STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055353	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shoreline Healthcare Center	4029 East Anaheim Street Long Beach, CA 90804

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were treated with dignity and respect for two of five sampled residents (Resident 82 and Resident 46) as evidenced by:A. Failing to ensure Resident 82 was dressed in the resident's own clothing appropriate to the time of day and consistent with the resident's preferences instead of hospital gowns.B. Failing to ensure staff spoke to Resident 46 in a respectful manner.These failures had the potential to negatively affect Resident 82 and 46's sense of dignity, autonomy (the ability to make your own choices and control your own actions), and psychosocial wellˆbeing. Findings: A. During a review of Resident 82's admission Record (Face Sheet-page of the chart that contains a summary of basic information about the resident), the admission Record (Face Sheet) indicated Resident 82 was admitted to the facility on [DATE] with diagnoses including morbid obesity (an extreme level of excess body fat that poses severe, life-threatening risks to your overall health and significantly reduces life expectancy), gout (painful form of inflammatory arthritis), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) on hips. During a review of Resident 82's History and Physical (H&P), dated 6/9/2026, the H&P indicated, Resident 82 had the capacity (ability) to make medical decisions. During a review of Resident 82's Minimum Data Set (MDS-a resident assessment tool), dated 6/11/2026, the MDS indicated Resident 82's cognitive skills for daily decision making was intact. TMDS indicated Resident 82 required maximal assistant (Helper does more than half the effort) from one staff for toilet hygiene, shower, dressing, bed mobility, transfer, and supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from one staff for eating, oral hygiene, dressing. During a concurrent observation and interview on 6/22/2026 at 11:08 a.m., with Resident 82 in her room, Resident 82 was in bed and wearing a hospital gown. Resident 82 stated she did not want to wear a hospital gown but did not have her clothes with her. Resident 82 stated she was admitted to the facility 14 days ago, on 6/8/2026 and had been wearing the same hospital gown since admission. Resident 82 stated no one had informed her the facility offered clothes (donated) to residents that need them. Resident 82 stated she wanted to wear regular clothing. Resident 82 stated she felt ashamed to leave the room and socialize with other residents, because the other residents wore their own clothing. During a concurrent interview and record review on 6/24/2026 at 10:55 a.m., with Registered Nurse (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Supervisor (RNS) 1, Resident 82's Resident's Clothing and Possessions document, dated 6/8/2026 was reviewed. The Resident's Clothing and Possessions indicated Resident 82 had one phone, one phone charger, one purple color sweater, one scarf, and one blood pressure cuff on 6/6/2026. The Resident's Clothing and Possessions document indicated, Resident 82 did not have any clothing other than the purple sweater. RNS 1 stated, all residents were expected to wear their own clothes rather than hospital gowns unless they preferred to wear a gown. RNS 1 stated the facility promoted a homeˆlike environment and noted individuals did not typically wear hospital gowns at home. RNS 1 stated, this was why all residents were encouraged to wear their regular clothing to honor and respect their dignity. During an interview on 6/24/2026 at 11:12 a.m., with the Social Service Director (SSD), the SSD stated that staff should have offered Resident 82 donated clothing or contacted the resident's family members to bring clothing from home. The SSD stated that the facility had a responsibility to provide proper clothing if residents were unable to obtain their own. The SSD stated that staff should have respected and honored the resident by ensuring the resident was dressed according to their preference so they could present themselves to others properly and with dignity. During an interview on 6/25/2026 at 3:39 p.m., with the Director of Nursing (DON), the DON stated the DON stated that staff should have contacted Resident 82's family to bring clothing as soon as they realized the resident did not have proper clothing when completing the admission inventory. The DON stated that the facility encouraged residents to be dressed in their own clothing appropriate to the time of day and consistent with the resident's preferences, but instead placed the resident in hospital gowns, which did not align with promoting dignity and respect. During a review of the facility's Policy and Procedure (P&P) titled, Dignity and Privacy, dated 11/2021, the P&P indicated, Policy: It is the policy of this facility that all residents be treated with kindness, dignity and respect. PROCEDURES: 2. Residents will be appropriately dressed in clean clothes arranged comfortably on their persons and be well groomed. During a review of the facility's Policy and Procedure (P&P) titled, Resident Rights, dated 10/4/2016, the P&P indicated, Respect and Dignity. You have the right to be treated with respect and dignity, including the right to: Retain and use personal possessions, including furnishings, and clothing, as space permits, and reside and receive services in the facility with reasonable accommodation of your needs and preferences. B. During a review of Resident 46's admission Record, the admission Record indicated the facility admitted the resident on 5/20/2026, with diagnoses including wedge compression fracture of fourth lumbar vertebrae (collapse of the lower back bone), dysphagia (difficulty swallowing), cognitive communication deficit (a communication impairment caused by disrupted brain function), bundle branch block (a delay or blockage in the electrical pathways of the heart's lower chambers), benign neoplasm of cerebral meninges (tumor), and inflammatory spondylopathy (chronic inflammation in the spine and joints). During a review of resident 46's Minimum Data Set (MDS – a resident assessment tool) dated 5/26/2026, the MDS indicated Resident 46 was capable to make decisions. The MDS indicated Resident 46 needed supervision and/or touch assistance with eating, oral hygiene, and personal hygiene. The MDS indicated, Resident 46 needed substantial or maximal assistance with toileting, showering, upper body dressing, lower body dressing, putting on and taking off footwear, rolling from left to right side, sitting to lying, sit to stand, chair to bed transfer, toilet transfer and walking 10 feet. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/22/2026, at 9:15 a.m., with Resident 46, Resident 46 stated Certified Nurse Assistant (CNA) 6 stated you need to clean yourself and turn off the light. Resident 46 stated CNA 6 was rude to her. Resident 46 stated when she called CNA 6 to assist her to use the restroom, CNA 6 stated first you are using the bathroom on the toilet, then in the bedside and now in the bed, what's wrong with you! Resident 46 stated she informed Restorative Nurse Assistant (RNA) 1 about the situation four days ago and has not heard from RNA 1 since the incident occurred. During an interview on 6/22/2026, at 1:00 p.m., with RNA 1, RNA 1 stated Resident 46 informed her that CNA 6 was rude to her. RNA 1 stated she notified the Director of Staff Development (DSD) about Resident 46's concern with CNA 6. During an interview on 6/22/2026, at 2:20 p.m., with the Director of Staff Development (DSD), the DSD stated she was aware of the incident with Resident 46 and CNA 6. The DSD stated she was informed by Resident 46 that she did not like the way CNA 6 treated her. The DSD stated Resident 46 reported feeling rushed while getting assistance from CNA 6 in the restroom. During a review of the facility's policy and procedures (P&P) titled Resident Rights, Dignity and Privacy, undated, the P&P indicated, staff shall display respect for residents when speaking, caring for, or talking about them as constant affirmation of their individuality and human beings.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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) and mobility (ability to move) for two of four sampled residents (Resident 2 and 5) with limited ROM and mobility (ability to move) concerns. a. For Resident 5, the facility failed to:1. Objectively measure Resident 5's ROM in both arms during the Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) Evaluations, dated 5/6/2025 and 11/11/2025.2. Provide passive range of motion ([PROM] movement of a joint through the range of motion with no effort from person) exercises and apply splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) to both of Resident 5's hands, elbows, knees, and ankles from 8/20/2025 to 9/4/2025 after Resident 5's discharge from Physical Therapy ([PT] profession aimed in restoration, maintenance, and promotion of optimal physical function) and OT services on 8/19/2025. b. For Resident 2, the facility failed to objectively measure Resident 2's ROM in both arms during the OT Evaluation, dated 4/16/2026. These failures had the potential for Resident 2 and 5 to experience undetected decline in ROM. Findings:a. During a review of Resident 5's Face Sheet (admission record details), the Face Sheet indicated the facility originally admitted Resident 5 on 12/13/2022 and readmitted on [DATE] with diagnoses including traumatic subarachnoid hemorrhage (type of stroke where bleeding occurs in the fluid-filled space between the brain and the tissues covering the brain), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting the left nondominant side, aphasia (disorder that makes it difficult to speak), dysphagia (difficulty swallowing), and contractures (a stiffening/shortening at any joint that reduces the joint's range of motion) of muscle.During a review of Resident 5's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 5/7/2026, the MDS indicated Resident 5 had no speech and had severely impaired cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 5 had ROM limitation in both arms and legs and was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required to complete the activity) for hygiene, toileting, bathing, dressing, rolling from the back to both sides in bed, and chair/bed-to-chair transfers.1. During a review of Resident 5's OT Evaluation and Plan of Treatment, dated 5/6/2025, the OT Evaluation indicated Resident 5's ROM in both shoulders, elbows/forearms, wrists, and hand were impaired. The OT Evaluation did not indicate a measurement of Resident 5's impairments in both arms.During a review of Resident 5's OT Evaluation and Plan of Treatment, dated 11/11/2025, the OT Evaluation indicated Resident 5's ROM in both shoulders, elbows/forearms, wrists, and hand were impaired. The OT Evaluation did not indicate a measurement of Resident 5's impairments in both arms.During an observation on 6/22/2026 at 10:43 a.m. in Resident 5's room, Resident 5 was awake while lying in bed and unable to speak. Resident 5 was observed wearing both elbow splints and hand splints.During an observation on 6/23/2026 at 9:26 a.m. with Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) 1 (RNA 1) in Resident 5's room, Resident 5 was lying awake in bed. RNA 1 provided PROM to both of Resident 5's shoulders, elbows, wrist, and hands. RNA 1 provided PROM on both shoulders to 90 degrees (unit of measurement for joint movement) at shoulder height. RNA 1 was unable to completely straighten both of Resident 5's elbows, which continued to have a slight bend. The middle joint of Resident 5's left-hand ring and small fingers were observed fixed (immovable) in a bent position. The large knuckles of Resident 5's right-hand were also observed in a fixed, bent position. RNA 1 applied both elbow extension splints and resting hand splints after completing the PROM exercises to both arms. During a concurrent interview and record review on 6/23/2026 at 2:43 p.m. