNA 1 paid the PTC to transport Resident 99 to a bank in Pasadena. CNA 1 stated that CNA 1 does not know how and when Resident 99 returned to the facility. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/9/2026 at 11:15 A.M., this writer attempted to call FM 3 for interview but was unsuccessful. On 7/13/2026 at 1:41 P.M. this writer made a second attempt to call FM 3 for interview but was unsuccessful. During an interview on 7/9/2026 at 12:36 P.M. with the DON, the DON stated DON was aware that FM 1 was the previous financial POA for Resident 99 and it was changed to FM 2. The DON stated called FM 2 and confirmed that FM 2 was Resident 99's financial POA. The DON confirmed and stated Resident 99 left the facility without adequate supervision on 4/2026 and that CNA 1 paid for a PTC for Resident 99 to go to a bank in Pasadena placing Resident 99 at risk for physical harm such as a vehicle accident. During a review of the facility's P&P titled, Therapeutic Leave Policy, with a review date of 1/12/2026, indicated, Therapeutic Leave: A planned absence of a resident authorized by a physician order. All therapeutic leaves, must sign the Release of Responsibility form with the receptionist for the safety and tracking of all residents. During a review of the facility's P&P titled, Safety and Supervision of Residents, with a review date of 1/12/2026, indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. ^		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services and equipment to improve toileting and toilet transfer abilities for one of four sampled residents (Resident 5) who was continent (having voluntary control of urination and bowel movements) and able to walk and transfer (move from one surface to another) with assistance. This deficient practice resulted in Resident 5 wearing adult briefs (absorbent, disposable garments worn to manage bowel and bladder loss) and toileting in bed instead of walking to the bathroom or using a commode (portable toilet) due to lack of available toileting equipment for safe transfers, feelings of humiliation and low self-worth, and placed Resident 5 at risk for functional decline, skin breakdown (tissue damage caused by friction, shear, moisture, or pressure), and incontinence (having no or insufficient voluntary control over urination or bowel movements). Cross Reference F557 and F676 Findings: During a review of Resident 5's admission Record (AR), the AR indicated Resident 5 initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including, but not limited to end stage renal disease (ESRD, chronic kidney disease that causes gradual loss of kidney function), morbid obesity (chronic disease characterized by excessive body fat), muscle weakness, and benign prostatic hyperplasia with lower urinary tract symptoms (enlargement of the prostate gland causing urinary symptoms such as frequent urination). During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 6/1/2026, the MDS indicated Resident 5 was cognitively (mental action or process of acquiring knowledge and understanding) intact. The MDS indicated Resident 5 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene and bathing, supervision or touching assistance with upper body dressing and walking 150 feet, set-up or clean-up assistance with sit to stand, bed to chair transfers, and toilet transfers, and was independent with eating, oral hygiene, rolling to both sides, and lying to sitting on the side of the bed. The MDS indicated Resident 5 was always continent of bowel and bladder. During a review of Resident 5's Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Discharge Summary (OT Discharge Summary), dated 3/22/2026, the OT Discharge Summary indicated Resident 5 required partial/moderate assistance with toilet/commode transfers. The OT Discharge Summary indicated OT discharged Resident 5 from OT services due to maximal potential achieved. During an observation and interview on 7/7/2026 at 9:07 am with Resident 5, Resident 5 was lying in bed wearing adult briefs. Resident 5 stated he primarily used a bed pan (shallow pan used by immobile individuals to urinate or have a bowel movement while in bed) and urinal (reusable or disposable container designed for urinating without access to a standard toilet) for toileting and wore adult briefs daily for possible accidents because the toilet in the bathroom was too low and he did not have a commode or device that elevated the toilet seat. Resident 5 stated he was over six feet tall and could not safely transfer on and off the toilet in his bathroom because the toilet seat was too low. Resident 5 stated he tried to sit on the toilet in his bathroom in the past, got stuck, and required two staff members to assist him off the toilet. Resident 5 stated he informed staff and requested equipment to elevate the toilet seat or commode that could accommodate his weight and size multiple times, but staff never gave him equipment and instructed him to use a bedpan, urinal, and adult brief