

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Long Beach Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 Cedar Avenue Long Beach, CA 90807	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the physician was notified when one sampled resident (Resident 1), who was diagnosed with hypertension ([HTN] high blood pressure) refused to take his 9 a.m., medications, which included high blood pressure medications. This deficient practice resulted in Resident 1's physician being unaware of Resident 1's refusal to take his medications and the inability of the physician to instruct staff on care options. This deficient practice had the potential for Resident 1's blood pressure to remain elevated and for him to suffer consequences related to prolonged elevated blood pressure readings. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 had diagnoses including, HTN, congestive heart failure ([CHF] a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), chronic obstructive pulmonary disease ([COPD], a chronic lung disease causing difficulty breathing), difficulty walking, and lack of coordination. During a review of Resident 1's History and Physical (H&P) dated 4/8/2026, the H&P indicated Resident 1 was oriented to person, place, and time (the resident knows who they are, where they are, who other people are, and knows the date and time). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 7/15/2026, the MDS indicated Resident 1's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated Resident 1 required set-up and clean up assistance (helper sets up or cleans up; resident completes the activity) from staff for eating, and maximal assistance (helper does more than half the effort) from staff for toileting, dressing lower body, and shower/bathing. During a review of Resident 1's Care Plan titled, Episodes of refusing his 9 a.m., medications and BP (blood pressure), VS (vital sign) check initiated 5/12/2026, the Care Plan's goals indicated for Resident 1 to take his medications on time, understand medication benefits, and comply with vital signs monitoring. The Care Plan's interventions indicated staff were to document Resident 1's refusal, monitor for signs and symptoms of complications related to him refusing his medications and vital signs checks, and to notify the MD for any significant changes promptly. During a review of Resident 1's Order Summary Report (Physician's Orders), dated 7/30/2026, the Physician's Order indicated the following: 1. Metoprolol Succinate ER (extended release) tablet 50 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount), give one tablet one time a day for hypertension ([HTN] high blood pressure), hold if the systolic blood pressure ([SBP] the top number of a blood pressure reading) was less than 100 millimeters of mercury ([mmHg] a unit of measurement). 2. Telmisartan oral tablet 40 mg, give 40 mg one time a day for HTN, hold if SBP was below 110 mmHg. 3. Furosemide oral tablet 20 mg, give one tablet one time a day for HTN, hold if SBP was less than 110 mmHg. 4. Aspirin oral (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tablet chewable 81 mg give one tablet one time a day to prevent blood clots. 5. Ezetimibe oral tablet 10 mg, give one tablet one time a day for high cholesterol. 6. Empagliflozin (a medication used to help the body remove extra sugar and fluid through the urine) oral tablet 10 mg, give one tablet one time a day. Gabapentin (a medication used to relieve nerve pain) 300 mg, give 1 capsule four times a day. During a review of Resident 1's Medication Administration Audit Report ([MAAR], a document used to check whether medications in a facility are being given safely, correctly, and according to required policies) dated 7/29/2026, the MAAR indicated Resident 1's 9 a.m., medications for 7/27/2026 that included Telmisartan 40 mg, Metoprolol Succinate Extended Release 50 mg, Furosemide 20 mg, Aspirin 81 mg, Ezetimibe 10 mg, Gabapentin 300 mg, and Empagliflozin 10 mg were administered on 7/27/2026 at 12:21 p.m. During an interview on 7/27/2026 at 11:38 a.m., Resident 1 stated he had not received his morning medications (7/27/2026), he had blood pressure medications due, and he was concerned his blood pressure would become elevated. Resident 1 stated he had not refused his morning medication, and he would frequently not get his 9 a.m., medications and would have to use his call light to ask the nurse for them. During an observation on 7/27/2026 at 11:51 a.m., Resident 1 activated his call light to request his morning medications. Licensed Vocational Nurse (LVN) 3 entered Resident 1's room to obtain Resident 1's blood pressure. During an observation on 7/27/2026 at 11:57 a.m., LVN 3 entered Resident 1's room and obtained Resident 1's blood pressure. Resident 1's left arm blood pressure was 161/96 with a heart rate of 58. Resident 1's right arm blood pressure was 166/96 with a heart rate of 55 (reference range for blood pressure 120/88 mmHg). During a concurrent interview and record review on 7/27/2026 at 12:10 p.m., with LVN 1, Resident 1's Nursing Progress Notes dated 7/27/2026 were reviewed. The Nursing Progress Notes indicated no documented evidence that Resident 1 refused to take his 9 a.m. medications or that Resident 1's physician was notified when Resident 1 refused to take his 9 a.m. medications. LVN 1 stated Resident 1's 9 a.m. medications were not administered until after 12 p.m., because he refused to take his medications when they were offered at 9 a.m., she did not document his refusal to take his medication, nor did she notify Resident 1's physician of his refusal to take his medications. LVN 1 stated when Resident 1 refused to take his medications, she should have offered the medications three times and documented each