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with the Director of Rehabilitation (DOR), Resident 5's OT Evaluation, dated 5/6/2025, was reviewed. The DOR stated Resident 5's OT Evaluation did not include ROM impairments to both shoulders, elbows, wrists, and hands. During a concurrent interview and record review on 6/23/2026 at 2:53 p.m. with the DOR, Resident 5's OT Evaluation, dated 11/11/2025, was reviewed. The DOR stated Resident 5's OT Evaluation did not include ROM impairments to both shoulders, elbow, wrist, and hands.During an interview on 6/23/2026 at 3:19 p.m. with the DOR, the DOR stated PT and OT's professional schooling included objectively measuring the joints using a goniometer (instrument used to measure angle of joint movement). The DOR stated the purpose of measuring joints included to determine any changes in measurements over time. The DOR stated the absence of ROM measurements in therapy evaluations prevented the therapist from monitoring changes in the resident's ROM. 2. During a review of Resident 5's OT Discharge summary, dated [DATE], the OT Discharge Summary indicated recommendations for Resident 5 to reside at the facility with 24 hours, seven days per week care.During a review of Resident 5's PT Discharge summary, dated [DATE], the PT Discharge Summary indicated recommendations for a (unspecified) restorative nursing program ([RNP] nursing aide program that helps residents to maintain their function and joint mobility).During a review of Resident 5's physician's orders, dated 9/3/2025, the physician's order indicated for the RNA to provide PROM to both arms and legs, five times per week as tolerated. Another physician's order, dated 9/3/2025, indicated for the RNA to apply both resting hand splints (splints secured with straps that extends from the fingers to the forearm to properly position the fingers and wrist), both elbow extension (straightening) splints, both knee extension splints, and both ankles splints, five times per week for four to six hours as tolerated. During an interview on 6/22/2026 at 9:25 a.m. with the DOR, the DOR stated residents (in general) transition to RNA services after reaching their maximum potential with therapy. The DOR stated the therapists (PT and OT) provide a physician's order to start RNA services upon discharge from therapy services. The DOR stated RNA services included providing ROM and applying splints which maintained a resident's ROM. During an observation on 6/22/2026 at 10:43 a.m. in Resident 5's room, Resident 5 was awake while lying in bed and unable to speak. Resident 5's arms had both elbow splints and hand splints applied. Resident 5's legs appeared to be rotated toward the right side with both hips and knees in a bent position. Resident 5's legs were not clearly visible due to the presence of a sheet. During a concurrent interview and record review on 6/23/2026 at 2:43 p.m. with the DOR, the DOR reviewed Resident 5's OT Discharge summary, dated [DATE], and stated the OT did not include recommendations for RNA services. During a concurrent interview and record review on 6/23/2026 at 2:49 p.m. with the DOR, the DOR reviewed Resident 5's PT Discharge summary, dated [DATE], and stated the PT Discharge Summary included RNP for splinting and ROM. During a concurrent interview and record review on 6/25/2026 at 11:46 a.m. with the DOR, Resident 5's OT and PT Discharge Summaries, dated 8/9/2025, and physician's orders, dated 9/3/2025, were reviewed. The DOR stated Resident 5 was dependent and unable to move both arms and legs. The DOR stated Resident 5 did not receive ROM exercises and application of splints from 8/10/2025 to 9/3/2025. The DOR stated Resident 5 could have developed a decline in ROM without the provision of RNA services. During a review of the facility's policy and procedure (P&P) titled, ROM and Contracture Prevention, the P&P indicated the facility ensured the residents receive services, care and equipment to assure that.Every resident with limited range of motion and mobility maintains or improves function.b. During a review of Resident 2's Face Sheet, the Face Sheet indicated the facility initially admitted Resident 2 on 4/9/2026 and readmitted on [DATE] with diagnoses including muscle weakness, atherosclerosis (thickening and hardening of the arteries) of coronary artery bypass grafts ([CABG] surgery to replace blocked heart circulation with healthy blood vessels), atrial fibrillation (irregular and very rapid heart rate), and healed traumatic fracture.During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had unclear speech, usually understood verbal content, had difficulty communicating some words or finishing thoughts, and had severely impaired cognition. The MDS indicated Resident 2 was dependent (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for toileting, showering, dressing, rolling from the back to both sides in bed, chair/bed-to-chair transfers, and sit-to-stand transfers.During a review of Resident 2's OT Evaluation and Plan of Treatment, dated 4/16/206, the OT Evaluation indicated Resident 2's medical history included a CABG, right humeral fracture (break in upper arm between the elbow and the shoulder), and right shoulder anterior dislocation (injury where the ball of the shoulder pops out of the shoulder joint) with closed reduction (non-surgical procedure to realign bones into the proper position) on 2/30/2026. The OT Evaluation indicated Resident 2's prior level of function (ability prior to admission to the facility) was independent for eating, toileting, showering, toilet transfers, and dressing. The OT Evaluation indicated Resident 2's right shoulder had (unspecified) ROM impairment. During an interview on 6/22/2026 at 12:22 p.m. with Resident 2 in the room, Resident 2 stated Resident 2 had recently (unknown date) fallen, shattered the right shoulder, underwent surgery for the right shoulder, and returned home after shoulder surgery. Resident 2 stated Resident 2 underwent heart surgery after experiencing pain in both legs, the inability to walk, and incontinence (lack of control over urination or defecation) at home.During an interview on 6/23/2026 at 3:19 p.m. with the DOR, the DOR stated PT and OT's professional schooling included objectively measuring the joints using a goniometer. The DOR stated the purpose of measuring joints included to determine any changes in measurements over time. The DOR stated the absence of ROM measurements in therapy evaluations prevented the therapist from monitoring changes the resident's ROM. During a concurrent interview and record review on 6/24/2026 at 9:24 a.m. with the DOR, Resident 2's OT Evaluation, dated 4/16/2026 completed by Occupational Therapist 1 (OT 1), was reviewed. The DOR stated the OT Evaluation did not include ROM measurements for the right shoulder. During an interview and record review on 6/25/2026 at 12:11 p.m. with OT 1, Resident 2's OT Evaluation, dated 4/16/2026, was reviewed. OT 1 stated the purpose of OT included working with residents toward independence with activities of daily living ([ADLs] basic tasks that individuals perform to maintain their daily lives and independence). OT 1 stated measuring ROM using a goniometer was apart of OT's professional schooling. OT 1 stated the purpose of measuring ROM was to obtain a resident's baseline to determine improvement or decline in ROM and to determine if interventions were effective. OT 1 stated Resident 2's right shoulder ROM was not but should have been measured during the OT Evaluation because shoulder ROM could impact Resident 2's ability to perform ADLs. During a review of the facility's P&P titled, ROM and Contracture Prevention, the P&P indicated the facility ensured the residents receive services, care and equipment to assure that.Every resident with limited range of motion and mobility maintains or improves function.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to:1.Administer polyethylene glycol (laxative to relieve constipation) correctly to one of four sampled residents (Resident 30).2.Administer pregabalin (medication used to treat nerve pain) to one of one sampled residents (Resident 6) and did not notify the physician or clarify administration on 5/20/2026, 5/31/2026, 6/4/2026, and 6/20/2026. This deficient practice had the potential to result in increased risk of constipation for Resident 30 and unrelieved pain for Resident 6.Findings: a. During a review of Resident 30's admission Record, the admission Record indicated Resident 30 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (any damage or disease that affects the brain), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and heart failure. During a review of Resident 30's History and Physical (H&P), dated 4/8/2026, the H&P indicated Resident 30 had the capacity to understand and make decisions. During a review of Resident 30's Minimum Data Set (MDS - a resident assessment tool), dated 4/7/2026, the MDS indicated Resident 30 had moderate cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required supervision when eating and for oral hygiene, and was dependent for toileting hygiene, bathing, personal hygiene, and dressing. During a review of Resident 30's Physician Order Summary, the Order Summary indicated an order for polyethylene glycol 3350 powder - Give 17 grams (g - a unit of measurement) by mouth two times a day for bowel management *mix with 8 ounces (oz - a unit of measurement) hold for loose stool - Start date 6/18/2025. During an observation on 6/23/2026 at 8:51 a.m., in the hallway outside Resident 30's room, Licensed Vocational Nurse (LVN) 2 prepared polyethylene glycol by mixing the polyethylene glycol in orange juice in a plastic cup for Resident 30. During an observation on 6/23/2026 at 8:56 a.m., in Resident 30's room, Licensed Vocational Nurse (LVN) 2 handed the polyethylene glycol to Resident 30. Resident 30 drank half of the polyethylene glycol in orange juice in the plastic cup and handed it back to LVN 2. LVN 2 disposed of the remaining polyethylene glycol in orange juice in the trash can. During an interview on 6/23/2026 at 8:57 a.m., with Resident 30, Resident 30 stated they (Resident 30) did not finish the orange juice. Resident 30 stated they (Resident 30) did not know that medication was mixed in the orange juice. During an interview on 6/23/2026 at 9:12 a.m. with LVN 2, LVN 2 stated Resident 30 drank half of the orange juice and did not receive the full dose of polyethylene glycol. LVN 2 stated not taking the full dose of polyethylene glycol could increase Resident 30's risk for constipation. b. During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or paralysis on one side of the body) following cerebral infarction (stroke - loss of blood flow to a part of the brain), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), and generalized muscle weakness. During a review of Resident 6's H&P dated 2/10/2026, the H&P indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6 had moderate cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required setup assistance when eating and for oral hygiene, required moderate assistance (helper does less than half the effort) for upper body dressing, required maximal assistance (helper does more than half the effort) for bathing and personal hygiene, and was dependent for toileting and lower body dressing. During a review of Resident 6's Physician Order Summary, the Order Summary indicated an order for pregabalin oral capsule 25 MG - Give 2 capsules orally three times a day for pain - start date (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/10/2026. During an interview on 6/22/2026 at 10:45 a.m., with Resident 6, Resident 6 stated there are a couple times a month when pregabalin is not in stock, and the facility does not give Resident 6 the medication. During a concurrent interview and record review on 6/25/2026 at 12:05 p.m., with LVN 4, Resident 6's May 2026 medication administrator record (MAR), June 2026 MAR, and nursing progress notes were reviewed. LVN 4 stated Resident 6's May 2026 MAR indicated Resident 6 did not receive pregabalin due to a pending pharmacy delivery. LVN 4 stated Resident 6's June 2026 MAR indicated Resident 6 did not receive pregabalin due to a pending pharmacy delivery. LVN 4 stated the physician should be notified if a resident did not receive the pregabalin. LVN 4 stated there was no documentation that indicated the physician was notified that Resident 6 did not receive pregabalin on 5/20/2026, 5/31/2026, 6/4/2026, or 6/20/2026. LVN 4 stated the facility should have clarified with the physician if it would be okay to give the pregabalin when it arrived or to wait until the next dose. During an interview on 6/25/2026 at 3:22 p.m., with the Director of Nursing (DON), the DON stated it was important for the Resident to take the entire medication dose as ordered by the physician to ensure the efficacy of the medication. The DON stated if a resident does not take the entire dose of polyethylene glycol, the resident may have bowel problems. During an interview on 6/25/2026 at 3:24 p.m., with the DON, the DON stated medications should be reordered within three days of remaining supply. The DON stated if a resident misses multiple doses of pregabalin, the resident's pain was not managed properly. The DON stated if a resident does not receive a dose of pregabalin, the physician should have been notified by facility staff to determine if an alternative can be administered or if the resident could be without the medication until the supply arrived. During a review of the facility's policy and procedure (P&P), titled Medication Administration, revised 11/2018, the P&P indicated medications must be administered in accordance with the written orders of the attending physician. The P&P indicated unless otherwise specified by the resident's attending physician, routine medications should be administered as scheduled.