instead. Resident 5 stated he was able to walk, tried to be as independent as possible, and felt humiliated and degraded because he had to wear an adult brief and toilet in bed. During an interview and record review on 7/7/2026 at 3:02 (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pm with Occupational Therapist 1 (OT 1), OT 1 stated OT evaluated a resident's activities of daily living (ADL, basic activities such as eating, dressing, toileting) function and provided treatment and equipment recommendations to improve ADLs, such as toileting and toilet transfers. OT 1 reviewed Resident 5's OT Discharge summary, dated [DATE], and confirmed OT 1 discharged Resident 5 from OT services because Resident 5 was no longer progressing in ADLs and no longer required skilled therapy (services that require specialized training and experience of a licensed therapist or therapy assistant). OT 1 confirmed OT 1 documented Resident 5 required partial/moderate assistance for toilet transfers at the time of discharge from OT services on 3/22/2026. OT 1 stated OT 1 simulated the toilet transfer only in the rehab gym with a chair and therapy mat (padded surface used for therapy treatment) and did not observe or provide treatment to address toilet transfers using a regular toilet. OT 1 stated the chair and therapy mat in the rehab gym were higher than the toilet in Resident 5's room and was not an adequate simulation since they were not the same height. OT 1 stated Resident 5 was very tall and required specialized equipment such as a raised toilet seat (bathroom accessory that attaches over an existing toilet to add height) or commode to safely transfer onto the toilet for toileting because the toilet in his room was very low to the ground. OT 1 stated Resident 5 requested to practice toilet transfers during therapy but refused to practice using a regular shower chair which could be placed over the toilet to elevate the surface as OT 1 suggested. OT 1 stated she did not know why and did not investigate Resident 5's reason for refusal but thought he likely refused because the regular shower chair she suggested was not bariatric (specialized medical and mobility equipment used to support individuals with obesity) and was likely scared to try. OT 1 stated she did not offer to practice toilet transfers with other bariatric equipment and discharged Resident 5 from therapy without further attempts to maximize Resident 5's toileting and toilet transfer abilities because she assumed he would refuse. OT 1 stated she should have investigated Resident 5's reason for refusal, offered and issued alternative equipment to ensure safe toilet transfers, and practiced toilet transfers in Resident 5's room or simulated a transfer on a surface equal to the toilet height in Resident 5's room but did not. OT 1 stated Resident 5 was able to walk and should be walking to the bathroom or using a commode instead of using an adult brief, bedpan, or urinal to promote good hygiene, dignity, and independence. During an interview on 7/7/2026 at 3:25 pm with the Director of Rehabilitation (DOR), the DOR stated residents who are continent and able to walk should be walking to the bathroom for toileting and should not be toileting in bed. The DOR stated that facility staff must notify the Rehabilitation Department (Rehab) when residents require specialized equipment, such as a bariatric raised toilet seat or commode to ensure Rehab properly assessed the resident for safe transfers and provided the necessary equipment to prevent functional decline, prevent skin breakdown, and preserve dignity. During an interview on 7/7/2026 on 4:01 pm with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated Resident 5 wore an adult brief and used a bed pan and urinal for toileting in bed. CNA 2 stated Resident 5 was able to walk and requested to use a regular toilet several times in the past but was not evaluated by Rehab and did not have the proper equipment to accommodate his height and weight for safe transfers in his bathroom. CNA 2 stated the toilet in his room was very low and the shower chair in the bathroom was not wide or high enough for safe transfers when placed over the toilet. During an interview on 7/8/2026 at 3:15 pm with the Director of Nursing (DON), the DON stated the facility provided Rehab evaluations, treatments, and nursing services to maintain and improve residents' abilities to perform ADLs. The DON stated that Rehab evaluates whether a resident can safely complete toilet transfers and determines the necessary equipment to ensure safe toilet transfers. The DON stated that if the facility did not provide the necessary opportunities, services, and equipment for residents who are continent and able to walk to (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	maintain or improve ADLs by using a toilet or commode, residents may experience functional decline, skin breakdown, and embarrassment. During a review of the facility's undated Policy and Procedure (P&P) titled Activities of Daily Living (ADLs) Assistance, the P&P indicated the facility .is committed to maintaining and improving each resident's abilities in ADLs to the highest practicable level. Assistance will be provided based on the resident's assessed needs, preferences, and care plan, ensuring: promotion of resident independence and self-care where possible, respect for resident dignity, privacy, and choices, prevention of avoidable declines in ADL function, and timely and appropriate intervention for dependent residents.		