refusal. LVN 1 stated it was important to notify the physician because Resident 1's blood pressure was elevated and missed blood pressure medications could cause Resident 1 to become ill. During an interview on 7/28/2026 at 4:17 p.m., and a subsequent interview on 7/30/2026 at 11:45 a.m., Director of Nursing (DON) stated medications could be administered one hour before and one hour after the prescribed medication time. If a resident refused to take their medications, the nurse should document the resident's refusal, explain the risks and consequences of not taking their medication, attempt to give the resident their medication two more times, and if the resident continued to refuse to take their medication, notify the resident's physician. The DON stated Resident 1's blood pressure was high, and refusal to take his blood pressure medications should have been addressed because Resident 1's vital signs were not within range. During a review of the facility's Policy and Procedure (P&P), titled Charting and Documentation revised 7/2017, the P&P indicated . medications administered, changes in the resident's condition, whether the resident refused the procedure or treatment, and notification of family, physician, or other staff, if indicated, were to be documented in the resident's medical record.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 1 did not taunt one of four sampled residents (Resident 1) by telling him to hit me Go ahead and hit me so we can send you out, following an altercation between Resident 1 and LVN 1. Following the altercation LVN 1 continued to be assigned to care for Resident 1. This deficient practice resulted in Resident 1 continuing to receive care from the LVN 1 who verbally abused him and had the potential to cause Resident 1 emotional distress, increased agitation, psychosocial harm, and loss of trust in facility staff. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 had diagnoses including congestive heart failure ([CHF] a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), chronic obstructive pulmonary disease ([COPD] a chronic lung disease causing difficulty breathing), difficulty walking, and lack of coordination. During a review of Resident 1's History and Physical (H&P), dated 4/8/2026, the H&P indicated Resident 1 was oriented to person, place, and time (the resident knows who they are, where they are, who other people are, and knows the date and time). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 7/15/2026, the MDS indicated Resident 1's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated Resident 1 required set-up and clean up assistance (helper sets up or cleans up; resident completes the activity) from staff for eating, and maximal assistance (helper does more than half the effort) from staff for toileting, dressing lower body, and shower/bathing. During a review of Resident 1's Change in Condition (CIC) Evaluation, dated 7/15/2026 and timed at 11:02 a.m., the CIC Evaluation indicated Resident 1 displayed increasing agitation, yelling and screaming towards staff while the nursing staff was providing care for Resident 1's roommate (Resident 10). The CIC Evaluation indicated Resident 1's behavior escalated to throwing a side table towards the charge nurse when the charge nurse moved Resident 1's side table to make room for a shower chair needed for Resident 10. During a review of the facility's Nurse Staffing Assignments, dated 7/2026 the Nurse staffing Assignments indicated LVN 1 was assigned to Resident 1's care following the altercation between them on 7/15/2026 on the following dates: 7/16/2026, 7/18/2026, 7/21/2026, 7/22/2026, 7/23/2026, 7/24/2026, 7/25/2026, 7/27/2026, 7/28/2026, and 7/29/2026. During an interview on 7/27/2026 at 11:38 a.m., Resident 1 stated on 7/15/2026, his overbed table became caught on his bed when the bed was raised, and the overbed table tipped over, and the tray of food fell off of the overbed table. Resident 1 stated LVN 1 accused him of throwing a tray of food at her, but he did not throw the tray at LVN 1. Resident 1 stated LVN 1 told him, Hit me, hit me, so I can get you out of here. The Psychiatric Evaluation Team ([PET] a mobile crisis units that consist of licensed mental health clinicians who evaluate individuals experiencing severe psychiatric distress, provide onsite deescalation and can facilitate voluntary or involuntary hospitalizations) and police were called after the incident, two CNAs, who were in the room when the incident happened, witnessed the incident and explained to PET and police what happened. During an interview on 7/28/2026 at 12:05 p.m., CNA 2 stated she was present during the 7/15/2026 incident involving Resident 1 and LVN 1. CNA 2 stated Resident 1 was eating breakfast when staff were preparing to assist Resident 10 with a shower and needed space to bring a mechanical lift (a device used to lift and/or transfer a person from place to place) into the room. The area was limited in space, and they needed to move Resident 1's overbed (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	table to get the mechanical lift positioned, which Resident 1 agreed to. LVN 1 came into the room, pulled Resident 1's table, and the table jammed under the bed. Resident 1 was eating oatmeal, and his oatmeal slid off the table. Resident 1 was frustrated and began swiping everything off his table onto the floor then pushed the table out of the way. Resident 1 was not trying to throw the tray at LVN 1. CNA 2 stated LVN 1 said to Resident 1, Go ahead and hit me so we can send you out. and then held her hands up to prevent her (CNA 2) and CNA 3 from approaching Resident 1, that's when Resident 1 threatened to hit LVN 1. LVN 1 did not try to deescalate the situation and instead said to them (CNA 2 and CNA 3) Let him hit me if he wants to hit me. CNA 2 stated she was interviewed by the police and told them that Resident 1 did not throw the table at LVN 1. CNA 2 stated she notified the Administrator (ADM) of the incident but she did not tell the ADM what LVN 1 said to Resident 1. During a telephone interview on 7/27/2026 at 2:07 a.m., CNA 3 stated on 7/15/2026 staff were assisting Resident 10 and Resident 1 became upset because staff were in his space and his table was being moved. CNA 3 stated LVN 1 attempted to move Resident 1's table, the table flipped, and items on the table fell to the floor. Resident 1 was upset, but he did not throw the table at LVN 1. CNA 3 stated Resident 1 became angrier when LVN 1 told him, Hit me, hit me, so we can get you out of here. CNA 3 stated staff were not trained to tell residents to hit them so they could get them out of the facility, he could have been taken to the patio for fresh air to calm him down. CNA 3 stated no one reported LVN 1's statement, but there were eyewitnesses. During an interview on 7/28/2026 at 3:19 p.m., LVN 1 stated she was called into Resident 1's room because the gastrostomy tube ([g-tube] a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) pump for Resident 10 was beeping, and staff wanted her to disconnect the Resident 10 from the G-tube to take him for a shower. There was limited space in the room, she asked Resident 1 if she could move his table. Resident 1 began yelling, screaming, and became verbally aggressive. LVN 1 did not address what she said to Resident 1. During an interview on 7/28/2026 at 4:17 p.m., the Director of Nursing (DON) stated on the day of the incident (7/15/2026), LVN 1 answered Resident 1's call light, accidentally moved Resident 1's table, and made Resident 1 upset. The DON stated because Resident 1 was upset, he moved the table and the tray fell. The DON stated if LVN 1 said, hit me, hit me, that way we can get you out of her, to Resident 1, that might make him more upset. The DON stated she was not aware that this was what LVN 1 said to Resident 1, had she known, she would have re-educated LVN 1, provided one-to-one in-service training, and reassigned LVN 1 from Resident 1's assignment. The DON stated Resident 1 would not feel good having the nurse who spoke to him that way providing his care, and he could become more upset every time he saw that nurse. During an interview on 7/28/2026 at 4:53 p.m., the ADM stated he was called to Resident 1's room when the incident occurred, he saw food on the floor from Resident 1's tray and heard that Resident 1 had thrown the tray on the floor. Resident 1 told him he did not throw the tray at LVN 1, but he did not hear anything about LVN 1 telling Resident 1, hit me, hit me. The ADM stated if Resident 1 was already angry, LVN 1's statement, hit me, hit me, did not help the situation. The ADM stated he would have taken aggressive action toward LVN 1 if he had known the incident occurred, and LVN 1 would have been removed from the care of the resident. The ADM stated the staff and Resident 1 did not mention to him what LVN 1 said to Resident 1. During an interview on 7/30/2026 at 11:45 a.m., with the DON, and a concurrent review of Resident 1's Nursing Progress Note dated 7/27/2026 and timed at 12:30 p.m., the Nursing Progress Note indicated Resident 1 refused to take medications from LVN 1 and staff should continue to have another nurse give Resident 1 his medications if he allowed it. The DON stated CNA 2 and CNA 3 should have stopped LVN 1 and reported the incident to her and the ADM because as mandated reporters they should (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	report abuse. The DON state she nor the ADM were made aware of what LVN 1 said to Resident 1 and acknowledged that LVN 1 continued caring for Resident 1 which could emotionally affect Resident 1 by seeing her daily. LVN 1's assignment should have been changed and if she had known the altercation occurred between LVN 1 and Resident 1, she would have separated them sooner. During a review of the facility's Policy and Procedure (P&P) titled, Protection of Residents During Abuse Investigations, revised 4/2021, the P&P indicated residents are protected from harm, retaliation, reprisal, discrimination, or coercion during investigations of abuse, neglect, exploitation, and misappropriation of resident property. If the alleged perpetrator is an employee or staff member, the individual is immediately reassigned to duties that do not involve resident contact or are suspended until the findings of the investigation are reviewed by the Administrator. The victim is evaluated for his or her feelings of safety if the victim communicates fear, insecurity, or other concerns, measures are taken to alleviate this, including changing the room assignment or providing more supervision. During a review of the facility's P&P titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 4/2021, the P&P indicated residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The P&P indicated this includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The facility will establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive, or emotional problems. During a review of the facility's undated P&P titled Business Ethics and Conduct and Staff Conduct and Work Rules, the P&P indicated physical, verbal, emotional, or psychological abuse of residents, visitors, or coworkers is strictly prohibited. Staff may not engage in physical altercations or aggressive behavior while on organization property or representing the organization. During a review of the facility's P&P titled Residents Rights Policy, revised 5/2025, the P&P indicated every resident shall be treated with respect and fairness and shall enjoy their rights without discrimination, harassment, abuse, neglect, or retaliation. Residents have the right to be treated with courtesy, dignity, and respect and to live in a safe, secure, and healthy environment, and to be free from physical, emotional, verbal, sexual, or financial abuse. Residents have the right to be free from neglect, exploitation, intimidation, coercion, and retaliation. Staff members shall respect and protect residents' rights at all times, maintain confidentiality, report suspected abuse, neglect, or rights violations immediately, support residents in exercising their rights, and participate in training related to residents' rights and ethical conduct.