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Shoreline Healthcare Center	4029 East Anaheim Street Long Beach, CA 90804

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review, the facility failed to ensure the standardized recipes for lunch menu were followed on 6/22/2026 by failing to:1.Ensure nine residents on pureed diet (foods that do not require chewing and are easily swallowed. All food should be smooth and pureed to the consistency of pudding) received corn texture in form that meet their needs and in accordance with international Dysphagia Diet Initiative (IDDSI-a framework made up of levels and describes food textures and drink thickness) Level Four (pureed foods and extremely thick drinks) when the texture of the pureed corn was dry, lumpy, not smooth and had pieces of corn present requiring chewing before swallowing.2.Follow the food production recipe for eight residents on the soft and bite size diet (food particle are soft and chopped into 1/2 inch pieces) who received minced (ground) texture meat and pureed potato instead of Salisbury steak and boiled potato chopped into bite size pieces 1/2 inch per diet order.These deficient practices had the potential to result in meal dissatisfaction, decreased nutritional intake and increased choking risk for the residents who received the pureed corn.Findings:1.During an observation of the tray line (tray line- a system of food preparation, in which trays move along an assembly line) service for lunch on 6/22/2026 at 12:00PM, the pureed corn looked lumpy, and dry while in a pan on the steam table.During a concurrent interview and taste test of the pureed corn with Dietary Supervisor, Cook1 and Registered Dietitian (RD1) on 6/22/2026 at 12:45PM, the pureed corn was dry, had a lumpy texture. There were small pieces of corn kernels that stayed in the mouth requiring chewing. During a spoon tilt test per the IDDSI guideline, the pureed corn was sticking to the spoon. DS stated it's the end of the tray line the corn became thicker and dry. Cook1 stated the pureed corn was prepared from the regular corn and pepper and blended with water. Cook1 stated we should add hot water when it's on the steam table and mix to make it soft. Cook1 stated DS stated the pureed corn was not smooth it should have been blended longer to make a smooth pureed texture. DS stated that when the pureed texture is lumpy it could be a risk for choking. During a review of the facility recipe titled Recipe: Corn with green peppers Week 4 Monday (dated 2026) the recipe indicated, IDDSI #4/Pureed: Make with creamed corn then puree.Utilize the critical tests and IDDSI audit to confirm texture meets level #4 specifications.During a review of the IDDSI guideline website titled IDDSI, dated 7/2019, the IDSSI guideline indicated that Level 4 Pureed is usually eaten with spoon, falls off spoon in a single spoonful when tilted and continues to hold shape on the plate, no lumps, not sticky, and liquid must not separate from solid. Food testing method: Spoon tilt test and Fork drip test. 2.During an observation in the kitchen on 6/22/2026 at 12:00PM, [NAME] 1 served minced/ground meat and pureed potato to residents who were on the soft and bite size diet (food particles are soft and chopped into 1/2 inch pieces)During a concurrent observation and interview with cook1, DS and Regional Dietitian (RD2) on 6/22/2026 at 12:30PM, RD2 stated the Salisbury steak prepared from scratch from ground beef and its soft. RD2 did not know why the soft and bite size was served ground beef. DS stated usually the spreadsheet (serving and portion guide) will indicate ground beef.During a concurrent interview and review of the cook's spreadsheet on 6/22/2026 at 12:30PM, DS stated it indicates to serve tender chopped Salisbury steak and not ground. DS stated we made a mistake and did not follow the correct texture.During an interview with RD1 on 6/23/2026 at 10:30AM, RD1 stated that soft and bite size diet texture is when food is cut into soft 1/2 inch pieces. RD1 stated we served ground textures to residents who were on soft and bite size diet. Changing the texture to ground can upset residents and decrease food intake.During a review of the facility's recipe titled Salisbury Steak with Onions Week 4 Monday (dated 2026) the recipe indicated, Soft and Bite size IDDSI level 6: tender meat, chop into pieces =1.5 cm by 1.5 cm in sizeDuring a review of the facility's recipe titled Diced potatoes (dated 2025), the recipe indicated, Soft and bit size: Serve fresh, boiled potatoes only. Soft no skin chop into pieces =1.5cm by 1.5cm in size.During a review of facility policy and procedures (p & p) titled, Menu (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Planning (dated 2023), the p & p indicated, The menus are planned to meet nutritional needs of residents in accordance with established national guidelines.Standardized recipes adjusted to appropriate yield shall be maintained and used in food preparation.During a review of the facility's cook's job description (dated 12/2021), the job description indicated, Essential Duties and Responsibilities: Prepare meals in accordance with planned menus, Inspect special diet trays to assure that the correct diet is served to the resident; prepare and serve meals that are palatable and appetizing in appearance; prepare food for therapeutic diets in accordance with planned menus; prepare food in accordance with standardized recipes and special diet orders.During a review of the IDDSI guideline website titled IDDSI, dated 1/2019, the IDSSI guideline indicated that Level 6 soft and Bite sized texture is for people who have ability to chew bite-sized pieces so that they are safe to swallow; Bite-Sized pieces no bigger than 1.5cm x 1.5cm in size and a knife is not required to cut this food.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that food was prepared by methods that conserved flavor and served at appetizing temperatures for 64 out of 67 residents who received food from kitchen and for Resident 4 who complained that food was cold and Resident 6 who complained food texture was chewy not palatable.This deficient practice had the potential to result in meal dissatisfaction, decreased food intake and placed residents at risk for unplanned weight loss. Findings: During initial facility tour on 6/22/2026 at 8:30AM, complaints about the temperatures and texture of food were identified. Complaints about the flavor and temperature of food were also discussed during resident council meeting on 6/23/2026 at 2:36PM During an observation in the kitchen on 6/22/2026 at 10:15AM at the request of resident family member, the dietary supervisor (DS) was warming up a bowl of oatmeal for a resident. During a concurrent observation and interview with DS on 6/22/2026 at 10:15AM, DS stated the oatmeal was from the breakfast meal. DS said residents' families or nurses bring in resident food to be warmed up in the microwave. DS said the facility uses the kitchen microwave dedicated to residents to warm up food per request. DS said we often warm up food for residents. During an observation and interview in the kitchen with cook1, DS and RD on 6/22/2026 at 11:45AM, cook1 checked the temperature of lunch items using facility thermometer. The temperature of food checked was as follows: Salisbury Steak at 179 degrees Fahrenheit (F) Corn with bell peppers 174 degrees F Fried potato (potato quarters with skin on) 186 degrees F Pureed potato 161 degrees F Pureed corn 164 degrees F Pureed meat 174 degrees F Brown rice 174 degrees F Milk 32 degrees F Water 40 degrees F During the same observation and interview, DS stated facility starts serving lunch at 12:00PM and by 12:30PM we should be done and last cart is out of the kitchen. During the lunch observation and interview with DS and RD2 on 6/22/2026 at 12:45PM, several pans (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with food were not directly held on a heat source. Observed minced carrots, minced beef and brown rice sitting on top of other pans that are in the steam table (steam table (used to hold precooked food at safe temperatures >135 degrees F; it has multiple stainless-steel compartments (wells) that use heated water to produce steam and keep food warm). DS stated we don't have enough space to keep extra pans of food in the steam table. RD2 stated we should get half size pans (smaller pans) to fit the food in the wells of the steam table. During the test tray on 6/22/2026 at 1:18PM (A food tray test (or tray audit) is a quality control evaluation used in hospitals, nursing homes, and catering to ensure meal trays meet safety, accuracy, and quality standards. It involves tracking a mock or live meal from the kitchen to the bedside to assess temperature, portion, and presentation.) food temperatures of sampled food varied from warm to lukewarm. RD 1 took temperatures of the test tray items using facility thermometer which recorded as follows: Salisbury steak at 120 degrees F Corn with peppers 112 degrees F Fried potatoes (potato quarters with skin) 115 F Milk 53 degrees F Ice cream at 30 degrees F melted During the same test tray, the Salisbury steak were lukewarm and had no flavor, the potato and corn were cold and bland and the ice cream was melted. During an observation and interview with RD on 6/22/2026 at 1:18PM, RD stated the tray line took a long time today and the food is not warm. During an interview with DS and RD1 on 6/23/2026 at 10:30AM DS stated we start tray line (tray line- a system of food preparation, in which trays move along an assembly line) service for lunch at 12:00PM and end by 12:30PM. DS stated yesterday the tray line went over the usuall time and the food got cold. During a review of facility's policy and procedure (P & P) titled Meal Service (dated 2023), the p&p indicated, Meals that [NAME] the nutritional needs of the resident will be served in an accurate and efficient manner and served at the appropriate temperatures. Temperature of the food when the resident receives it is based on palatability. The goal is to serve cold food cold and hot food hot. See table below for suggested temperatures. Recommended Temp at Delivery to residents: Cold Entrée < 50 degrees F Fruit or Cold Dessert < 50 degrees F Salads < 45 degrees F (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Milk/Cold Beverages < 45 degrees F Frozen Dessert < 20 degrees F Hot Entrees > 120 degrees F Starch > 120 degrees F Vegetables > 120 degrees F Hot beverage > 140 degrees F Soup or Hot cereal > 140 degrees F During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or paralysis on one side of the body) following cerebral infarction (stroke - loss of blood flow to a part of the brain), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), and generalized muscle weakness. During a review of Resident 6's History and Physical (H&P), dated 2/10/2026, the H&P indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's Minimum Data Set (MDS – a resident assessment tool), dated 6/8/2026, the MDS indicated Resident 6 had moderate cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required setup assistance when eating and for oral hygiene, required moderate assistance (helper does less than half the effort) for upper body dressing, required maximal assistance (helper does more than half the effort) for bathing and personal hygiene, and was dependent for toileting and lower body dressing. During a review of Resident 6's Physician Order Summary, the Order Summary indicated an order for a Regular diet – start date 2/9/2026. During an interview on 6/22/2026 at 10:45 a.m., with Resident 6, Resident 6 stated the chicken here tasted like rubber and the fish was raw. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including wedge compression fracture (when the front part of the bones of the spine body creating a wedge shape) of the lumbar vertebra (lower bones of the spinal column), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and end stage renal disease (ESRD - chronic kidney disease that causes gradual loss of kidney function). During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 had moderate cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required maximal assistance (helper does more than half the effort) for eating, oral hygiene, and upper body (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dressing, and was dependent for toileting hygiene, bathing, and lower body dressing. During a review of Resident 4's Physician Order Summary, the Order Summary indicated an order for a Regular Diet – start date 4/17/2026. During an interview on 6/22/2026 at 10:41 a.m., with Resident 4, Resident 4 stated the food was cold most of the time. Resident 4 stated they (Resident 4) asked the staff to reheat the food almost every day. During a review of facility policy and procedure (p&p) title Food Preparation (dated 2023) the p&p indicated, Hold foods prior to service for as short time as practical. A maximum 1 hour holding time is recommended.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure 2 of 24 sampled residents were served the food preference listed on the lunch tray cards (a printed sheet that includes resident diet order, preferences and dislikes) when:1.Resident 43 food preferences were not honored when corn was served during lunch, despite corn being listed as a dislike on resident's lunch tray card.2.Resident 8 whose diet order indicated vegan (a person whose diet does not include animal products) received whole milk and dairy ice cream for lunch on 6/22/2026)These deficient practices had the potential to result in decreased meal satisfaction, decreased caloric intake, and negatively affect nutritional status of residents whose food preferences were not honored for lunch.Findings: 1.A review of Resident 43's Face sheet (admission record) indicated the resident was admitted to the facility on [DATE], with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD) (is a progressive, inflammatory lung disease that restricts airflow and makes breathing difficult. A review of Resident 43's Order Summary Report dated 6/8/2026, indicated No added salt fortified diet with 1200ml/day fluid restriction. (Fortified diet-A fortified diet incorporates foods and drinks with added concentrated calories to maximize nutritional intake without increasing portion size. It is highly effective for combating unintentional weight loss, especially for individuals with small appetites.) A review of resident 43's tray card for lunch dated 6/22/2026 indicated resident food dislikes included corn. During an observation in the kitchen on 6/22/2026 at 12:30PM, Dietary Supervisor (DS) was checking the tray cards and reading out loud the diet orders for the cook to serve. During the same observation DS did not read the dislikes on resident 43 tray card and the [NAME] (cook1) served corn with peppers to resident 43. During a dining observation in resident room on 6/22/2026 at 1:06PM, resident 43 tray on the bedside table had corn. During an interview with resident 43 on 6/22/2026 at 1:06PM, resident 43 stated I can't eat that food. Resident 43 stated I don't like beef and I cannot eat corn. Resident 43 pointing to the tray card, said its written in my paper and they still put corn in my food and refused to eat lunch. During an interview with the dietary supervisor (DS) on 6/23/2026 at 10:30AM, DS stated that there was a mistake for Resident 43 to receive corn. DS stated did not know resident dislikes beef. DS stated that when residents receive food that they don't like they become upset and will not eat food which can cause weight loss. During a review of the Facility's Nutrition Evaluation and RDN Review dated 6/8/2026 for sections Food likes and food dislikes it was documented as None given at this time and no food preference were indicated. During a review of the Facility's policy and procedures (p&p) titled Food Preferences (not dated) the (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	p&p indicated, Food preference will be obtained as soon as possible though the initial resident screen. This screening must be completed within 7 days of admission by the food and nutrition director. Food preferences can be obtained from the residents, family or staff members. Updating of food preferences will be done as the resident's needs change and or during the quarterly review. 2. During a review of Resident 8's admission Record (Face Sheet-page of the chart that contains a summary of basic information about the resident), the admission Record (Face Sheet) indicated Resident 8 was initially admitted to the facility on [DATE] and last readmission was on 5/20/2026 with diagnoses including dysphagia (difficulty swallowing), dementia (a progressive state of decline in mental abilities), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and scoliosis (an abnormal, sideways curvature of the spine that often forms a C or S shape) During a review of Resident 8's History and Physical (H&P), dated 5/21/2026, the H&P indicated, Resident 8 had no capacity (ability) to make medical decisions. During a review of Resident 8's Minimum Data Set (MDS-a resident assessment tool), dated 5/25/2026, the MDS indicated Resident 8's cognitive skills for daily decision making were severely impaired (never or rarely made decisions). The MDS indicated Resident 8 required dependent assistance (Helper does all of the effort) from two or more staff for bed mobility, transfer, dressing, toilet hygiene, and moderate assistance (Helper does less than half the effort) from one staff for oral hygiene, eating. During a concurrent observation and record review on 6/22/2026 at 12:29 p.m., with Resident 8 in the dining room, Resident 8 was seated in a wheelchair in the dining room next to a dining table. Restorative Nurse Assistant (RNA) 2 was assisting the resident with eating her meal. Resident 8's lunch tray contained pureed (smooth, lumpˆfree foods with a pudding-like consistency) food items, a fourˆounce carton of whole milk, and ice cream. RNA 2 mixed the pureed food items together and fed them to Resident 8. RNA 2 also served Resident 8 ice cream and whole milk. Resident 8 stated she did not know what foods she was being served or whether she liked them. Resident 8 was unable to express her food preferences, likes, or dislikes. During a concurrent interview and record review on 6/22/2026, at 12:39 p.m., with RNA 2 in the dining room, Resident 8's Meal Ticket (a detailed, customized slip generated for each resident's meal that directs dietary staff exactly what to serve, ensuring the food matches the resident's medical diet order, swallowing requirements, allergies, and personal preferences), undated was reviewed. The Meal Ticket indicated Resident 8 had an allergy to pepper. The Meal Ticket indicated Resident 8's order and was pureed, fortified (foods enhanced with added vitamins, minerals, or calories), Vegan diet. The Meal Ticket indicated to provide a fourˆounce carton of milk and listed no disliked items. RNA 2 stated it was her responsibility to ensure Resident 8 received the correct food items and diet according to the Meal Ticket. RNA 2 stated she confirmed the Meal Ticket reviewed was for Resident 8's lunch on 6/22/2026. RNA 2 stated Resident 8 should have received Vegan food items. RNA 2 stated the tray contained dairy products such as ice cream, whole milk, and melted butter mixed into the pureed items, which included pureed chicken or beef. RNA 2 stated a Vegan diet consisted of vegetables and fruits and excluded meat and dairy products. She stated she had doubts about the tray but Resident 8 did not complain to her. During a phone interview on 6/24/2026 at 8:30 a.m., with the Resident 8's Responsible Party (RP- the person designated to handle a resident's affairs), the RP stated that Resident 8 and the RP had been (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Vegan for a long time. The RP stated that serving ice cream occasionally was acceptable, but the RP did not want Resident 8 to receive meat or dairy products if it could be avoided. The RP stated that Vegan substitutes are available, such as almond milk or vegetable patties, and did not understand why the facility was not honoring this preference. The RP stated no one had contacted the RP regarding food preferences. During a concurrent interview and record review on 6/24/2026, at 10:10 a.m., with the Dietary Supervisor (DS), Resident 8's Nutrition Evaluation and Registered Dietitian Nutritionist (RDN) Review, dated 5/27/2026 was reviewed. The Nutrition Evaluation and RDN Review indicated Resident 8's food likes included tofu and vegetable patties, and her dislikes included meat per RP. The DS stated she believed she had spoken with Resident 8's RP regarding food preferences at some point, but she could not recall the date and was not sure if she documented the communication. The DS stated the cook used melted butter to fortify food to prevent weight loss for Resident 8. The DS stated a Vegan diet should contain vegetables and fruits and should exclude meat, cheese, and dairy products. The DS stated she thought she could provide dairy products because Resident 8's RP seemed to be okay with ice cream. The DS stated she should have reconfirmed this with the RP. During an interview on 6/24/2026 at 3:15 p.m., with the Registered Dietitian (RD), the RD stated there were substitutes available for a Vegan diet such as tofu, almond milk, vegetable patties, and Vegan meat. The RD stated she did not recall the exact date, but she had spoken with Resident 8's RP regarding food preferences and believed the RP seemed to be fine with providing dairy items but not meat. The RD stated the nursing staff should have clarified the diet order because it still indicated a Vegan diet only. The RD stated margarine should have been used for fortification instead of butter, which is a dairy product. The RD stated that even though the RP and Resident 8 did not oppose dairy products, staff should have followed the Vegan diet order until it was clarified with the physician. During an interview on 6/25/2026 at 3:39 p.m., with the Director of Nursing (DON), the DON stated staff must assess, document, and honor residents' food preferences to prevent unintended weight loss, which can negatively affect their quality of life. The DON stated all communication with the residents and the family should have been documented. The DON stated Resident 8's food preferences and diet order should have been clarified to prevent conflict. The DON stated that if the diet order indicated Vegan, ice cream, whole milk, melted butter, and meat should not have been provided. During a review of Resident 8's Order Summary Report (OSR), dated 6/24/2026, the OSR indicated, Vegan diet with fortified, pureed texture, thin liquids was ordered on 5/27/2026. During a review of Resident 8's Care Plan Report (CPR) titled, Resident 8 had potential nutritional problems, revised 5/27/2026, the CPR [NAME] indicated, Resident 8 would maintain weight and nutritional balance by target date of 8/19/2026. The CPR interventions indicated to provide the diet as ordered by the physician and to honor the resident's right to make dietary choices. During a review of the facility's Policy and Procedure (P&P) titled, Food Preferences, undated, the P&P indicated, POLICY: Resident's food preferences will be adhered to within reason. Substitutes for all foods disliked will be given by the appropriate food group. Condiments such as salt, pepper, and sugar are available at each meal unless contraindicated by the diet order. PROCEDURE: Food preferences will be obtained as soon as possible through the initial resident screen. This screening must be completed within 7 days of admission by the FNS Director. Food preferences can be obtained from the residents, family, or staff members. Updating of food preferences will be done as the residents' needs change and/or during the quarterly review.