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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 observation interview and record review, the facility failed to: 1. Provide appropriate monitoring of insulin for one of five sampled residents (Resident 5). 2. Initiate a comprehensive care plan that addressed Resident 5's diagnosis of diabetes or the administration of insulin. These deficient practices had the potential to result in complications from the use of insulin such as hypoglycemia and lethargy. Findings: A review of Resident 5's admission Record indicated the facility admitted the resident on 5/26/2023 and readmitted on [DATE] with diagnoses including but not limited to diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), morbid obesity and ESRD (End Stage Renal Disease-irreversible kidney failure). A review of Resident 5's Minimum Data Set (MDS - a resident assessment tool) dated 6/1/2026, indicated Resident 5 has intact cognition (ability to think and reason), required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, bathing and lower body dressing. The MDS also indicated Resident 5 was receiving insulin. A review of the physician order, dated 11/20/2025, indicated to administer Lantus Insulin five units) solution subcutaneously (applied under the skin) at bedtime for diabetes mellitus with hyperglycemia (high blood sugar). A review of the physician order, dated 2/5/2026, indicated the facility was to administer to Resident 5 regular insulin Pen 100 units per milliliter (ml) before meals per sliding scale insulin (refers to the progressive increase in the pre-meal or nighttime insulin dose, based on pre-defined blood glucose ranges), for diabetes mellitus as follows: Blood sugar less than 60 or greater than 401 to notify physician Blood sugar 60 - 200 administer = 0 units of insulin Blood sugar 201 - 250 administer = 3 units of insulin Blood sugar 251 - 300 administer = 4 units of insulin Blood sugar 301 - 350 administer = 6 units of insulin Blood sugar 351 - 400 administer = 9 units of insulin Blood sugar 261-280 administer = 5 units of insulin A record review of all Resident 5's physician orders on 7/9/2026 at 8:21 AM, indicated there was no orders for to monitor for hypoglycemia, vomiting or lethargy. A review of Resident 5's June 2026 and July 2026 medication administration records (MAR) indicated that Resident 5 was receiving regular insulin and Lantus insulin. The same MARs also indicated no documented evidence the license nurses monitored the resident's monitoring for the side effects of insulin. During a concurrent interview and record review on 7/09/2026 at 9:13 AM, Resident 5's electronic medical chart was reviewed. Upon review of Resident 5's physician orders, the Director of Nursing (DON) stated Resident 5 was taking Lantus and regular insulin. The DON stated a side effect of insulin included hypoglycemia and the nurses should be monitoring the resident for the signs of symptoms of low blood sugar and this monitoring should have been on the resident's MAR. The DON further stated there was no care plan that addressed Resident 5's insulin medications. The DON stated there should be a care plan and the care plan interventions should include, the administration of insulin and there should be monitoring for the signs and symptoms of hypoglycemia. A review of the facility policy and procedures (P&P), Insulin Administration, revised 1/12/2026, indicated the goal was To provide guidelines for the safe administration of insulin to residents with diabetes. The P&P also indicated nursing staff were to notify the physician if the resident has signs and symptoms of hypoglycemia that are not resolved by following the facility protocol for hypoglycemia management. A review of the facility's P&P, Care Plans, Comprehensive Person-Centered, dated 1/12/2026, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P also indicated the comprehensive, person-centered care plan: a. Includes measurable objectives and (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	timeframes;b. Describes the services that are to be furnished to attain or maintain the resident's highestpracticable physical, mental, and psychosocial well-being, reflects currently recognized standards of practice for problem areas and conditionsg. Incorporate identified problem areas;h. Incorporate risk factors associated with identified problems;k. Reflect treatment goals. timetables and objectives in measurable outcomes.		