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an allegation of verbal abuse was immediately reported to the Administrator (ADM) when staff witnessed Licensed Vocational Nurse (LVN) 1 tell one of four sampled residents (Resident 1) to hit me Go ahead and hit me so we can send you out. This deficient practice resulted in the facility's inability to conduct a timely investigation and a delay in reporting the allegation to the California Department of Public Health (CDPH). This deficient practice had the potential for LVN 1 to continue verbally abusing Resident 1. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 had diagnoses including congestive heart failure ([CHF] a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), chronic obstructive pulmonary disease ([COPD] a chronic lung disease causing difficulty breathing), difficulty walking, and lack of coordination. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 7/15/2026, the MDS indicated Resident 1's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated Resident 1 required set-up and clean up assistance (helper sets up or cleans up; resident completes the activity) from staff for eating, and maximal assistance (helper does more than half the effort) from staff for toileting, dressing lower body, and shower/bathing. During a review of Resident 1's Change in Condition (CIC) Evaluation, dated 7/15/2026 and timed at 11:02 a.m., the CIC Evaluation indicated Resident 1 displayed increasing agitation, yelling and screaming towards staff while the nursing staff was providing care for Resident 1's roommate (Resident 10). The CIC Evaluation indicated Resident 1's behavior escalated to throwing a side table towards the charge nurse when the charge nurse moved Resident 1's side table to make room for the shower chair needed for Resident 10. During an interview on 7/27/2026 at 11:38 a.m., Resident 1 stated on 7/15/2026, his overbed table became caught on his bed when the bed was raised, and the overbed table tipped over, and the tray of food fell off of the overbed table. Resident 1 stated LVN 1 accused him of throwing a tray of food at her, but he did not throw the tray at LVN 1. Resident 1 stated LVN 1 told him, Hit me, hit me, so I can get you out of here. The Psychiatric Evaluation Team ([PET] a mobile crisis units that consist of licensed mental health clinicians who evaluate individuals experiencing severe psychiatric distress, provide onsite deescalation and can facilitate voluntary or involuntary hospitalizations) and police were called after the incident, two CNAs, who were in the room when the incident happened, witnessed the incident and explained to PET and police what happened. During an interview on 7/28/2026 at 12:05 p.m., CNA 2 stated she was present during the 7/15/2026 incident involving Resident 1 and LVN 1. CNA 2 stated Resident 1 was eating breakfast when staff were preparing to assist Resident 10 with a shower and needed space to bring a mechanical lift (a device used to lift and/or transfer a person from place to place) into the room. The area was limited in space, and they needed to move Resident 1's overbed table to get the mechanical lift positioned, which Resident 1 agreed to. LVN 1 came into the room, pulled Resident 1's table, and the table jammed under the bed. Resident 1 was eating oatmeal, and his oatmeal slid off the table. Resident 1 was frustrated and began swiping everything off his table onto the floor then pushed the table out of the way. Resident 1 was not trying to throw the tray at LVN 1. CNA 2 stated LVN 1 said to Resident 1, Go ahead and hit me so we can send you out. and then held her hands up to prevent her (CNA 2) and CNA 3 from approaching Resident 1, that's when Resident 1 threatened to hit LVN 1. LVN (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Certified Nursing Assistant (CNA) 3 remained awake and available to respond to resident care needs during the 11 p.m. to 7 a.m., shift on 7/29/2026 or one sampled resident (Resident 1). This deficient practice resulted in CNA 1 being unaware and unavailable to assist with resident care needs and/or emergencies. This deficient practice had the potential for delayed and/or missed care/emergency response. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 had diagnoses including congestive heart failure ([CHF] a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), chronic obstructive pulmonary disease ([COPD] a chronic lung disease causing difficulty breathing), difficulty walking, and lack of coordination. During a review of Resident 1's History and Physical (H&P) dated 4/8/2026, the H&P indicated Resident 1 was oriented to person, place, and time (the resident knows who they are, where they are, who other people are, and knows the date and time). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 7/15/2026, the MDS indicated Resident 1's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated Resident 1 required set-up and clean up assistance (helper sets up or cleans up; resident completes the activity) from staff for eating, and maximal assistance (helper does more than half the effort) from staff for toileting, dressing lower body, and shower/bathing. During a review of the facility's Grievance Log, dated 5/2026, the Grievance Log indicated on 5/12/2026 Resident 1 had a call light concern. During an interview on 7/27/2026 at 3:23 p.m., Resident 1 stated during the 11 p.m. to 7 a.m., shift staff did not change his brief and did not respond to his call light. Resident 1 stated he filed a grievance regarding the concern with his call light and staff improved answering his call light for a short period of time and then went back to not responding to it. Staff ignored him during the 11 p.m., to 7 a.m., shift when he asked to be change and he was left in soiled briefs and had to wait until morning to get a shower and have his soiled brief changed. During an observation on 7/29/2026 from 3:43 a.m. to 3:53 a.m., on the East Station, CNA 1 was observed covered with a blanket, asleep in a chair outside the shower room at the end of the hallway, he remained asleep for approximately 10 minutes and did not wake when approached. During an interview on 7/29/2026 at 3:53 a.m., CNA 1 stated he was not on break and was not supposed to be asleep while on duty. CNA 1 stated it was important not to sleep while on duty because some residents were fall risks, residents had safety concerns, and he was responsible for monitoring the residents. During an interview on 7/29/2026 at 4:23 a.m., Registered Nurse (RN) 2 stated it was not acceptable for CNA 1 to be asleep while on duty. Staff must be fully awake during their shift because sleeping while on duty was a safety issue. RN 2 stated CNA 1 could fail to hear residents calling out for help and he could not provide care to residents while asleep. RN 2 stated CNA 1 was assigned to the East Station and was covering the area for the CNA 9 who was assigned to Resident 1. During a concurrent observation and interview on 7/29/2026 at 5:31 a.m., with Resident 1, Resident 1 was observed sitting upright in his wheelchair next to his bed, awake and alert. Resident 1 asked, Did you see that CNA (CNA 1) sleeping in the corner this morning? Resident 1 stated CNA 1 frequently sleeps there during the night shift and on multiple occasions he has witnessed CNA 1 asleep while other residents called for assistance and he (CNA 1) did not respond. Resident 1 stated he on previous occasions when CNA 1 provided his care, CNA 1 did not respond when he activated his call light and called out for assistance. He requested (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that CNA 1 not be assigned to his care because CNA 1 repeatedly slept during the night and did not respond to the call lights. During an interview on 7/30/2026 at 11:45 a.m., the Director of Nursing (DON) stated she was unaware that CNA 1 was sleeping during the 11 p.m. to 7 a.m. shift or that Resident 1 did not want CNA 1 assigned to provide his care because of concerns with CNA 1 sleeping. The DON stated if CNA 1 was sleeping during his shift he would not hear when residents' when they requested assistance by using their call light and residents' were at risk of falling if their call lights were not being answered. During an interview on 7/30/2026 at 1:51 p.m., the Administrator (ADM) stated he was aware of the concerns that Resident 1 had with his call light not being answered, was aware, per Resident 1's report to him that Resident 1 was not being changed, but he was not aware that CNA 1 sleeping during the 11 p.m., to 3 a.m., shift. During a review of the facility's undated Policy and Procedure (P&P), titled Section 3 Staff Conduct, the P&P indicated staff must follow departmental policies, procedures, and perform their responsibilities in an ethical manner and within assigned timeframes. Staff must refrain from engaging in behavior that could endanger others. Staff may not sleep while on duty. During a review of the facility's P&P, titled Daily Work Assignments, revised 8/2006, the P&P indicated all nursing service personnel shall follow daily work assignment and perform assigned duties in accordance with the professional standards of practice and facility policy. CNAs and trainees are expected to carry out their daily assignments in a professional manner and in accordance with established nursing procedures. During a review of the facility's Job Description titled Certified Nursing Assistant (CNA) updated 11/1/2024, the Job Description indicated the Certified Nursing Assistant (CNA) provided essential personal care and support to residents, ensuring their comfort and well-being. The CNA was responsible for supporting residents in their daily activities. The CNA provided AM and PM care, ensuring residents received appropriate support throughout the day. The CNA promptly answered resident call lights and addressed requests with appropriate responses.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure for two of three sampled residents (Resident 1 and Resident 14): 1. Medications prepared for Resident 1 by Licensed Vocational Nurse (LVN) 1 were not administered to Resident 1 by LVN 3. 2. Resident 14's discontinued medication, Gabapentin (a medication that calms overactive nerves in the body) was removed from the Medication Cart immediately after it was discontinued. These deficient practices resulted in LVN 3 administering medications to Resident 1 that she did not prepare, without verifying the order to ensure the correct medication and dosage was given, as well as the discontinued Gabapentin remaining in the Medication Cart and being administered to Resident 14. These deficient practices had the potential for medications errors to occur and for Resident 1 and Resident 14 to receive incorrect medications, harm and, adverse consequences to occur. Findings: During a review of Resident 1's Order Summary Report (Physician's Order) dated 7/30/2026, the Physician's Order indicated the following 9 a.m., medication orders: 1. Aspirin (a medication used to prevent blood clots) oral tablet chewable 81 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount), give one tablet one time a day for cerebrovascular accident for ([CVA] stroke, loss of blood flow to a part of the brain). 