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Shoreline Healthcare Center	4029 East Anaheim Street Long Beach, CA 90804

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when:1.One juice machine dispenser nozzle was dirty with dried red color residue.2.One reach in freezer (a commercial upright standing refrigeration unit with standard front door allows staff to quickly grab, store or organize items on shelving.) bottom shelf was dirty with food debris.3.The (Robot Coupe) Food processor bowl was wet, not air dried and not clean after they were washed, there was water inside the bowl and food stains stuck on the lid. One blender jar was not maintained clean. The base of the blender jar was covered with a gel seal. The seal was torn and not smooth to clean and sanitize.These deficient practices had the potential to result in harmful bacteria growth, compromised food quality and cross contamination (transfer of harmful bacteria from one place to another) that could lead to food borne illness (infectious organisms or their toxins are the most common cause of food poising symptoms may include cramping, nausea, vomiting, or diarrhea) for 64 out of 67 residents who received food from the kitchen.Findings: 1. During an observation in the kitchen on 6/22/2026 at 8:50AM, observed juice machine dispenser nozzle was not clean, there was dry red stains and residue inside the nozzle. A clean paper towel swipe inside the nozzle produced dark red stains on the paper towel.During a concurrent observation with Dietary supervisor (DS), and dietary aide (DA1), DS verified there were dark red stains and stated looks like dried up grape juice. DS stated the nozzle is removable and should be soaked in warm water every day and then washed to remove the residues before washing.During the same observation and interview with DS and DA1 on 6/22/2026 at 8:50AM DA1 was washing dishes. DA1 stated that they used a brush to clean the nozzle. DA1 said they did not soak the nozzle just cleaned the outside. DA1 stated facility does not have the correct brush to clean the inside of the juice machine dispenser nozzle. DS stated it is important to clean all parts of the juice machine to prevent bacteria growth that can contaminate juices and have bad effects on residents' health. DS stated will add cleaning the juice machine dispenser holder and nozzle on the schedule.During a review of facility's Daily Cleaning Schedule for the week of 6/15/2026-6/21/2026, the schedule did not include cleaning the juice machine dispenser holder and nozzle.During a review of the 2022 U.S. Food and Drug Administration Food Code 4-602.11 tilted Equipment Food-Contact Surfaces and Utensils, the code indicated, (E) Except when dry cleaning methods are used as specified under S 4-603.11, surfaces of UTENSILS and EQUIPMENT contacting FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cleaned:(1) At any time when contamination may have occurred;(2) At least every 24 hours for iced tea dispensers and CONSUMER self-service UTENSILS such as tongs, scoops, or ladles;(3) Before restocking CONSUMER self-service EQUIPMENT and UTENSILS such as condiment dispensers and display containers; and(4) In EQUIPMENT such as ice bins and BEVERAGE dispensing nozzles and enclosed components of EQUIPMENT such as ice makers, cooking oil storage tanks and distribution lines, BEVERAGE and syrup dispensing lines or tubes, coffee bean grinders, and water vending EQUIPMENT:(a) At a frequency specified by the manufacturer, or(b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold.2. During an observation in the kitchen on 6/22/2026 at 9:00AM one reach in freezer was not maintained clean. There was dried food debris on the bottom shelf of the freezer.During a concurrent observation and interview with DS, DS stated we have a cleaning schedule where we have deep cleaning of the refrigeration units. DS stated I will remind staff to clean better. DS said there is no cleaning log for the refrigerators and freezers. DS said it's important to keep refrigerators and freezers clean so it does not cross contaminate the food.During a review of facility's Daily Cleaning Schedule for the week of 6/15/2026-6/21/2026, the schedule did not include cleaning the refrigerators and freezers.During a review of the facility's schedule titled, Thursday Cleaning Schedule (not dated), the schedule is divided into 4 weeks, and it indicates, Week 1: Deep (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cleaning all carts; Deep clean refrigerator; and Racks, shelves, floors. Week 2: Clean the hood, shelves.Week3: Coffee machine, stream table. and Week4: Ice cream freezer, juice machine.During a review of facility's policy titled, Refrigerator and Freezer (not dated), the policy indicated, Maintaining a clean refrigerator and freezer can improve the safety and quality of your foods. Refrigerator and freezer should be on a weekly cleaning schedule. Wipe up spills immediately. Remove all the items and clean shelves. Wipe with sanitizer.3. During an observation in the kitchen on 6/22/2026 at 9:30AM, the food processor machine (Robot Coupe brand) bowl was stored wet, and the lid was dirty with dried food stains. The blender jar had a gap at the base and was covered with a gel like seal. The seal was torn and not smooth.During a concurrent observation and interview with DS, DA1 and [NAME] (Cook1) on 6/22/2026 at 9:30AM, Cook1 stated the DA1 just washed the food processor, and we should let it drain and air dry before storing. DA1 stated it was just washed and sanitized. DS stated the lid is not clean has food residue and returned to DA1 to wash again. During the same observation and interview DS stated the blender jar was loose and requested to be repaired by the facility maintenance department. DS stated it was only a temporary fix until purchasing a new blender jar/pitcher. DS agreed that surface of the blender jar is not smooth because of the glue and cannot be washed and sanitized which can lead to growth of microorganisms and contaminate food.During a review of facility's' policy and procedures (p&p) titled Sanitation (not dated) the p&p indicated, All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain accurate and complete medical records for two of four sampled residents (Resident 3 and 5) with limited range of motion ([ROM] full movement potential of a joint) and mobility (ability to move) concerns and failed to develop and implement a policy and procedure for medical record accuracy. a. For Resident 3, the facility failed to:1. Accurately document Resident 3's inability to perform sit-to-stand transfers and ambulation for 10 feet (unit of measure) during multiple dates from 4/2026 to 6/2026.2. Document Resident 3's sitting tolerance in the wheelchair during Physical Therapy ([PT] profession aimed in restoration, maintenance, and promotion of optimal physical function) Treatment sessions prior to discharge from PT services on 6/25/2026. b. For Resident 5, the facility failed to accurately document Resident 5's inability to perform sit-to-stand transfers and ambulation for 10 feet during multiple dates from 4/2026 to 6/2026. These failures resulted in inaccurate medical records for the provisions of care to Resident 3 and 5 and lack of guidance for completing documentation in the medical record. Findings: a. During a review of Resident 3's Face Sheet (admission record details), the Face Sheet indicated the facility re-admitted Resident 3 on 4/29/2026 with diagnoses including cellulitis (skin infection that causes swelling and redness) of both lower limbs, heart failure, chronic obstructive pulmonary disease ([COPD] long-term lung disease causing difficulty in breathing), muscle weakness, and morbid obesity (extremely high amount of body fat that seriously threatens health and well-being).During a review of Resident 3's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 3/23/2026, the MDS indicated Resident 3 had clear speech, understood verbal content, expressed ideas and wants, and had moderately impaired cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 3 was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required to complete the activity) for toileting, showering, lower body dressing. The MDS indicated Resident 3 required partial/moderate assistance (helper does less than half the effort) for rolling from the back to both sides in bed and transferring from lying to sitting at the side of the bed and required substantial/maximal assistance (helper does more than half the effort) for chair/bed-to-chair transfer. Resident 3's MDS indicated transferring from sit-to-stand and walking 10 feet were not applicable (not attempted and the resident did not perform the activity prior to the current illness, exacerbation, or injury).1. During a review of Resident 3's Documentation Survey Report (record of nursing assistant tasks), dated 4/2026, the Documentation Survey Report indicated Resident 3 was dependent for sit-to-stand transfers and walking 10 feet on 4/4/2026, 4/5/2026, 4/6/2026, 4/7/2026, 4/14/2026, 4/18/2026, 4/19/2026, 4/20/2026, and 4/21/2026. During a review of Resident 3's Documentation Survey Report, dated 5/2026, the Documentation Survey Report indicated Resident 3 was dependent for sit-to-stand transfers and walking 10 feet on 5/1/2026, 5/2/2026, 5/3/2026, 5/4/2026, 5/5/2026, 5/8/2026, 5/9/2026, 5/10/2026, 5/11/2026, 5/12/2026, 5/13/2026, 5/22/2026, 5/23/2026, 5/24/2026, 5/25/2026, 5/29/2026, 5/30/2026, and 5/31/2026.During a review of Resident 3's PT Evaluation and Plan of Treatment, dated 5/22/2026, the PT Evaluation indicated Resident 3 was dependent for chair/bed-to-chair transfers. Resident 3's PT Evaluation also indicated that sit-to-stand transfers and walking 10 feet were not applicable. The PT Evaluation indicated Resident 3 was unable to sit supported in a wheelchair and included a short-term goal for Resident 3 to sit supported in a wheelchair for two hours.During a review of Resident 3's Documentation Survey Report, dated 6/2026, the Documentation Survey Report indicated Resident 3 was dependent for sit-to-stand transfers and walking 10 feet on 6/1/2026, 6/5/2026, 6/6/2026, 6/10/2026, 6/11/2026, 6/14/2026, 6/18/2026, 6/21/2026, 6/22/2026, 6/23/2026, and 6/24/2026.During a concurrent observation and interview on 6/22/2026 at 12:51 p.m. with Resident 3 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in the resident's room, Resident 3 was awake and lying in bed with the head-of-bed (HOB) fully upright and both legs outstretched. During an observation on 6/23/2026 at 8:15 a.m. in Resident 3's room, Resident 3 was awake and lying in bed with the HOB fully upright.During an interview on 6/23/2026 at 2:09 p.m. with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated Resident 3 required a mechanical lift to transfer from the bed to the wheelchair.During an observation on 6/24/2026 at 8:59 a.m. in Resident 3's room, Resident 3 was lying in bed with the HOB fully upright. During a concurrent interview and record review on 6/24/2026 at 2:40 p.m. with Certified Nursing Assistant 2 (CNA 2), Resident 3's Documentation Survey Report for sit-to-stand transfers, dated 6/2026, was reviewed. CNA 2 stated Resident 3 was unable to perform sit-to-stand transfers. CNA 2 stated the Documentation Survey Report indicated Resident 3 was dependent for sit-to-stand transfers because Resident 3 was unable to perform sit-to-stand transfers. During an interview on 6/25/2026 at 11:19 a.m. with PTA 1 and the Director of Rehabilitation (DOR), PTA 1 stated Resident 3 had been bed bound (person spends most or all of the time in bed which prevents them from standing, walking, or moving independently) for five years prior to admission to the facility. The DOR and PTA 1 stated Resident 3 was unable to stand and walk. During a concurrent interview and record review on 6/25/2026 at 1:08 p.m. with the Director of Staff Development (DSD), Resident 3's Documentation Survey Reports for sit-to-stand transfers and walking 10 feet, dated 4/2026 to 6/2026, were reviewed. The DSD stated Resident 3's Documentation Survey Reports for 4/2026 to 6/2026 should have indicated sit-to-stand transfers and walking 10 feet were not attempted or not performed because Resident 3 was unable to stand and walk. During a concurrent interview and record review on 6/25/2026 at 2:01 p.m. with the Director of Nursing (DON), Resident 3's Documentation Survey Reports for sit-to-stand transfers and walking 10 feet, dated 4/2026 to 6/2026, were reviewed. The DON stated medical records (in general) should include complete and accurate documentation regarding a resident's health information. The DON reviewed Resident 3's Documentation Survey Report for sit-to-stand transfers and walking 10 feet and stated the medical record was inaccurate because Resident 3 was unable to perform sit-to-stand transfers and walk. 2. During a review of Resident 3's PT Evaluation and Plan of Treatment, dated 5/22/2026, the PT Evaluation indicated Resident 3 was unable to sit supported in a wheelchair and included a short-term goal for Resident 3 to sit supported in a wheelchair for two hours.During a review of Resident 3'a PT Treatment Encounter Notes, dated 5/27/2026 and 6/2/2026 completed by PTA 1, the PT Treatment Encounter Notes indicated Resident 3 participated in therapeutic exercises and functional group activities. The PT Treatment Encounter Notes indicated the goal of the group was to successfully progress the resident with individual treatment plan/goals by addressing patient's strength impairments and balance deficits.During a review of Resident 3's PT Discharge summary, dated [DATE] and completed by the Director of Rehabilitation (DOR), the PT Discharge Summary indicated Resident 3 tolerated sitting supported in a wheelchair for two hours.During a concurrent observation and interview on 6/22/2026 at 12:51 p.m. with Resident 3 in the resident's room, Resident 3 was lying awake in bed with the HOB fully upright and both legs outstretched. Resident 3 stated PTA 1 trying to obtain a custom wheelchair for Resident 3's personal use since the facility's larger wheelchair was not available. Resident 3 stated feeling very upset that a wheelchair was not available for Resident 3 to go outside. During an interview on 6/23/2026 at 2:16 p.m. with CNA 2 in Resident 3's room, CNA 2 stated Resident 3 was transferred to a wheelchair about two months ago.During an interview on 6/23/2026 at 2:18 p.m. with PTA 1, PTA 1 stated Resident 3 was transferred to wheelchair about two months ago and will be measured for a custom wheelchair.During a concurrent interview and record review on 6/24/2026 at 9:46 a.m. with the DOR, Resident 3's PT Evaluation, dated 5/22/2026, and PT Discharge summary, dated [DATE], were reviewed. The DOR stated Resident 3 was unable to tolerate sitting in a wheelchair during the PT Evaluation but achieved two hours of sitting in the wheelchair upon discharge from PT. The DOR stated Resident 3 required a mechanical lift with two to three people to transfer Resident 3 from the bed to a bariatric wheelchair (wheelchair for larger individuals). During a concurrent interview and (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	record review on 6/24/2026 at 10:40 a.m. with PTA 1, Resident 3's PT Treatment Encounter Notes from 5/22/2026 to 6/2/2026 and the PT Discharge summary, dated [DATE], were reviewed. PTA 1 stated Resident 3 transferred from the bed to the bariatric wheelchair on 5/27/2026 and 6/2/2026. PTA 1 stated the PT Treatment Encounter Notes, dated 5/27/2026 and 6/2/2026, did not indicate the amount of time Resident 3 tolerated sitting up in the wheelchair. PTA 1 stated Resident 3's PT Discharge Summary indicated Resident 3 tolerated sitting up in the wheelchair for two hours because PTA 1 verbally communicated Resident 3's sitting tolerance upon discharge from PT on 6/5/2026. During an interview on 6/25/2026 at 11:19 a.m. with PTA 1 in the presence of the DOR, PTA 1 stated Resident 3's sitting tolerance of two hours was verbally communicated to the DOR. PTA 1 stated Resident 3's medical record did not have documented evidence Resident 3 sat in a wheelchair for two hours prior to discharge from PT services. During an interview on 6/25/2026 at 4:27 p.m. with the Administrator (ADM), the ADM stated that the facility's policy and procedures (P&P) (in general) included guidance to staff in providing care for the residents. The ADM stated the facility's expectation was for the staff to complete accurate documentation in the residents' medical record. The ADM stated the facility's expectation for staff to complete accurate documentation was not included in a P&P because the facility did not have a P&P for medical record documentation.b. During a review of Resident 5's Face Sheet, the Face Sheet indicated the facility originally admitted Resident 5 on 12/13/2022 and readmitted on [DATE] with diagnoses including traumatic subarachnoid hemorrhage (type of stroke where bleeding occurs in the fluid-filled space between the brain and the tissues covering the brain), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting the left nondominant side, aphasia (disorder that makes it difficult to speak), dysphagia (difficulty swallowing), and contractures (a stiffening/shortening at any joint that reduces the joint's range of motion) of muscle.During a review of Resident 5's Documentation Survey Report, dated 4/2026, the Documentation Survey Report indicated Resident 3 was dependent for sit-to-stand transfers and walking 10 feet on 4/1/2026, 4/4/2026, 4/5/2026, 4/6/2026, 4/7/2026, 4/10/2026, 4/13/2026, 4/14/2026, 4/16/2026, 4/25/2026, 4/29/2026, and 4/30/2026.During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5 had no speech and severely impaired cognition. The MDS indicated Resident 5 had ROM limitation in both arms and legs and was dependent for hygiene, toileting, bathing, dressing, rolling from the back to both sides in bed, and chair/bed-to-chair transfers. Resident 5's MDS indicated sit-to-stand transfers and walking 10 feet were not attempted and the resident did not perform this activity.During a review of Resident 5's Documentation Survey Report, dated 5/2026, the Documentation Survey Report indicated Resident 3 was dependent for sit-to-stand transfers and walking 10 feet on 5/1/2026, 5/2/2026, 5/3/2026, 5/4/2026, 5/6/2026, 5/7/2026, 5/10/2026, 5/12/2026, and 5/27/2026.During a review of Resident 5's Documentation Survey Report, dated 6/2026, the Documentation Survey Report indicated Resident 3 was dependent for sit-to-stand transfers and walking 10 feet on 6/2/2026, 6/5/2026, 6/6/2026, 6/7/2026, 6/8/2026, 6/9/2026, 6/11/2026, 6/12/2026, 6/14/2026, 6/15/2026, 6/17/2026, 6/18/2026, 6/19/2026, 6/20/2026, 6/22/2026, 6/23/2026, and 6/24/2026.During an observation on 6/22/2026 at 10:43 a.m. in Resident 5's room, Resident 5 was awake while lying in bed and unable to speak. During an observation on 6/23/2026 at 9:24 a.m. in Resident 5's room, Resident 5 was awake while lying in bed and unable to speak.During a concurrent interview and record review on 6/25/2026 at 10:52 a.m. with Certified Nursing Assistant 1 (CNA 1), Resident 5's Documentation Survey Report for sit-to-stand transfers, dated 6/2026, was reviewed. CNA 1 stated Resident 5 was dependent with the mechanical lift and two-person assistance to transfer from the bed to Resident 5's wheelchair or shower chair. CNA 1 stated Resident 5 was unable to stand. CNA 1 stated Resident 5's Documentation Survey Report for 6/2026 was not accurate because Resident 5 was unable to stand.During a concurrent interview and record review on 6/25/2026 at 1:23 p.m. with the DSD, Resident 5's Documentation Survey Report for sit-to-stand transfers and walking 10 feet, dated 4/2026 to 6/2026, were reviewed. The DSD stated Resident 5's Documentation Survey Report for (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/2026 to 6/2026 should have indicated sit-to-stand transfers and walking 10 feet were not attempted or not performed because Resident 5 was unable to stand and walk. During a concurrent interview and record review on 6/25/2026 at 2:01 p.m. with the DON, Resident 5's Documentation Survey Report for sit-to-stand transfers and walking 10 feet, dated 4/2026 to 6/2026, were reviewed. The DON stated medical records (in general) should include complete and accurate documentation regarding a resident's health information. The DON reviewed Resident 5's Documentation Survey Report for sit-to-stand transfers and walking 10 feet and stated the medical record was inaccurate because Resident 5 was unable to perform sit-to-stand transfers and walk. During an interview on 6/25/2026 at 4:27 p.m. with the ADM, the ADM stated that the facility's P&P (in general) included guidance to staff in providing care for the residents. The ADM stated the facility's expectation was for the staff to complete accurate documentation in the residents' medical record. The ADM stated the facility's expectation for staff to complete accurate documentation was not included in a P&P because the facility did not have a P&P for medical record documentation.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written bed hold notice upon transfer for one of one sampled residents (Resident 68). This deficient practice had the potential to result in the resident or responsible party not knowing their rights and not being able to return to the facility.Findings: During a review of Resident 68's admission Record, the admission Record indicated Resident 68 was initially admitted to the facility on [DATE] with diagnoses including leukemia (illness that affects blood cells) and fractures (break) of the left humerus (long bone in upper arm), maxilla (bone that forms the upper jaw), and ribs. The admission Record indicated Resident 68 was transferred to a general acute care hospital (GACH) on 4/10/2026. During a review of Resident 68's History and Physical (H&P), dated 4/10/2026, the H&P indicated Resident 68 did not have the capacity to understand and make decisions. During a review of Resident 68's Minimum Data Set (MDS - a resident assessment tool), dated 4/10/2026, the MDS indicated Resident 68 had severe cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, was dependent for eating, oral hygiene, toileting hygiene, bathing, and dressing. During a concurrent interview and record review on 6/25/2026 at 1:07 p.m., with Registered Nurse Supervisor (RNS) 2, Resident 68's Bed Hold Notification dated 4/10/2026 was reviewed. RNS 2 stated the Bed Hold Notification should be signed by the resident or responsible party on admission and upon transfer. RNS 2 stated Resident 68's Bed Hold Notification was not completed in writing upon transfer. RNS 2 stated the section To be completed upon transfer was blank. RNS 2 stated Resident 68's medical record did not indicate that the responsible party was notified of the seven day bed hold in writing. During an interview on 6/25/2026 at 3:32 p.m., with the Director of Nursing (DON), the DON stated facility staff should explain the bed hold process to the resident and/or responsible party on admission and upon transfer.During a review of the facility's policy and procedure (P&P), titled Bed Hold, revised April 2025, the P&P indicated it is the policy of this facility to inform the resident or resident's representative in writing of the right to exercise the bed hold provision of (7) days upon admission and provide a second notice before transfer to a general acute care hospital or before the resident goes on therapeutic leave. In the event of an emergency transfer, the second notice will be provided within 24 hours. This applies to all residents, regardless of their payment source. A copy of this notification shall become a part of the resident's health record at the time of transfer.