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on interview and record review, for one of one sampled residents (Resident 99), the facility failed to ensure Certified Nursing Assistant (CNA) 1 followed/verified a physician's order for minced and moist diet (therapeutic diet-a personalized meal plan prescribed by a doctor or registered dietitian to treat a medical condition or manage symptoms) dated 4/8/2026. CNA 1 brought and gave Resident 99 protein bars (a convenient, ready-to-eat snack designed to deliver a concentrated dose of protein) to eat. Resident 99 has a diagnosis of dysphagia (difficulty swallowing). This failure resulted in Resident 99 eating the protein bar/s placing Resident 99 at increased risk for choking, hospitalization, and death. Findings: Cross Reference F689 and F835 During a review of Resident 99's admission record, dated 6/14/2025, indicated Resident 99 was admitted to the facility on 6/14/2025 with diagnoses but not limited to transient ischemic attack (TIA-a temporary blockage of blood flow to the brain causing stroke symptoms), end stage renal disease (kidneys have permanently stopped working), anarthria (inability to speak clearly), dysphagia, and hemiplegia (severe or complete loss of voluntary movement on one entire side of the body) affecting the right side. During a review of Resident 99's Minimum Data Set (MDS- a resident assessment tool), dated 3/16/2026, indicated Resident 99 used a wheelchair (an assistive device) and required total physical assistance transferring from a bed to a chair (wheelchair). The MDS also stated Resident 99's cognitive patterns were moderately impaired (a person's memory or thinking have started to weaken). During a review of Resident 99 Physician's Order dated 4/8/2026, indicated, Resident 99 diet was downgraded from soft bite-sized diet to minced and moist diet (food that is soft, wet, and cut into small pieces) because of Resident 99's dysphagia (difficulty swallowing). During a review of Resident 99's Care Plan (CP- a personalized roadmap of your health), dated 6/14/2025, indicated, The resident (Resident 99) has a swallowing problem. The resident will not have injury related to aspiration (inhaling something into your lungs by accident) through the review date. The resident will have no choking episodes when eating through the review date. During a review of Resident 99's Speech Therapy Treatment Encounter Notes (Summary of Daily Skilled Services), dated 5/5/2026, indicated, It is not optimal to upgrade pt (Resident 99) to a regular or soft and bite sized diet due to prolonged oral phase and previous weight loss with upgraded diet. During a telephone interview on 7/7/2026 at 3:11 P.M. with FM 1, FM 1 stated that before Resident 99 was discharged from the facility on 5/26/2026, CNA 1 paid for protein bars and brought protein bars and water bottles for Resident 99 while resident was at the facility. During an interview on 7/8/2026 at 11:28 A.M. with CNA 1, CNA 1 confirmed and stated CNA 1 used CNA 1's own money to buy Resident 99 protein bars but did not consult with the facility's dietitian (a medical trained food expert), licensed nurses or facility leadership. CNA 1 stated Resident 99 ate the protein bars and was aware Resident 99 was on a minced diet. During an interview on 7/9/2026 at 12:36 P.M. with the DON, the DON stated CNA 1 used CNA 1's own money to buy protein bars for Resident 99 while the resident was at the facility. The DON stated Resident 99 should not be receiving/eating protein bars because Resident 66 is on a puree diet (consists of foods that are blended, whipped, or mashed into a smooth, lump-free consistency similar to pudding). The DON stated that CNA 1 purchased bottled water and protein bars for Resident 99. The DON also stated Resident 99 was at risk for choking from eating the protein bars. During a review of facility's P&P titled, Resident Food Preferences, with a review date of 1/12/2026, (continued on next page)		

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated, The Dietitian and nursing staff, assisted by the Physician, will identify nutritional issues and dietary recommendations that might be in conflict with the resident's food preferences.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure a garbage dumpster lid completely closed and covered for one of two garbage dumpsters. This failure had the potential to attract pests (any living thing that can spread disease) and spread infection (when harmful germs like bacteria or viruses can enter your body and make you sick) to facility residents. Findings: During a concurrent observation and interview on 7/6/2026 at 9:10 A.M. with Dietary Aid (DA) 1 in the outdoor garbage area, a garbage dumpster was filled with trash bags to the point that the lid could not fully close. DA 1 stated the garbage dumpster lid should be fully closed to prevent pests and vermin (a small animal, bug, or parasite that can spread disease or destroy