2. Empagliflozin (a medication used to help the body remove extra sugar and fluid through the urine) oral tablet 10 mg, give one tablet one time a day for heart failure 3. Ezetimibe (a medication used to lower cholesterol levels) oral tablet 10 mg, give one tablet one time a day for hyperlipidemia (elevated levels of fat in the blood). 4. Furosemide (a medication used to lower blood pressure and remove extra fluid from the body) oral tablet 20 mg, give one tablet one time a day for HTN; hold if systolic blood pressure ([SBP, the pressure in the arteries when the heart beats) is below 110 millimeters of mercury ([mmHg] a unit of measurement). 5. Gabapentin 300 mg, give one capsule four times a day for neuropathy (nerve damage that can cause numbness, tingling, weakness, or pain). 6. Metoprolol Succinate (a medication used to lower blood pressure and heart rate) ER (extended release) tablet 50 mg, give one tablet one time a day for HTN; hold if SBP is below 100 mmHg. 7. Telmisartan (a medication used to lower blood pressure) oral tablet 40 mg, give 40 mg one time a day for HTN; hold if SBP is below 110 mmHg. During a review of Resident 1's Medication Administration Audit Report ([MAAR] a document used to check whether medications in a facility are being given safely, correctly, and according to required policies) X dated 7/29/2026, the MAAR indicated Aspirin Oral Tablet Chewable 81 mg, Empagliflozin Oral Tablet 10 mg, Ezetimibe Oral Tablet 10 mg, Furosemide Oral Tablet 20 mg, Gabapentin Capsule 300 mg, Metoprolol Succinate ER Tablet Extended Release 24 Hour 50 mg, and Telmisartan Oral Tablet 40 mg were administered on 7/27/2026 at 12:21 p.m., by LVN 2. During a concurrent observation and interview on 7/27/2026 at 12:10 p.m., with LVN 1, several medication cups were observed on a tray on top of a Medication Cart. The medication cups contained Resident 1's 9 a.m., medications. LVN 1 stated she LVN 2 to give Resident 1 his medications, LVN 2 agreed and was observed entering Resident 1's room to administer Resident 1's 9 a.m. medications. During an interview on 7/28/2026 at 3:19 p.m., LVN 1 stated the nurse who prepares the medications should administer the medications because the person who prepares the medications were aware of what was prepared. During an interview on 7/28/2026 at 3:39 p.m., LVN 2 stated LVN 1 asked her to administer Resident 1's medications after LVN 1 had already prepared Resident 1's medications and placed the medications in medication cups. LVN 2 stated this was not the proper way to prepare and administer medications because of the risk for medication errors. The (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse who prepares the medications for administration should be the one who administers the medication to the resident. During an interview on 7/30/2026 at 11:45 a.m., the Director of Nursing (DON) stated if LVN 1 needed assistance from LVN 3 with administering medications, LVN 1 should have allowed LVN 3 to prepare the medications that she would be administering to ensure she (LVN 3) knew what she was giving to Resident 1. Not following the correct procedure for medication administration could result in a wrong medication administration and harm to the resident. During a review of the facility's undated Policy and Procedure (P&P), titled Administering Medications the P&P indicated individual administering the medication checked the label three (3) times to verify the right resident, right medication, right dosage, right time, and right method/route of administration before giving the medication. During a review of the facility's undated P&P, titled Licensed Nurse (LN) Medication Administration Policy the P&P indicated Licensed Nurses safely prepare, administer, monitor, and document medications according to physician orders, facility policy, state and federal regulations, and accepted standards of nursing practice. Licensed Nurses verified the physician's order before administering any medication. b. During a review of Resident 14's admission Record (Face Sheet), the Face Sheet indicated Resident 14 was admitted to the facility on [DATE]. Resident 14 had diagnoses including anorexia nervosa (an eating disorder that involves severe calorie restrictions and, often, a very low body weight), and polyneuropathy (a disease or dysfunction of many nerves, typically causing numbness or weakness in hands and feet), and abnormalities of gait (a particular way or pattern of walking, running, or moving on foot) and mobility. During a review of Resident 14's History and Physical (H&P), dated 6/25/2026, the H&P indicated Resident 14 had the capacity to understand and make medical decisions. During a review of Resident 14's Minimum Data Set ([MDS] a resident assessment tool), dated 6/29/2026, the MDS indicated Resident 1's cognition (ability to register and recall information) was intact and she was able to understand and be understood by others. During a review of Resident 14's Physician's Orders, dated 7/20/2026, the Physician's Orders indicated Resident 1 was to receive Gabapentin (a prescription medicine that calms overactive nerves in the body) oral tablet 100 milligrams ([mg] - a metric unit of measurement, used for medication dosage and/or amount) give one tablet three times a day for neuropathy. During a review of Resident 14's Change of Condition (COC) note