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	055353	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shoreline Healthcare Center	4029 East Anaheim Street Long Beach, CA 90804

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the licensed nursing staff failed to meet professional standards and clarify the doctor's orders and plan of care for one of five sample residents (Resident 30). This deficient practice placed Resident 30 at risk for experiencing unmanaged pain. Findings During a review of Resident 30's admission Record, the admission Record indicated Resident 30 was originally admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with diagnoses including pain in left knee, unilateral (limited to only one side of the body) osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) in right knee, and Systemic Inflammatory Response Syndrome (SIRS, is a widespread severe inflammatory response triggered by a major stressor such as severe infection, trauma, burns, or lack of blood flow (ischemia) of non-infectious origin with acute organ dysfunction (life-threatening medical emergency where one or more organs can no longer function without medical intervention). During a review of Resident 30's Minimum Data Set (MDS, a resident assessment tool), dated 4/7/2026, the MDS indicated Resident 30 was mildly cognitively (ability to make decisions of daily living) impaired. The MDS indicated Resident 30 was dependent on lying to sitting on side of bed, personal hygiene, upper (above waist) and lower (below waist) body dressing, bathing, toileting hygiene, required substantial assistance (Helper does more than half) for sit to lying, required partial assistance (Helper does less than half) for rolling left to right, and required supervision for eating and oral hygiene. The MDS indicated Resident 30 had impairments on both sides of the lower (hip/leg) extremities.During a review of Resident 30's order summary report, the order summary report indicated Norco Oral Tablet (Hydrocodone-Acetaminophen, medication used to treat moderate to severe pain) 5-325 milligram (unit of measure of mass), give 1 tablet by mouth every six hours as needed for pain with a start date of 4/2/2026.During a review of Resident 30's history and physical (H&P) dated 4/8/2026, the H&P indicated Resident 30 had the capacity to understand and make decisions.During a review of Resident 30's Physical Medicine and Rehabilitation (PM&R) document dated 6/14/2026, the PM&R indicated to continue Norco Oral Tablet 5-325 mg every four hours. During an interview on 6/22/2026 at 11:20 a.m., with Resident 30, Resident 30 stated he does get Norco 1 tablet and it helps a little but indicated it does not do any good for him as it wears off quickly. During a concurrent interview and record review on 6/25/2026 at 2:55 p.m., with Registered Nurse Supervisor (RNS) 2, Resident 30's order summary report dated 7/1/2026 and PM&R dated 6/14/2026 were reviewed. RNS 2 stated there was conflicting information because Resident 30 had an order for Norco 5-325 mg 1 tablet every 6 hours as needed for severe pain with start date 4/2/2026and Resident 30's PM&R indicating, Norco Oral Tablet 5-325 mg every four hours. RNS 2 stated the orders should have been clarified with the doctor if the order was for every 4 hours or every 6 hours. RNS 2 stated confusion may arise as the resident could have been told that the pain medication was for every 4 hours but the order was for every 6 hours and indicated the residents pain level would be uncontrolled without clarification. During an interview on 6/25/2026 at 4:54 p.m. with the Director of Nursing (DON), the DON stated licensed staff must clarify whether Resident 30's pain medication should be given every four or six hours to ensure proper pain management.During a review of the facility's policy and procedures (P&P) titled, Recognition and Management of Pain dated 1/2022, the P&P indicated it is the policy of this facility to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.During a review of the facility's P&P titled, Physician Orders revised date 11/2018, the P&P did not indicate procedures for clarifying orders when there is a discrepancy between the order and the plan of care from the doctor's notes.

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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 interview and record review, the facility failed to address the following for one of five sampled residents (Resident 3): 1. Failed to ensure Resident 3's foley catheter (f/c: a hollow tube inserted into the bladder to drain or collect urine) urine output was monitored and documented.2. Failed to implement Resident 3's care plan for monitoring R for edema (swelling caused by excess fluid trapped in the body's tissues) and urine output. These deficient practices placed Resident 3 at risk for complications related to unmanaged fluid balance. Findings During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with diagnoses including congestive heart failure (CHF, a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), cellulitis (a skin infection that causes swelling and redness) of left and right lower limb, and generalized edema (swelling caused by excess fluid trapped in the body's tissues).During a review of Resident 3's history and physical (H&P) dated 4/30/2026, the H&P indicated Resident 3 had the capacity to make medical decisions.During a review of Resident 3's care plan, titled, Resident refusal of indwelling foley catheter change dated 5/23/2026, the care plan interventions indicated observe catheter function, urine output, and signs/symptoms of complications.During a review of Resident 3's care plan, titled, Has hypertension (high blood pressure) dated 5/23/2026, the care plan interventions indicated monitor for and document any edema and monitor/document abnormalities for urinary output.During a review of Resident 3's care plan, titled, Has impaired circulation related to (r/t) hyperlipidemia (high amounts of lipids (fat) dated 5/23/2026, the care plan interventions indicated inspect foot/ankle/calf skin for changes: weeping, edema, tenderness.During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 5/25/2026, the MDS indicated Resident 3 was dependent on on staff for bathing, lower body (below waist) dressing, sit to lying, chair/bed-to-chair transfer, toilet transfer, and required substantial assistance (Helper does more than half) for eating and oral hygiene.During a review of Resident 3's order summary report, dated 6/24/2026, the order summary report indicated Resident 3's medication included Furosemide (brand name Lasix [medication that enables the body to get rid of excess fluids) oral tablet 20 milligram (mg, unit of mass) give two (2) tablets by mouth two times a day for fluid overload. During a concurrent interview and record review on 6/24/2026 at 2:09 p.m., with the Registered Dietitian (RD), Resident 3 medical records were reviewed. The RD stated on 6/17/2026, Resident 3's Lasix was increased from once a day to twice a day. The RD stated Resident 3's weights should be monitored to ensure Resident 3 did not get fluid overload and assess to see if medication dosage needs to be changed. The RD stated without monitoring the fluid output, the blood pressure (amount of force the blood uses to get through the arteries (thick, muscular, elastic blood vessels that carry blood away from the heart to the rest of the body) could be affected and cause electrolyte (essential minerals necessary for the body to operate) imbalance. During a concurrent interview and record review on 6/25/2026 at 3:30 p.m. with Registered Nurse Supervisor (RNS) 2, Resident 3's medical records were reviewed. RNS 2 stated staff are required to follow care plans, as they function as orders, and indicated the purpose of a care plan was to guide staff in understanding the resident and providing care specific to the residents' condition. RNS 2 stated they would not notice any sudden changes if they did not follow the care plan. RNS 2 stated according to Resident 3's care plans titled Is on diuretic therapy (Furosemide) r/t fluid overload dated 5/23/2026, indicated the interventions included to monitor for signs and symptoms (s/s) of dehydration: decreased or no urine output. RNS 2 stated the care plan titled Has renal insufficiency (kidneys (bean shaped organ below the rib cage) cannot properly filter waste and fluids from your blood) r/t chronic kidney disease (CKD, (gradual loss of kidney function to filter waste and excess fluid from the blood) dated 5/30/2026 indicated to monitor/document/report to the doctor as needed for the following s/sx: edema and weight gain of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	over two pounds (lbs) a day. RNS 2 stated based on Resident 3's care plans, the care plans are not being implemented. RNS 2 stated there were no orders to monitor urine output and indicated they should have one since Resident 3 was on Lasix and would want to know the output to see if she was removing fluids and not retaining. RNS 2 stated there was no fluid output documented in the tasks (section where the Certified Nursing Assistant (CNA) documented fluid output).During an interview on 6/25/2026 at 4:47 p.m. with the Director of Nursing (DON), the DON stated when a resident had a diagnosis of CHF, and was taking Lasix the facility staff should monitor for fluid overload and weight gain. The DON stated monitoring a resident's edema allows staff to determine whether the condition was improving or getting worse, and if the medication should change increase or decrease.The DON stated that when a resident was on Lasix, they would want to monitor their output to determine whether the resident was retaining fluids or to see if the medication was working. The DON stated that care plans are residentˆcentered and are designed to provide individualized care tailored to the resident's needs in order to minimize or resolve identified issues. The DON stated care plans need to be followed to ensure the interventions are implemented and to determine whether those interventions are effective. The DON stated they would not know if the interventions were effective if they do not follow the care plan.During a review of the facility's policy and procedures (P&P) titled, Comprehensive Resident Centered Care Plan: Care Planning revised date 1/2021, the P&P indicated is it the policy of this facility that the interdisciplinary team (IDT, healthcare team consisting of various specialties that share and combine their knowledge and information to create the best possible care plan for the resident) shall develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identifies in the comprehensive assessment.