property) which can potentially make the residents sick. During an interview on 7/7/2026 at 2:10 P.M. with the Dietary Supervisor (DS), the DS stated insects or animals could travel inside the garbage dumpster if the lid is not fully closed and this can result in the residents becoming sick. During a record review of the facility's policy and procedures (P&P) titled, Miscellaneous Areas - Garbage and Trash, dated 2023, indicated: All food waste must be placed in sealed leak-proof, non-absorbent, tightly closed containers (i.e., plastic bags) and shall be disposed of as necessary to prevent a nuisance or unsightliness. Adequate, clean, vermin-proof areas must be provided for storage of garbage and rubbish. During a record review of the facility's P&P titled, Trash Removal, dated 1/12/2026, indicated, Be sure that the trash cart remains covered at all times. During a review of Food Code 2022, dated 1/18/2022, the Food Code page 527, indicated, Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents.		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Certified Nursing Assistant (CNA) 1 adhered to the facility's professional code of conduct (rules for how employees should behave at work) by not engaging in an inappropriate romantic relationship with one of one resident (Resident 99) according to the facility's Employee Handbook, dated 3/2025 and evidenced by: 1. CNA 1 making arrangements with a private transportation company (PTC) to pick up Resident 99 from the facility, transported Resident 99 to a bank in Pasadena 20 miles away from the facility, and transported Resident 99 back to the facility unaccompanied and without supervised, and without the knowledge of Resident 99's family members, and facility staff. 2. CNA 1 visiting Resident 99 at a general acute care hospital (GACH) 1 on multiple occasions in the months of 5/2026 and 6/2026 when Resident 99 was admitted at GACH 1.3. CNA 1 bringing and giving protein bars (a convenient, ready-to-eat snack designed to deliver a concentrated dose of protein) despite a physician's order for Resident 99 to consume minced and moist diet (therapeutic diet-a personalized meal plan prescribed by a doctor or registered dietitian to treat a medical condition or manage symptoms) dated 4/8/2026. Resident 99 has a diagnosis of dysphagia.4. CNA 1 exchanging romantic text messages with Resident 99. This failure resulted in Resident 99's Family Member (FM) 1 alerting the facility of (CNA 1)'s inappropriate relationship with Resident 99 and placed Resident 99 at increased risk for accidents, falls, injuries, choking, hospitalization and death. Findings: Cross Reference F689 and F808 During a review of Resident 99's admission record, dated 6/14/2025, indicated Resident 99 was admitted to the facility on 6/14/2025 with diagnoses but not limited to transient ischemic attack (TIA-a temporary blockage of blood flow to the brain causing stroke symptoms), end stage renal disease (kidneys have permanently stopped working), anarthria (inability to speak clearly), dysphagia (difficulty swallowing), and hemiplegia (severe or complete loss of voluntary movement on one entire side of the body) affecting the right side. During a review of Resident 99's physician order, dated 2/5/2026, indicated, (Resident 99) may go out on Therapeutic pass on Monday, Wednesday, and Friday with an outside agency. They will be riding with resident to and from the Fitness gym (gymnasium- is a dedicated indoor or outdoor facility equipped for physical exercise, sports, and athletic training). During a review of Resident 99's Minimum Data Set (MDS- a resident assessment tool), dated 3/16/2026, indicated Resident 99 used a wheelchair (an assistive device) and required total physical assistance transferring from a bed to a chair (wheelchair). The MDS also stated Resident 99's cognitive patterns were moderately impaired (a person's memory or thinking have started to weaken). During a review of Resident 99's notarized (a document that has been officially verified, witnessed, and authenticated by a neutral public official known as a notary public) Financial Power of Attorney (POA) Packet, the Acknowledgement form, dated 4/26/2026, indicated Resident 99's name. The date of the signed Signature and Acceptance form was illegible. During a review of the facility's Release of Responsibility for Leave of Absence sign in/out form, undated, indicated no documented evidence that Resident 99 signed in or signed out for OOP for the month of April 2026. During a review of Resident 99's Discharge summary, dated [DATE], indicated Resident 99 was discharged to GACH 1 on 5/26/2026 at 4:25 P.M. During a review of Resident 99's Physician's Order dated 4/8/2026, indicated, Resident 99 diet was downgraded from soft bite-sized diet to minced and moist diet (food that is soft, wet, and cut into small pieces) because of Resident 99's dysphagia (difficulty in swallowing). During a review of Resident 99's Speech Therapy Treatment Encounter Notes (Summary of