that the COC indicated Resident 14 claimed she felt her heart rate elevate after taking Gabapentin. The physician was notified on 7/21/2026 at 10:04 a.m. and gave an order to discontinue the Gabapentin. During a review of Resident 14's Physician Order, dated 7/21/2026 at 11:14 a.m., the Physician's Order indicated Gabapentin 100 mg was discontinued. The Physician's Order was received and confirmed by Registered Nurse (RN) 3. During an interview on 7/29/2026 at 10 a.m., Resident 14 stated on 7/21/2026 she felt like her heart was beating faster after taking Gabapentin. Resident 14 stated her physician discontinued the medication that same day (7/21/2026). Resident 14 stated after the Gabapentin was discontinued on 7/21/2026, several nursing staff continued to place the Gabapentin tablet in a medication cup along with her other medications on at least three occasions. She refused the Gabapentin each time. I kept informing the nursing staff that the Gabapentin had been discontinued., If she had she not questioned the nursing staff, she might have mistakenly taken the medication and experienced side effects again. During an interview on 7/29/2026 at 11:30 a.m., RN 3 stated on 7/21/2026, Resident 14 informed him she felt her heart was beating fast after taking Gabapentin. He notified Resident 1's physician, and the Gabapentin was discontinued on 7/21/2026. RN 3 stated he did not remove the discontinued Gabapentin pills from the drawer but instead instructed Resident 14's assigned medication nurse on that shift to remove the Gabapentin from Resident 14's medication drawer and place it in the discontinued medication bin in the medication room. RN 3 stated the facility's practice was for the (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	licensed nurse receiving a discontinuation order to immediately remove the medication from the cart to prevent a medication error and eliminate the risk of administering unnecessary medication. RN 3 stated he did not follow this process. During an interview with RN 3 and a concurrent observation of the Medication Cart on 7/29/2026 at 11:40 a.m., the Medication Cart was noted to contain Gabapentin 100 mg prescribe to Resident 14. es. RN 3 stated the Gabapentin remained in Resident 14's drawer eight days after it had been discontinued and not removing the Gabapentin placed Resident 14 at risk of receiving medication that had been discontinued and could cause her harm. During a telephone interview on 7/29/2026 at 11:50 a.m., and a subsequent interview at 12 p.m., Licensed Vocational Nurse (LVN) 4 stated on 7/28/2026 she prepared all of Resident 14's 9 a.m., oral medications for administration, placed them in one medication cup and handed the cup to Resident 14 to swallow the pills. Resident 14 informed her that one of the medications in the cup was Gabapentin, which had been discontinued on 7/21/2026. LVN 4 stated she then reviewed Resident 14's Medication Administration Record ([MAR] a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) to verify Resident 14's medications. The MAR did have t Gabapentin listed for administration to Resident 14. LVN 4 stated she did not follow the proper medication administration process, that included confirming each medication and dosage against the MAR. She did not remove the discontinued medication from the drawer because she was busy on that shift. Not following this appropriate process could result in administering discontinued or incorrect medications, placing Resident 1 at risk for harm. During an interview on 7/29/2026 at 4 p.m., the Director of Nursing (DON) stated nurses were required to confirm each medication and dosage against the MAR, and ensure the medication was ordered before preparing and administering the medication Nurses should remove discontinued medications from the Medication Cart and place them in the designated discontinued medication bin to prevent accidental administration. Failure to follow those steps could lead to medication errors, including administering discontinued or incorrect medications. This posed specific harm to Resident 14 because she had previously experienced tachycardia (increased heart rate) after taking Gabapentin. During a review of the facility's Policy and Procedure (P&P) titled, Medication Labeling and Storage, revised 2/2023, the P&P indicated if the facility had discontinued medications the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.		

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F 0826 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide specialized rehabilitative services by qualified personnel, when ordered for a resident by a doctor. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Director of Rehabilitation ([DOR] oversees the rehabilitation department operations, not required to be a licensed Occupational Therapist [OT] a licensed healthcare professional who evaluates and treats individuals to improve their ability to perform everyday activities safely and independently) and is a Certified Occupational Therapy Assistant [COTA] trained to provide OT services only under the supervision of a licensed OT and cannot independently perform evaluations, assessments, determine the need for assistive devices, or initiate occupational therapy treatment plans) referred one of three sampled residents (Resident 14), who was non weight bearing (no weight placed on the affected leg, foot, or joint), to the OT when Resident 14 requested a drop arm commode (toileting assistive device with arms that lower or release to allow lateral transfers [seated movement from one surface to another without standing or bearing weight]). This Deficient practice resulted in Resident 14 not receiving an evaluation by an OT to determine if a drop arm commode was an appropriate