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 61) was positioned above 30 degrees while enteral feeding (G-tube - the delivery of nutrients through a feeding tube directly into the stomach, duodenum, or jejunum) was being delivered.This failure had the potential to place the resident at risk for aspiration (accidental breathing of food, liquid, or stomach contents to the airway and lungs).Findings:During an observation on 6/22/2026 at 3:12 p.m., Resident 61 was lying in bed supine, halfway down the bed. The resident's head was against the back rest of the bed with the neck bent forward.During an interview on 6/22/2026 at 3:20 p.m. with Certified Nurse Assistant (CNA) 4, CNA 4 stated, Resident 61 was lying lower than what she should be when the tube feeding was running. CNA 4 stated when the resident needs to be repositioned, the tube feeding (medical device used to provide liquid nourishment, fluids, and medications by bypassing oral intake) should be turned off.During a concurrent observation and interview on 6/22/2026 at 3:25 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 assessed the resident upon entering the room and stated that the resident should not be lying supine, was at less than 30 degrees while enteral feeding was being delivered. The LVN paused the tube feeding and indicated the need to obtain additional assistance to safely elevate the resident from the supine position. LVN 1 stated that the tube feeding should not be on when the resident was lying flat because it can lead to aspiration and choking.During an interview on 6/25/2026 at 2:33 p.m. with the Director of Nursing (DON), the DON stated the importance of making sure the residents' head was elevated above 30-45 degrees was to prevent aspiration. The DON stated the resident should never be lying flat.During a review of the facility's policy and procedure (P&P) titled Gastrostomy Tube Care and Management, revised 12/2023 indicated, Before every feeding, verify the tube position. If feeding is continuous, check the position every shift and as needed using aspiration of gastric contents, air auscultation, X-ray examination, or external graduation marks.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview, and record review, the facility failed to implement non-pharmacological interventions for one of one sampled resident (Resident) 26 prior to administering pain medication.This failure had the potential to place the resident at risk for the increased use of unnecessary medications.Findings:During an interview and record review on 6/24/2026 at 10:14 a.m. with Licensed Vocational Nurse (LVN) 2, Medication Administration Report (MAR), for month of June was reviewed. The MAR indicated that no non-pharmacological interventions were implemented for the entire month of June for Resident 26. Licensed Vocational Nurse (LVN) 2 stated there should be documentation of non-pharmacological interventions before giving the medication because we need to make sure we are not giving unnecessary medications.During an interview and record review on 6/25/2026 at 9:50 a.m. with Licensed Vocational Nurse (LVN) 4, the MAR and Progress Notes for month of June were reviewed. The MAR and Progress Notes indicated that no non-pharmacological interventions were implemented for the entire month of June for Resident 26. LVN 4 stated non-pharmacological interventions should be implemented first because that can minimize the amount of medication being given to a resident.During an interview and record review on 6/25/2026 at 2:22 p.m. with the Director of Nursing (DON), the MAR for month of June and Progress Notes for month of June were reviewed. The MAR and Progress notes indicated that the implementation of non-pharmacological interventions were not documented. The DON stated providing non-pharmacological interventions before giving pain medications should be implemented first. The DON stated the nurses were not accurately assessing resident's pain by not checking non-pharmacological interventions first.During a review of the facility's policy and procedure (P&P) titled, Nursing Administration: Recognition and Management of Pain, dated 1/2022 indicated The interdisciplinary care plan will reflect the location and type of pain, pharmacological, and non-pharmacological interventions, with evaluation and revision as indicated.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure one of 24 sampled residents (Resident 9) dialysis subclavical (anatomical structure situated directly beneath the clavicle (collarbone) port was covered. This deficient practice had the potential to delay or lack of identifying complications (such as pain, infection, accidental trauma, and dislodgement) of the dialysis access site and could lead to a delay provision of dialysis treatment. Findings During an observation on 6/23/2026 at 8:34 a.m., Resident 9's right dialysis port, located beneath the collarbone, was noted to be exposed with tape residue present. During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was originally admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with diagnoses including dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), dementia (a progressive state of decline in mental abilities), and cognitive communication deficit. During a review of Resident 9's history and physical (H&P) dated 8/16/2025, the H&P indicated Resident 9 had fluctuating capacity to understand and make decisions. During a review of Resident 9's Minimum Data Set (MDS, a resident assessment tool), dated 5/15/2026, the MDS indicated Resident 9 was moderately cognitively impaired. The MDS indicated Resident 9 was dependent on sit to lying, required substantial assistance (Helper does more than half) for lower body (below waist) dressing, bathing, toileting hygiene, required partial assistance (helper does less than half the effort) for oral hygiene, upper body (above waist), personal hygiene, chair/bed-to-chair transfer, toilet transfer, supervision for lying to sitting on side of bed, sit to stand, and required set up for eating and rolling left and right. The MDS indicated Resident 9 had impairments on one side of the upper (shoulder/arm) extremity and impairments on both sides of the lower (hip/leg) extremities. During a concurrent observation and interview on 6/23/2026 at 8:46 a.m. with the Director of Staff Development (DSD), the DSD stated Resident 9's dialysis port has a lot of tape residue on it and was not covered. The DSD stated that any licensed personnel could put the dressing on and indicated the dialysis port should be covered to prevent infection from occurring. The DSD stated that the site should be routinely checked for redness, swelling, or other issues, and that leaving the port uncovered could potentially result in infection or other adverse outcomes. During an interview on 6/25/2026 at 3:22 p.m. with Registered Nurse Supervisor (RNS) 2, RNS 2 stated the dialysis port assessments were done by the Registered Nurses (RN), and the Licensed Vocational Nurses (LVN) could check if the bandage for the dialysis port was intact. During an interview on 6/25/2026 at 5:04 p.m., with the Director of Nursing (DON), the DON stated that the dialysis port should always be covered to prevent infection or foreign material from entering the access site. During a review of the facility's policy and procedures (P&P) titled, Dialysis (Renal), Pre- and Post-Care, revised date12/2023, the P&P indicated dialysis access should be assessed upon return to the facility.any problems with a resident's access should be addressed immediately.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility staff failed to implement its policy and procedure (P&P) titled, Infection Prevention and Control Program: Infection Prevention-Foley Catheter and Central Lines revised 12/2024, for one out of 24 sampled residents (Resident 9) by failing to ensure staff took off the non-sterile gloves (everyday disposable gloves that are clean and safe for general use, but have not undergone special treatments to kill all microorganisms) prior to putting on sterile gloves to apply a clean dressing on Resident 9's dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) subclavical part of the body situated directly beneath the collarbone) port (surgically created site that allows blood to safely flow through a dialysis machine for filtering) This deficient practice had the potential to transmit infectious microorganisms and increase the risk of infection for the residents.Findings:During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including dialysis, dementia (a progressive state of decline in mental abilities), and cognitive communication deficit.During a review of Resident 9's history and physical (H&P) dated 8/16/2025, the H&P indicated Resident 9 had fluctuating capacity to understand and make decisions. During a review of Resident 9's Minimum Data Set (MDS, a resident assessment tool), dated 5/15/2026, the MDS indicated Resident 9 was moderately cognitively (ability to make decisions of daily living) impaired. The MDS indicated Resident 9 was dependent on facility staff for sit to lying, required substantial assistance (Helper does more than half) for lower body (below waist) dressing, bathing, toileting hygiene, required partial assistance (helper does less than half the effort) for oral hygiene, upper body (above waist), personal hygiene, chair/bed-to-chair transfer, toilet transfer, supervision for lying to sitting on side of bed, sit to stand, and required set up for eating and rolling left and right. The MDS indicated Resident 9 had impairments on one side of the upper (shoulder/arm) extremity and impairments on both sides of the lower (hip/leg) extremities.During an observation on 6/23/2026 at 9:36 a.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 put on a pair of non-sterile gloves (gloves and unbuttoned Resident 9's shirt to have a better view of the dialysis port. RNS 1 continued to put on sterile gloves (disposable medical gloves that are completely free of all germs and living microorganisms) over the non-sterile contaminated gloves. RNS 1 did not take the non-sterile gloves off, and perform hand hygiene before putting on the sterile gloves.During an interview on 6/23/2026 at 9:51 a.m., with RNS 1, RNS 1 stated while wearing the non sterile gloves she sanitized her work area. RNS 1 stated she did not, but should have taken off the non sterile gloves and perform hand hygiene before putting on the sterile gloves to change Resident 9's port dressing. RNS 1 stated sterile gloves were worn to ensure the field was sterile as breaking sterile field could cause cross contamination and infection of Resident 9's dialysis port.During an interview on 6/25/2026 at 4:52 p.m. with the Director of Nursing (DON), the DON stated changing dressing for a dialysis port must be performed using a sterile procedure (a strict set of medical practices used to eliminate all microorganisms such as bacteria and viruses from an area). The DON stated it was not acceptable to put sterile gloves over contaminated nonˆsterile gloves, as doing so breaks the sterile field and increases the risk of infection.During a review of the facility's policy and procedures (P&P) titled, Infection Prevention and Control Program: Infection Prevention-Foley Catheter and Central Lines revised date12/2024, the P&P indicated it is the policy of the facility to ensure that appropriate infection prevention and control measures are taken to prevent the spread of infection in accordance with State and Federal Regulations, and national guidelines. Perform hand hygiene prior to accessing a central line of performing a dressing change and don a mask and clean or sterile gloves.