Daily Skilled Services), dated 5/5/2026, indicated, It is not optimal to (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	upgrade pt (Resident 99) to a regular or soft and bite sized diet due to prolonged oral phase and previous weight loss with upgraded diet. During a review of an e-mail (electronic mail) from FM 1 to the facility, dated 6/3/2026, indicated, Please forward this message to the appropriate staff members at (the facility). Since leaving (the facility) to (GACH 1), (CNA 1) has followed (Resident 99) to (GACH 1) visiting him frequently and I've observed that the care for him is not within the realm of a professional manner. (CNA 1) should not have continued engagement with (Resident 99) after his stay at (the facility). During a telephone interview on 7/7/2026 at 3:11 P.M. with FM 1, FM 1 stated that between 4/26/2026 to 4/30/2026, CNA 1 organized and paid a PTC to transport Resident 99 to a bank 20 miles away from the facility and to also meet Resident 99's FM 3. FM 1 stated that Resident 99 (FM 1's father) had changed his financial POA (Power of Attorney) from FM 1 and FM 4 to FM 2. FM 1 stated that on 5/2026 (unable to recall the date), Resident 99 was admitted at GACH 1 and while FM 1 was visiting Resident 99 at GACH 1, CNA 1 came to visit Resident 99 at GACH 1 on 5/2026 and 6/2026 (unable to state dates). FM 1 stated that before Resident 99 was discharged from the facility on 5/26/2026, CNA 1 paid for Resident 99's protein bars and brought the protein bars and water bottles for Resident 99 while resident was at the facility. FM 1 also stated Resident 99 had given FM 5 a birthday card with \$25 cash inside. FM 1 stated when FM 1 asked CNA 1 about the birthday card, CNA 1 stated, (Resident 99) asked me to get the card, so I got the card for (Resident 99). FM 1 stated that while visiting Resident 99 at GACH 1, FM 1 had access to Resident 99's personal cellular phone. FM 1 stated that either 5/2026 or 6/2026, while Resident 99 was admitted at GACH 1, FM 1 stated FM 1 started noticing CNA 1 having an inappropriate relationship with Resident 99. FM 1 also stated that FM 1 read the inappropriate text messages on Resident 99's phone from Resident 99 to a recipient with the same first name as CNA 1. During a telephone interview on 7/8/2026 at 9:15 A.M. with FM 2, FM 2 stated, Resident 99 changed Resident 99's financial Power of Attorney (POA- is a legal document that allows one person (the principal) to designate a trusted person or entity (the agent or attorney-in-fact) to make legal, financial, or medical decisions on their behalf) from FM1 and FM 4 to FM 2 in 4/2026 per Resident 99 and FM 3's requests. FM 2 stated Resident 99 wanted control over Resident 99's finances. FM 2 stated FM 2 was aware that Resident 99 had traveled to the resident's bank to change over the resident's financial POA but did not know how Resident 99 arrived at the bank or if FM 3 was able to meet Resident 99 at the bank. During an interview on 7/8/2026 at 10:10 A.M. with DSD, the DSD stated DSD was aware that CNA 1 had visited Resident 99 at GACH 1 on 5/2026. DSD confirmed and stated DSD received and read the e-mail dated 6/3/2026 from FM 1 that indicated that CNA 1 was having inappropriate/romantic relationship with Resident 99 since 5/2026 or 6/2026 (not very sure of the month) when Resident 99 was admitted at GACH 1. DSD stated the facility Admin was already aware of the email sent by FM 1 when DSD went to inform the Admin. DSD stated any allegation of abuse must be reported immediately to keep the residents safe at the facility. During an interview on 7/8/2026 at 10:31 A.M. with the Admin, the Admin stated and confirmed that he was aware (did not give dates) of the email FM 1 had sent to the facility regarding CNA 1 and Resident 99. The Admin stated he could not recall if the email from FM 1 indicated that CNA 1 was having inappropriate relationship with Resident 99. The Admin stated he was aware that CNA 1 was visiting Resident 99 at GACH 1. The Admin stated the inappropriate behavior by CNA 1 was a potential for conflict of interest. During an interview on 7/8/2026 at 11:28 A.M. with CNA 1, CNA 1 confirmed and stated CNA 1 was at CNA 1's residence when CNA 1 used an application (app- a software designed to run on handheld devices like smartphones and tablets) on CNA 1's cellular phone to make transportation arrangements with a PTC and also paid the PTC to (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Culver West Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4035 Grandview Blvd. Los Angeles, CA 90066	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transport Resident 99 to the bank in Pasadena on 4/2026. CNA 1 did not provide the date and refused to share proof of the PTC records. CNA 1 stated that CNA 1 did not inform the facility Admin, Director of Nursing (DON) or any facility staff. CNA 1 stated that Resident 99 traveled alone to a bank in Pasadena via PTC without adequate supervision which placed