assistive device. Instead of using a regular commode, which the DOR recommended, Resident 14 chose to wear adult diapers for bowel and bladder elimination, which made her feel humiliated and angry. Findings : During a review of Resident 14's admission Record (Face Sheet), the Face Sheet indicated Resident 14 was admitted to the facility on [DATE]. Resident 14 had diagnoses including anorexia nervosa (an eating disorder that involves severe calorie restrictions and, often, a very low body weight), polyneuropathy (a disease or dysfunction of many nerves, typically causing numbness or weakness in hands and feet), and abnormalities of gait (a particular way or pattern of walking, running, or moving on foot) and mobility. During a review of Resident 14's History and Physical (H&P), dated 6/25/2026, the H&P indicated Resident 14 had the capacity to understand and make medical decisions. During a review of Resident 14's Minimum Data Set ([MDS] a resident assessment tool), dated 6/29/2026, the MDS indicated Resident 1's cognition (ability to register and recall information) was intact and she was able to understand and be understood by others. During a review of Resident 14's Physician Orders, dated 7/8/2026, the Physician's Order indicated no weight bearing (both legs) until seen by orthopedic specialist (a medical doctor who diagnoses, treats, and helps present problems in the musculoskeletal system). During an interview on 7/29/2026 at 10 a.m., Resident 14 stated since she was non weight bearing as of 7/8/2026 she requested a drop arm commode from the DOR. She previously pivoted onto a standard commode, but once she became non`weight`bearing she could no longer use the standard commode. The DOR told her she did not need a drop arm commode and could continue using the existing commode by scooting her bottom from the bed onto the commode. Resident 14 stated this was not workable for her because she had significant pain in her wrists, which made scooting difficult. The DOR told her she would make the rehabilitation team aware of her request; however, the rehabilitation team was never made aware of her request. Resident 14 stated because she was unable to obtain the drop arm commode, she began wearing adult diapers to urinate and defecate (to discharge solid or semi-solid waste [feces]). She felt humiliated, angry, and frustrated that her request was dismissed by the DOR. Resident 14 stated she cleaned herself up independently after toileting in the diaper because she was so embarrassed to have anyone else clean her. During a phone interview on 7/28/2026 at 2:27 p.m., the DOR stated Resident 14 asked her for a drop arm commode. The DOR stated she told Resident 14 she did not need a drop arm commode and advised her to position and angle her existing commode to allow her to scoot into it. When Resident 14 informed her (continued on next page)		

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F 0826 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(the DOR) that she was unable to use the commode in that manner, she (the DOR) suggested that Resident 14 use a bedpan instead. The DOR stated she should have informed the supervising OT so an evaluation could be completed for Resident 14 because she (the DOR) could not screen or evaluate residents. During an interview on 7/28/2026 at 4:19 p.m., the OT stated the DOR is a COTA and works under the supervision of a licensed OT and could not independently evaluate a resident or initiate OT treatment plans. The OT stated she had not been informed that Resident 14 requested a drop arm commode. The OT stated a drop arm commode is used for residents who could not stand, bear weight, or perform pivot transfers. For a non-weight bearing resident, such as Resident 14, a drop arm commode supports safety, maintains dignity, and promotes independence by allowing the resident to transfer from the bed to commode using a lateral scoot rather than standing or relying on a bedpan. She (the OT) should have been notified of Resident 14's request so she could have conduct an evaluation. The lack of referral caused a delay in care and did not uphold the residents' rights to maintain dignity and promote independence. During an interview on 7/29/2026 at 4 p.m., the Director of Nursing (DON) stated she was not aware that Resident 14 had requested a drop arm commode or that the DOR had attempted to address Resident 1's toileting needs without notifying the supervising OT or the nursing department. The DON stated all residents have the right to receive timely assessments and appropriate assistive devices to maintain their dignity, independence, and safety. The DON stated any request for specialized equipment, such as a drop arm commode, must be promptly communicated to the licensed OT for proper evaluation. The failure to notify the OT was inconsistent with facility expectations and residents' rights to receive needed equipment and services. During a review of the facility's Policy and Procedure (P&P) titled, Resident's Rights Policy revised 5/2025, the P&P indicated this organization is committed to protecting and promoting the rights, dignity, privacy, independence and well-being of all residents. During a review of the facility's P&P titled, Dignity revised 10/2025, the P&P indicated each resident is cared for in a manner that promotes and enhances individuality a sense of well-being, satisfaction with life and feelings of self-worth and self-esteem. During a review of the facility's undated Job Description, titled Occupational Therapist Assistant (OTA) the Job Description indicated the OTA works under the supervision of a licensed occupational therapist (OT) to assist with a patient's treatment program in accordance with federal guidelines and state practice acts.		