Resident 99 at increased risk for physical harm such as a vehicle accident. CNA 1 stated Resident 99 said was to meet FM 3 at the bank in Pasadena, however, CNA 1 does not know if Resident 99 met with FM 3 at the bank. CNA 1 refused to provide/share the month and or the date when CNA 1 paid the PTC to transport Resident 99 to a bank in Pasadena. CNA 1 stated that CNA 1 does not know how and when Resident 99 returned to the facility. CNA 1 confirmed and stated CNA 1 gave FM 5 a birthday card with cash inside per Resident 99's request. CNA 1 stated the cash given to FM 5 inside the birthday card was from Resident 99's room. CNA 1 confirmed and stated that when Resident 99 was admitted at GACH 1, CNA 1 wore work scrubs (two-piece uniforms worn by healthcare staff) and no identification badge when CNA 1 went to visit Resident 99 at GACH 1 on 5/2026 and 6/2026. CNA 1 stated that CNA 1 went to help feed Resident 99 but did not wear an identification badge. CNA 1 further stated that CNA 1 used CNA 1's own money to buy Resident 99 protein bars but did not consult with the facility's dietician (a medical trained food expert), licensed nurses or facility leadership. CNA 1 stated Resident 99 ate the protein bars and was aware Resident 99 was on a minced diet. CNA 1 denied having a romantic relationship with Resident 99 but when asked to confirm if inappropriate text messages were exchanged between CNA 1 and Resident 99, CNA 1 did not respond. During a review of text messages on Resident 99's cellular phone provided by FM 1 on 7/9/2026 at 7:48 A.M., one of the text messages between Resident 99 and CNA 1 dated 5/13/2026 indicated, an individual with CNA 1's first name wrote, Hi [NAME], how are you today? I can't wait to see you. I miss you. During an interview on 7/9/2026 at 12:36 P.M. with the DON, the DON stated that beginning of 6/2026, staff member from facility Admissions office (did not name the staff member) forwarded the DON the email from FM 1 was concerned about CNA 1 not within the realm of professional manner. The DON confirmed and stated Resident 99 left the facility without adequate supervision on 4/2026 and that CNA 1 paid for a PTC for Resident 99 to go to a bank in Pasadena. The DON further stated that CNA 1 visited Resident 99 at GACH 1 on 5/2026 approximately 3-4 times after CNA 1 completed work at the facility work. The DON stated that CNA 1 used CNA 1's own money own money to buy Resident 99 protein bars while the resident was at the facility. The DON stated Resident 99 should not be receiving/eating protein bars because Resident 66 is on a puree diet (consists of foods that are blended, whipped, or mashed into a smooth, lump-free consistency similar to pudding). The DON stated that CNA 1 and Resident 99 had an inappropriate relationship by exchanging romantic text messages, CNA 1 visiting Resident 99 at GACH 1, purchasing bottled water and protein bars for Resident 99. The DON also stated that this relationship had the potential to cause physical harm to Resident 99 such as a vehicle accident or choking from the protein bars provided. During a review of the facility's Employee Handbook, dated 3/2025, indicated the following: Employees must avoid situations involving actual or potential conflict of interest. If employees are involved in any of the types of relationships or situations described in this policy, they should immediately and fully disclose the relevant circumstances to their immediate supervisor, or any other appropriate supervisor, for a determination about whether a potential or actual conflict exists. Employees are expected to conduct their personal affairs in a manner that does not adversely affect the Facility's or their own integrity, reputation, or credibility. During a review of the facility's P&P titled, Therapeutic Leave Policy, with a review date of 1/12/2026, indicated, Therapeutic Leave: A planned absence of a resident authorized by a physician order. All therapeutic leaves, must sign the Release of (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Responsibility form with the receptionist for the safety and tracking of all residents. During a review of the facility's P&P titled, Safety and Supervision of Residents, with a review date of 1/12/2026, indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility to ensure the medical record contained sufficient information for one of four sampled residents (Resident 10) was complete by failing to indicate the recommendations and plan of care on the Joint Mobility Assessment (JMA, a brief assessment of a resident's range of motion [ROM, full movement potential of a joint] in both arms and both legs), dated 4/2/2026, for Resident 10, who was identified as having a decline in ROM of both shoulders compared to the previous JMA, dated 9/9/2025. This deficient practice had the potential to delay and negatively affect the delivery of necessary care and services and result in ROM decline leading to contracture (loss of motion of a joint associated with stiffness and joint deformity) development and functional decline for Resident 10. Findings: During a review of Resident 10's admission Record (AR), the AR indicated Resident 10 initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including, but not limited to chronic (ongoing) obstructive pulmonary disease (COPD, lung disease that causes obstruction of airflow and can limit normal breathing), Parkinson's disease (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement), and weakness. During a review of Resident 10's Joint Mobility Assessment (JMA), dated 9/9/2025, the JMA indicated Resident 10's ROM of both shoulders was Within Functional Limits (WFL, variance due to normal aging process allowed up to 25 percent). The JMA indicated for Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) to evaluate and treat Resident 10. During a review of Resident 10's Joint Mobility Assessment (JMA), dated 4/2/2026, the JMA indicated Resident 10's ROM of both shoulders was moderately impaired (resident has 50 to 75 percent available ROM in the joint). The following portions of the JMA form were blank: Patient/Resident was reviewed for rehabilitative needs on this date: Physical Therapy, Occupational Therapy, Speech Therapy Evaluation orders requested (check appropriate boxes) No skilled therapy intervention is needed at this time (check box blank) Additional comments/Notes: During a review of Resident 10's Minimum Data Set (MDS, a resident assessment tool), dated 6/4/2026, the MDS indicated Resident 10 had moderate cognitive impairment. The MDS indicated Resident 10 required supervision or touching assistance for eating and rolling to both sides, partial/moderate assistance (helper does less than half the effort) for oral hygiene, upper body dressing, personal hygiene, and bed to chair transfers, and substantial/maximal assistance (helper does more than half the effort) for toileting hygiene, bathing, lower body dressing, and tub/shower transfers. During an observation on 7/7/2026 at 12:48 pm, in Resident 10's room, Resident 10 was sitting in a wheelchair with both elbows bent and resting on the wheelchair armrests. Resident 10 opened and closed both hands and bent and straightened both elbows. Resident 10 did not attempt to move both shoulders or raise both arms overhead when asked. During a concurrent interview and record review on 7/8/2026 at 3:08 pm with the Director of Rehabilitation (DOR), the DOR stated the Rehabilitation Department (Rehab) conducted detailed JMAs which included a ROM assessment of each resident's both arms and legs upon admission, quarterly, and upon a change of condition (COC, major decline or improvement in a resident's status that will not resolve itself without intervention) to monitor for changes in a resident's ROM. The DOR stated the purpose of JMAs was to monitor ROM changes, identify any improvements or declines in a resident's ROM, and determine whether the current services were effective or if a resident required skilled therapy (services delivered by a (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	licensed therapist or therapy assistant who has specialized training and experience) services. The DOR reviewed Resident 10's JMA, dated 9/9/2025, and confirmed Resident 10's ROM of both shoulders was WFL. The DOR reviewed Resident 10's JMA, dated 4/2/2026, and confirmed Resident 10's ROM of both shoulders was moderately impaired, which was a decline compared to the previous JMA, dated 9/9/2025. The DOR stated Resident 10's JMA, dated 4/2/2026, was incomplete because the portion of the JMA which included the interpretation of the ROM results, whether skilled therapy services were recommended, and comments/notes section were blank. The DOR stated the evaluating therapist must complete all sections of the JMA to include an interpretation of the findings to indicate if the resident maintained, improved, or had a decline in ROM, recommendations, and plan of care to ensure the resident had the appropriate services to prevent further decline. The DOR stated if staff did not complete all sections of the JMA, it could result in ROM and functional decline, lack of effective treatment and services, and inability or missed opportunities to detect declines. During an interview on 7/8/2026 at 3:15 pm with the Director of Nursing (DON), the DON stated the facility monitors for changes in ROM by staff report and therapy assessments, which included JMAs which were done upon admission and quarterly by Rehab. The DON stated it was important that staff completed all portions of the JMA to ensure the facility promptly identified any ROM changes and provided appropriate services to address any declines and prevent contractures. During a review of the facility's Policy and Procedures (P&P) titled, Charting and Documentation, revised 1/12/2026, the P&P indicated the medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The P&P indicated documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.		